NHS
Lewisham and Greenwich
NHS Trust

Annual report **2016/17**

Our values

Respect our patients and colleagues

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

Commitment to quality of care

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

Compassion

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

Improving lives

- Deliver the right care in the right place at the right time
- Encourage innovation in all that we do
- Work together for patients

Working together for patients

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

Everyone counts

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

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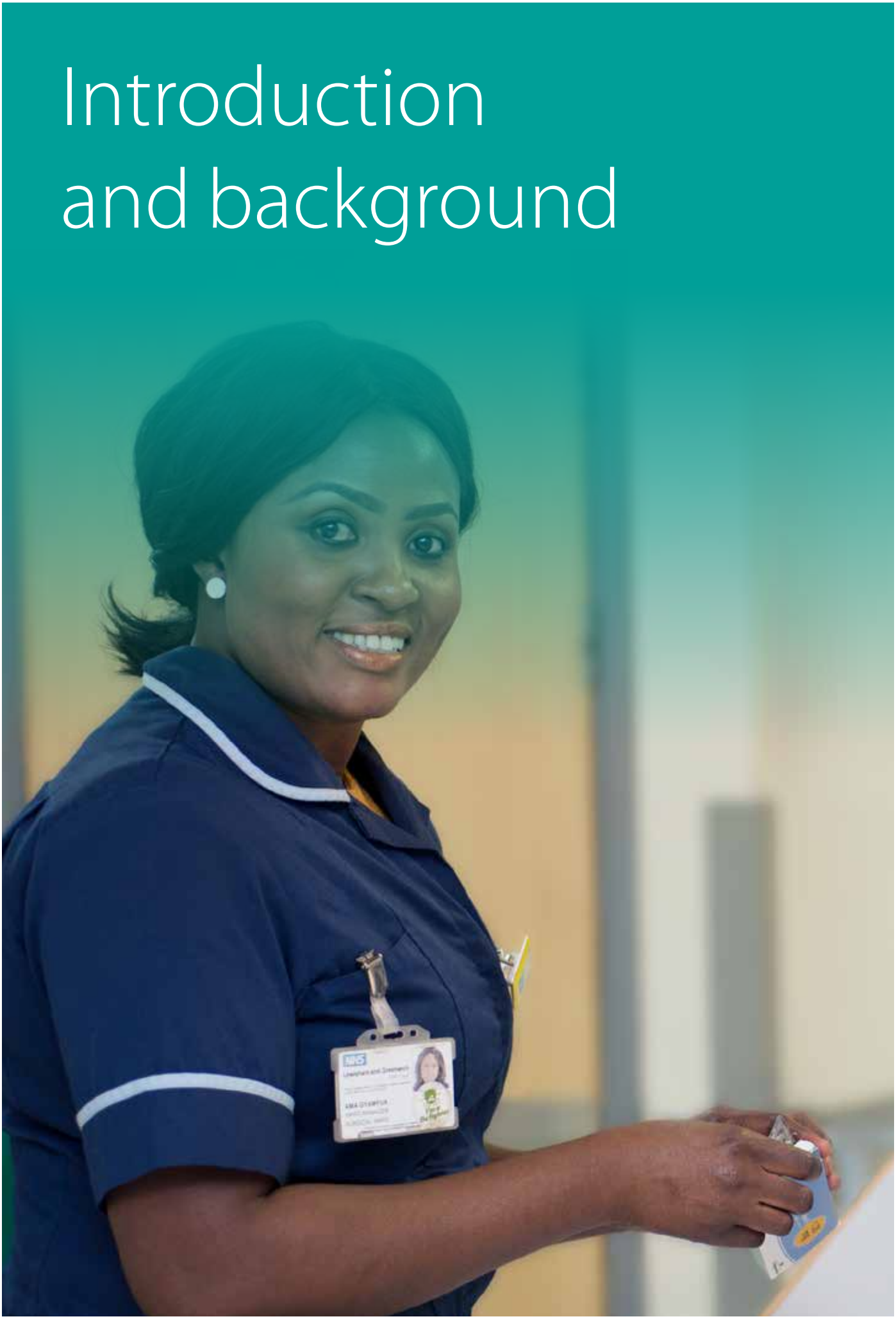
Introduction and background



Chair's foreword 1

We hope you find the annual report a useful guide to our work over the last year. We have also covered how we are continuing to improve quality and safety to meet the needs of local people.

We have made good progress in key areas over the last year. Highlights include providing more timely treatment for patients with cancer (section 8) and expanding theatre capacity so we can treat more patients who need planned surgery within 18 weeks (section 9). In addition, we are using technology to improve patient care (section 14) and have introduced a range of initiatives to improve the experience of both patients and staff (sections 12 and 13). We have made important developments through the "Sign up to Safety" initiative (section 6), including improved staff hand hygiene and a reduction in patient falls in our hospitals.

Our Trust-wide inspection by the Care Quality Commission (CQC) took place between 9 and 11 March 2017. At the time of writing, we have not received the full findings of the inspection yet. In their initial feedback, the CQC commented on the professionalism and caring attitude of the majority of staff they met. The CQC recognised a number of areas of good practice and the improvements we've made since the last Trust-wide CQC visit in 2014.

The CQC also raised serious concerns regarding risks to quality and safety and the emergency care pathway. This is especially the case at Queen Elizabeth Hospital (QEH), where high numbers of people attend our emergency department. Whilst the CQC recognise that we have made improvements to the emergency care pathway, they have told us that we need to do more and we need to do it quickly. This is our key priority, and we have launched a major safety and quality improvement plan with our partners to make improvements across the whole system (see section 5).

I have been a non-executive director and Chair in the NHS for 23 years and it has been my privilege to lead some remarkable organisations and work with outstanding colleagues. Non-executive roles are exceptionally rewarding, not least because they are constantly challenging, interesting and varied. The downside is that they are time limited; this is to ensure that non-executives stay independent minded and their challenge stays strong. Unbelievably, I am coming to the end of my second term of office at Lewisham and Greenwich NHS Trust and will be making way for my successor, with my departure planned for May 2017.

This has been the best job I have ever had, and I would like to take this opportunity to thank everyone I have worked with since becoming Chair of the Trust – including our partners and staff – for the support they have given me and for the support they give to our patients, service users and their families today and every day.

Elizabeth Butler, Chair
April 2017

2 Chief Executive's introduction

Welcome to our 2016/17 annual report.

Once again, I am proud of the way in which staff have worked tirelessly to serve our local communities. We can point to many areas of progress over 2016/17, which you can read about in the following pages.

However, it is clear that we have more to do. As noted by our Chair, Elizabeth Butler in her foreword, we have launched a safety and quality improvement plan following the Trust-wide inspection by the Care Quality Commission (CQC) in March 2017. Delivering the plan is our number one priority over the coming year, and our partners are working hard at the same time to deliver improvements across the whole health and social care system.

You can find out more about our approach to improving quality and safety over 2017/18 in section 5. The safety and quality improvement plan will be a fast moving project and we will issue regular updates on progress. At the time of writing, I am pleased to say that we are already seeing improvements resulting from the work which we and our partners are doing.

This report gives you an overview of recent developments and our priorities for the coming year. We have also looked beyond this and included a section on our vision and our plans to develop our clinical services.

In simple terms, our goal is to get it right for every patient, every time. Clearly, we can only achieve this if our hospitals and community services have the right staff and the right facilities for the future, including both our A&Es. We also need to deal with the financial challenges we face and work with our partners to support the development of community health and social care facilities for people who do not need to be treated at our hospitals. We have been developing exciting plans to do this (outlined in section 18) and to secure the future of the Trust as a high performing organisation. We will continue to engage with partners, the public and staff during 2017/18 to finalise these plans.

Of course, we do not work in isolation, so I would like to thank all our partners for their ongoing support. I would also like to take this opportunity to thank Elizabeth Butler, who is stepping down at the end of May 2017, for all her work as Chair. This has included overseeing the formation of Lewisham and Greenwich NHS Trust in 2013 and many important developments since. I am sure that all who read this report will join me in wishing her all the best for the future.

Tim Higginson, Chief Executive
April 2017

Background

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

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

One Trust – serving our local communities

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

Services and key activities

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

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

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

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

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

"The staff were fantastic – from kitchen to consultant I could not have been looked after any better."

Patient on Ward 17, QEH

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Academic activities and research

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

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

Key improvements since the Trust was formed

We have made many improvements since the Trust was formed in October 2013, including important clinical developments at our hospitals. At Queen Elizabeth Hospital we've developed a birth centre, state-of-the-art centralised pathology services (see section 11), opened a clinical decision unit alongside the emergency department and developed a new discharge lounge. Developments at University Hospital Lewisham include our new ambulatory care centre (see page 17), a kidney treatment centre under construction, additional operating theatre capacity, and expanded stroke services. We have also:

- Made significant health and safety improvements - "Sign up to safety" has reduced serious falls and pressure ulcers
- Recruited more staff – 500 additional permanent staff members since October 2013, and attracted 43 consultant doctors to join our Trust
- Developed stronger links between hospital and community services in Lewisham, Greenwich and Bexley – we set up the "Connect Care" computer system, which enables GPs, hospital staff, district nurses and key staff in health and social care organisations to share important information about the people they care for. For example they can now check which medications a patient is taking or a child's immunisation history. For more information, visit www.lewishamandgreenwich.nhs.uk/connectcare
- Better use of IT and technology – we have introduced electronic patient records across the Trust so that healthcare professionals can get key information at the press of a button. We have also introduced Wi-Fi for staff, patients and visitors and are introducing technology to save staff time when working with patients in the community (see section 15 for more information).

Performance report

4 Overview
Our performance against key targets

The Trust's performance is measured against a number of national and local targets. Information on how we did in 2016/17 is below and in the table on page 12. You can find up-to-date performance data on our website: www.lewishamandgreenwich.nhs.uk/performance.

Emergency department four-hour wait

The national standard is to ensure that 95 per cent of patients are treated within four hours of entering our emergency departments. In 2016/17, we agreed with NHS England a local target of 90.5%.

We did not meet the 90.5% target over 2016/17 at either of our hospitals. Whilst we have made improvements over the year, it is clear that we need to do more and we need to do it quickly. This is our number one priority over 2017/18, and we have launched a safety and quality improvement plan. You can read more about this in sections 5 and 7 of this report, and we will post regular updates about our progress on our website. Our partners recognise that there is a need to make improvements across the whole health and social care system, so they are working with us to deliver the changes needed for our patients.

Infection control

We were set a target of having no Trust assigned MRSA bacteraemia cases in 2016/17. The Trust reported one case of MRSA bacteraemia, which was investigated thoroughly. The case related to a patient who tested positive for MRSA upon admission to University Hospital Lewisham. The patient was treated promptly and was discharged home following their recovery.

Clostridium difficile, also known as C. difficile, is a bacterium that can infect the bowel and cause diarrhoea. Over 2016/17 we reported 23 cases of C. difficile against a target of no more than 39. This is a significant improvement from the previous year, when we reported 37 cases of C. difficile. Although we are pleased to have met our target, we continue to investigate each Trust assigned case of C. difficile so that we can take appropriate action.

Cancer targets

We have provided much more timely treatment for cancer patients in 2016/17. More detail on this work is provided in section 8.

Two-week waiting standard

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

We made a series of improvements over 2016/17 to ensure that we are now meeting the two-week wait target consistently.

31-day standard

Following diagnosis, all patients who need treatment for cancer should begin their treatment within 31 days of the decision to treat. The Trust met this target consistently over 2016/17 following a range of improvements that we introduced during the previous year.

62-day standard

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

Lewisham and Greenwich NHS Trust is meeting the 62-day target for all the cancer patients that we treat ourselves. However some of the patients assessed by us then require treatment at other specialist centres. At present, our official figures on the 62 day standard include breaches when patients are referred to other specialist centres within the agreed timeframe – but then do not start the treatment they need outside the Trust as soon as they should. For patients only treated within Lewisham and Greenwich NHS Trust we met the target for all months other than February 2017.

The way in which cancer treatment performance is reported will change from September 2017 and the new system will more accurately reflect Trusts' performance. In the meantime, like most Trusts, we monitor our true position, and have included it in the table overleaf.

Safer staffing

The safer staffing target specifies the number of nursing and midwifery staff needed to deliver high-quality patient care. We met the target consistently over 2016/17 and actively continue to recruit and retain high quality staff.

Referral to treatment targets

The NHS standard is that 92 per cent of patients should be treated either as an inpatient or as a day case within 18 weeks of referral. We narrowly missed this target in some months during 2016/17, so we are working hard to improve our performance for 2017/18. See section 9 for more information.

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 2016/17.

Childhood obesity

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

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

Breastfeeding

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

We are delighted that our Trust gained level 3 UNICEF Baby Friendly accreditation at Queen Elizabeth Hospital in 2016, and we are working towards this at University Hospital Lewisham. The UNICEF Baby Friendly standards aim to improve the information, support and encouragement provided to parents in order to promote, protect and support breastfeeding and appropriate introduction to solid foods. Level three means that relevant staff have reached the highest level in supporting breastfeeding effectively.

Our community team in Lewisham have met all targets for ensuring that the majority of infants are fully or partially breastfed at 6 to 8 weeks. Again, this is not a target for our Trust in Greenwich as the Trust only directly provides community services in Lewisham.

Mortality data

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

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

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

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

Over 2016/17, Lewisham and Greenwich NHS Trust score was "as expected" (Band 2) in the SHMI.

Meeting our financial targets

We met our financial target for 2016/17, which was to deliver a deficit of no more than £20.2 million. For 2017/18, our target is to deliver a deficit of no more than £22.8 million. This will be challenging as we will have to deal with additional cost pressures of around £12 million due to changes in accounting rules about Private Finance Initiative (PFI) payments. We have joined the national NHS financial improvement programme to identify savings and opportunities to strengthen our financial sustainability over 2017/18.

Performance against key targets 2016/17

National target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Emergency cases: 95% of all patients attending A&E should be treated, admitted or discharged within a maximum of four hours	85.9%	86.3%	83.2%	85.1%	85.9%	86.4%	82.8%	83.1%	81.2%	80.4%	85.1%	87.4%
Infection control: the Trust should have no cases of MRSA bacteraemia	0	1	0	0	0	0	0	0	0	0	0	0
Infection control: the Trust should have no more than 39 cases of Clostridium difficile. The table lists the total number of cases in each month of the year to date (so there was a total of 25 cases over the year)	1	1	3	2	2	2	5	3	1	1	2	2
Cancer: patients should wait no more than two weeks for an urgent referral. The standard is 93%	93.0%	92.8%	92.4%	93.4%	90.1%	93.1%	94.1%	97.0%	97.0%	96.4%	96.0%	96.4%
Cancer: patients with symptoms of breast cancer should wait no more than two weeks for treatment following an urgent referral. The standard is 93%	89.9%	81.8%	93.6%	86.8%	88.6%	90.8%	99.0%	93.3%	98.7%	98.7%	98.3%	98.2%
Cancer: patients should not wait more than 31 days from confirmed diagnosis to treatment. The standard is 96%	98%	99%	100%	100%	100.0%	96.8%	100.0%	100.0%	98.6%	97.7%	97.1%	99.0%
Cancer: patients should not wait more than two months for treatment from GP referral. The standard is 85%	79.0%	85.1%	88.2%	80.6%	80.4%	84.4%	82.0%	79.1%	89.1%	75.9%	72.6%	83.5%
Cancer: patients should not wait more than two months for treatment from GP referral. The standard is 85% (using new breach allocation rules effective from Sept 2017)	78.0%	83,9%	88.6%	82.5%	82.2%	85.6%	87.0%	85.3%	93.0%	79.7%	72.4%	84.5%

National target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer 62 day performance excluding shared pathway patients	88.7%	94.8%	95.9%	90.2%	86.0%	93.6%	92.0%	90.0%	97.8%	91.5%	81.3%	88.4%
18 weeks target: patients who have not been treated yet should not have waited longer than 18 weeks. The standard is 92%	91.5%	91.7%	92.1%	92.1%	90.9%	91.7%	91.0%	92.2%	91.7%	91.0%	90.6%	90.7%
Safer staffing: we should be meeting 90% of staffing requirements	95.6%	96.1%	96.0%	93.6%	94.9%	98.6%	97.9%	99.4%	96.8%	99.2%	98.4%	98.3%
95% of inpatients should receive a VTE assessment	95.5%	95.5%	95.1%	95.0%	95.8%	95.6%	95.2%	95.9%	95.8%	96.6%	96.5%	96.2%
Breastfeeding: ensure the feeding status of 95% of infants is checked within 6-8 weeks after birth	98.6%			95.2%			97.9%			98.7%		
Breastfeeding: ensure that 72.5% of infants are fully or partially breastfed at 6-8 week check	75.8%			76.9%			76.9%			77.35%		
Childhood obesity: ensure that 87% of children in reception are measured as part of the Government's National Childhood Measurement Programme	Annual figure of 94.1% (academic year 2015/16)											
Childhood obesity: ensure that 87% of children in Year 6 are measured	Annual figure of 93.4% (academic year 2015/16)											
Standardised Hospital Mortality Indicator (SHMI)	1.01			0.99			1.003			0.99		

5 Safety and Quality Improvement Plan

The Care Quality Commission (CQC) carried out an unannounced inspection of the emergency department and medical services at Queen Elizabeth Hospital (QEH) in June 2016. The CQC gave the QEH emergency department and medical care an overall rating of "Requires Improvement".

We then received a Trust-wide inspection by the CQC between 9 and 11 March 2017. Tim Higginson, Chief Executive, explains: "We have not received the CQC's full report yet, but in their initial feedback to the Trust, we were pleased that the CQC recognised a number of positive developments.

"However, the CQC did raise serious concerns about risks to safety and quality and about the emergency care pathway – particularly at Queen Elizabeth Hospital (QEH), where we have high levels of attendances through the A&E. The CQC acknowledged that we had been doing the right things to improve the emergency pathway, but said that the pace of change needed to be faster.

"In response, we have launched a Safety and Quality Improvement Plan to address the patient safety issues highlighted by the CQC. Delivering this plan is our main priority over 2017/18.

"Our partners recognise that improvements are needed across the whole health and social care system and are working with us to make these happen. Within the Trust we have four key priorities, with work in each area led by a Trust director. These are:

- Improving patient flow
- Clinical leadership
- Improving safety and quality of care
- Upgrading our working environment.

"You can read background information on each of these areas of work below. We will be issuing regular progress reports on all the safety and quality work which we – and our partners – are doing, on our website: www.lewishamandgreenwich.nhs.uk."

Improving patient flow

Lee McPhail, Director of Service Delivery

"We have started a project to improve the flow of patients through QEH. In short, this means increasing how many patients we discharge every day – which frees up beds in the hospital so patients can be transferred from our emergency department to wards in a timely manner. All of this improves the patient experience and helps ensure that patients are treated in the right place at the right time.

"We are improving our processes – for example ensuring that we run our wards and clinics in the right way to support flow through the hospital. Our discharge lounge at QEH provides a comfortable waiting area for patients who are ready to return home. By using this as soon as patients are fit for discharge, we can free up beds earlier in the day. We are taking the same approach as we did recently at University Hospital Lewisham, where we have succeeded in increasing how many patients we discharge every day, as well as ensuring that more patients are discharged earlier in the day.

"Our focus is on the discharge of patients who are well enough to return home. Our partners are working with us to ensure that care is in place for patients who have more complex health and social care needs so that their discharge is not delayed."

Clinical leadership

Dr Elizabeth Aitken, Medical Director

"We need to make sure that all our clinical experts are at the heart of our improvement plan and fully involved in making these changes which are needed for patients. To achieve this, we are working to improve clinical engagement and strengthen leadership. We need to identify and implement changes in how we work – principally, but not exclusively, in the emergency care pathway.

"We have a range of projects underway, including ensuring timely appropriate investigations with new ways of working in a number of areas reviewing the ordering and timing of diagnostic investigations. We are also working with our partners to reduce hospital admissions by providing treatment as an outpatient."

Improving safety and quality of care

Selina Trueman, Interim Director of Nursing and Infection Control

"We have made improvements to how we monitor safety and quality of care for patients who come through our emergency departments, so we can take early action if issues arise. As part of this, we are running hourly quality and safety rounds in the emergency departments at both our hospitals.

"We have also commissioned the Good Governance Institute to review our governance processes, including our systems for monitoring safety risks and issues – from ward to Board. This review will be completed by the end of April and will inform our improvement plan."

Upgrading our working environment

Keith Howard, Director of Estates

"We have major plans to improve the clinical facilities at QEH, including these initiatives which we will be starting in 2017:

- Additional capacity for the Acute Medical Unit to be created alongside the Emergency Department
- A new hospital front entrance, to give us extra room and the opportunity to redesign the emergency department
- Major investment in the hospital's infrastructure
- An expansion and upgrade of the Intensive Care Unit
- Improvements to the Urgent Care Centre.

"As well as the above, we will make a range of other improvements across both our hospital sites. We are working with staff and patients to ensure that we have the right working environment to deliver safe quality care."

6 Quality and safety developments over 2016/17
Patient safety

Sign up to Safety

In July 2014 we joined the national "Sign up to Safety" initiative in which NHS trusts made a commitment to reducing avoidable harm.

We have made significant improvements to safety through this initiative, as outlined in the table below.

Sign up to Safety – our progress

Goal	Progress
Improve hand hygiene compliance with staff	We continued to promote hand hygiene through our staff training programme and ran a high profile 'clean your hands' campaign. We assess progress by carrying out regular audits, with staff in each clinical area monitoring whether colleagues are cleaning their hands correctly. In 2017, our audits showed 95% per cent of staff were meeting hand hygiene guidance for cleaning their hands. This is an improvement from 2014/15 (when we launched the Sign up to Safety programme), when audits showed 91% of staff met the guidelines. Our goal is for 100% of staff to clean their hands correctly, so we will continue to promote hand hygiene in 2017/18.
Identify when the health of a patient starts to get worse suddenly through blood poisoning or infection (sepsis), so early action can be taken. This helps to save lives and reduces avoidable heart attacks	Since joining the Sign up to Safety programme, we have introduced a new observation scoring chart across the Trust – so that staff monitor patients' conditions in line with best practice guidelines and can take any early action needed. We have also appointed staff to lead on sepsis in key clinical areas. We have reduced avoidable heart attacks significantly since launching the Sign up to Safety programme. We are on track to achieve an overall reduction of 10% by the end of 2017.
Improve the safety of maternity services	Our safety improvements include ensuring maternity staff have had additional training on fetal heart monitoring to ensure early action is taken when we detect risks to babies' health. All our midwives have also been issued with electronic handheld fetal heart monitoring devices.
Protect patients from developing pressure sores	We have introduced an enhanced staff training programme to meet best practice, and ensure patients at risk of developing pressure sores are monitored regularly.
Improve medication safety	No patients suffered severe harm from medication incidents in 2016/17.
To reduce the incidence of harm from patient falls	Over 2016/17, the number of serious injuries caused by patient falls has continued to decrease.

Protecting our patients from flu

One of our goals is to protect patients and visitors from flu by ensuring that our staff have the flu vaccine.

We ran a major campaign in 2016/17 to increase uptake of the flu jab amongst our frontline healthcare workers. By the end of January 2017, 80% of frontline staff had taken the flu jab, doubling the number of frontline staff who were vaccinated the previous year over the same period. As a result, the Trust was shortlisted for a 2017 Flu Fighter Award in the 'Most Improved Campaign' category.

Sam Platt, Matron in Critical Care and Pain Management, explains: "Flu is a serious illness, and every year we treat patients in critical care because of flu. The Trust has done a huge amount of work to encourage staff to get the flu jab, with a range of clinics for staff and visits to each clinical area from a flu nurse. We also ran an extensive campaign to combat common myths – ie that the flu jab can give you flu (which is not true!).

"All this work has made a huge difference in ensuring many more staff get the flu jab, protecting our patients against illness."

Emergency care improvements 7

"We have been developing services to provide early treatment and reduce the need for hospital services. However, we need to do more, and building on this work will be our main priority over 2017/18."

Dr Elizabeth Aitken, Medical Director

One of the Trust's key objectives is to ensure everyone who needs emergency care gets treatment in a timely manner. Despite improvements to the emergency care pathway over 2016/17, we failed to meet NHS standards at both University Hospital Lewisham (UHL) and Queen Elizabeth Hospital (QEH). Delivering improvements over 2017/18 is our main priority as an organisation, particularly at QEH where the demand for our services is especially high. Our partners recognise that improvements need to be made across the whole health and social care system and are working with us to make these. Our safety and quality improvement plan for 2017/18 is described in more detail in section 5 of this report.

Over 2016/17, the Trust has been developing "ambulatory care" services – providing early testing such as X-ray and ultrasound for local people in an outpatient setting, with results reviewed by specialist consultants. The new £1.2m Ambulatory Care Centre at UHL was officially opened in December 2016 by Terry Waite MBE. We are also working to expand the ambulatory care offered at QEH by summer 2017.

Dr Elizabeth Aitken, Medical Director, explains: "Ambulatory care helps patients to get the treatment they need sooner, avoiding unnecessary hospital admissions and reducing pressures on the hospital's emergency department. Ambulatory care also means that some patients can safely be discharged sooner, as we can schedule follow-up appointments for patients to return and have tests as an outpatient."

Over 2016/17, we have been reviewing how we can improve the flow of patients through the hospitals. We continue to work with partners to improve the discharge process and free up hospital beds by enabling patients who do not need to be in hospital to return home sooner. As part of this work, we have appointed care navigators to manage the discharge of patients who have a complex set of health and social care needs, so we can speed up the process for them.

We are also expanding our Rapid Assessment and Treatment (RAT) services at both hospitals – to ensure early treatment for patients who do not need to be admitted to hospital.

"All of the staff were very friendly and we cannot praise them enough."

Patient treated at A&E, UHL

8 More timely treatment for cancer patients

"We have made huge progress in providing more timely care for cancer patients."

Mr Kislaya Thakur, Consultant Breast Surgeon and Clinical Director for Cancer

Early treatment for cancer saves lives, and over the last year our clinical leads for cancer have been making improvements to ensure that patients get the right treatment sooner. Mr Kislaya Thakur explains: "We have focused on seeing patients as soon as possible after a referral; we are now seeing more people within just seven days. Where possible, we are arranging for people to have tests before their first appointment with a consultant – this gives their doctor more information sooner and reduces the number of trips our patients have to make to the hospital, and ensures they get the right treatment sooner."

Lee McPhail, Director of Service Delivery, adds that working closely with other providers of cancer treatment is key to making sure patients get timely treatment: "Our weekly phone calls with cancer treatment partners look at the details of every single patient referred to ensure there are plans in place for their treatment. We have also been making sure that, when patients need treatment at specialist centres, we refer them as early as possible. We are now meeting the target for referring patients by day 38, and often doing it much sooner."

Over 2017/18, the Trust is holding a series of workshops to review each part of the patient journey for cancer patients – so we can look at how we can improve and ensure that we get it right for every patient every time. These workshops will involve the Trust's clinical leaders, GPs, patients, national teams (such as the NHS Transforming Cancer Services team) and commissioners. Other NHS providers are also invited, so that we can learn how others are implementing best practice.

One of the challenges is coping with rising demand for cancer tests; the NHS as a whole is expecting a 7% increase in cancer tests each year between now and 2020/21. Many cancer tests involve using a fibre optic camera called an endoscope to look inside patients and take biopsies. As a result, our Trust needs to improve endoscopy services and in 2017/18 we will be upgrading our endoscopy suite at Queen Elizabeth Hospital. We are also applying for funds from NHS Improvement to expand endoscopy services at University Hospital Lewisham.

"Our focus is on providing timely treatment for our patients, and we are expanding our theatre capacity to do so."

Mr Midhat Siddiqui, Consultant Surgeon and Director of Surgery

Meeting the 18 week target consistently has been challenging over 2016/17. The reasons for this include additional pressures on the hospital over winter and a reduction in theatre capacity at Queen Mary's Hospital.

Mr Midhat Siddiqui explains: "We have clear plans to address the longer waiting times experienced by patients in the areas where we have had problems, namely orthopaedics, ear, nose and throat, gynaecology and neurology. To clear the backlog of patients waiting for treatment by March 2017, we provided extra surgery sessions at weekends. In the longer term, we are expanding our theatre capacity to cope with increasing demand for services and to help us meet the target."

At University Hospital Lewisham we are building a new state-of-the art operating theatre complete with a specialist air filtering system called "laminar flow", which is part of the infection control system. The theatre will be dedicated to orthopaedic surgery and will enable the Trust to meet the demand for referrals. The new theatre will be ready by summer 2017.

At Queen Elizabeth Hospital a theatre that was no longer in use is being recommissioned to provide extra capacity for all surgical specialties. This will be ready by April 2017, and will mean more patients receive timely treatment – meeting increasing demand and helping the Trust to meet the 18 week referral to treatment target.

The Trust is also running a major programme to improve how we manage our operating theatres. Our focus is on ensuring that theatre lists are not cancelled for non-clinical reasons. In addition, we are reviewing our internal processes – for example making sure that beds will be available so that we can start theatre sessions on time, theatre lists are fully booked, and reducing the waiting list for emergency surgery. This work is being led by our clinicians with the support of the Trust's transformation team.

Finally, we are working to manage winter pressures to ensure that our surgical beds are not used as escalation areas when the emergency departments are extremely busy and we need to admit a high number of patients. The work with our health and social care partners around managing emergency pressures (see section 7) will help with this, as – in the longer term – will our plans for the future (see section 18).

"Everyone was a great mix of professional and friendly. I was given all the attention and time I needed."

Patient after their pre-op assessment at University Hospital Lewisham

10 Developing our maternity services

"Over the last year, our award-winning midwives have continued to go the extra mile for local people. In addition, we have been working to meet the national recommendations from the 'Better Births' review, which was one of the Trust's objectives for 2016/17."

Helen Knower, Director of Midwifery

Midwifery team of the year

Our midwives were named "Midwifery Team of the Year" for 2016 by the Royal College of Midwives (RCM), and received a visit from the RCM's patron, HRH The Princess Royal, in February 2017 to mark their achievement.

The RCM awarded the midwives this prize for their commitment to excellence and the innovative approaches they use to provide maternity services to local women and their families, as well as for improving team working, staff involvement and motivation.

Some of the initiatives which the team have implemented include "Whose shoes?" which is an interactive workshop designed to improve the maternity experience through hearing the experiences and thoughts of both mothers and fathers. Our maternity service has also developed an electronic midwife called Edie the e-midwife. Women can ask questions via email or Twitter and a qualified midwife responds within 48 hours.

Promoting better health

As well as being the 2016 Midwifery Team of the Year, Lewisham and Greenwich NHS Trust's maternity team also won the RCM's 2016 Public Health Award. This was for our "Active Mothers in Bexley" project which was set up and led by midwife Sherrie Barnes. The project supports pregnant women to manage their weight effectively during and after pregnancy by providing exercise classes and support from a range of experts, including physiotherapists and health visitors.

Cathy Warwick, Chief Executive of the Royal College of Midwives, commented: "To win an RCM award is a real achievement; to win two is simply stunning. I congratulate the whole team on this achievement and thank them and their colleagues for their dedication, skill and commitment to mothers, babies and their families."

Other award-winning maternity staff

Staff at Lewisham and Greenwich NHS Trust have also won the British Medical Journal's (BMJ) Student Midwife of the Year Award for the last two years. In 2016, Heidi Stone won the award, followed by Claire Axcell in 2017. Vikki Coleman, Practice Based Clinical Facilitator and Supervisor of Midwives, said that, as well as promoting individual achievement, the awards were "testament to the fantastic mentoring that our midwives give at Lewisham and Greenwich NHS Trust."

In addition, Pip Stalberg, the Trust's Full time Supervisor of Midwives, was named Supervisor of the Year in February 2017. This award was in recognition of Pip's work in supporting midwives and families who use the Trust's maternity services.

Meeting national "Better Births" guidelines

We have been working to meet the national "Better Births" guidelines for providing continuity of care and ensuring that each woman's care is personalised.

Helen Knower, Director of Midwifery, explains: "We have introduced new guidelines to ensure that we have discussions with pregnant women about their birth choices as soon as possible. This means we can support women and give them more choice.

"We have also made a range of other changes, including introducing the new role of consultant midwife. This role supports pregnant women and ensures that they get continuity of care from our midwives.

"In addition, we have set up a new team to support women at risk of having a premature birth, for example if they are heavy smokers, or are expecting more than one baby."

"I received kind help and reassurance today when I was feeling vulnerable – it was so appreciated."

New mum after midwife visit

"We are committed to serving our local communities and have been developing services to meet their needs."

Tim Higginson, Chief Executive

New urology service closer to home

In summer 2016, we launched a new urology service to provide treatment closer to home for local people with health problems related to the kidneys, ureters, bladder, prostate and male reproductive organs.

Patients can now be treated at the Queen Elizabeth Hospital (QEH) and we offer planned urological surgery in a new theatre at University Hospital Lewisham (UHL). This means that urology patients who previously had to travel to the Princess Royal University Hospital can now be treated locally.

Consultant Urology Surgeon Mr Mohamed Hammadeh explains the benefits: "This new service offers local people an improved service closer to home and they will be treated in a specially allocated theatre so we can maximise the numbers of patients we can treat in a day. With the increased numbers of patients with urological problems, this investment in developing services will be really beneficial to local people."

Improving pathology services

In 2016 we consolidated our microbiology services at QEH, moving services from UHL. This has enabled us to invest in new technology to provide faster, more accurate test results.

Dr Tacim Karadag, Consultant Microbiologist, describes the improvements: "We have invested in the latest technology and equipment, such as molecular diagnostic testing for suspected viral meningitis. In the past, our Lewisham laboratory had to send these tests to a reference laboratory in Cambridge for analysis and it could take up to a week to get the results back. Now, we can carry out the tests ourselves and get the results back within 48 hours.

"With the newly purchased machines in the laboratory, we can now do many more tests in-house. This is much faster and better value for money."

Developing a kidney dialysis unit

In 2016, work began on building a new satellite kidney dialysis unit on the site of University Hospital Lewisham, in partnership with Guy's and St Thomas' NHS Foundation Trust.

Due to open in early 2018, this new unit will provide accessible dialysis for local people. It will also ensure that inpatients at UHL do not need to be transferred to another hospital for routine dialysis – ensuring continuity of care, and helping patients to recover faster and return home sooner.

The new unit will also provide dialysis for UHL patients who are currently transferred to the Intensive Care Unit (ICU) for urgent dialysis. This will help free up beds in our ICU for patients most in need.

"I think the staff are all amazing people and it has changed the way that I look at the National Health Service."

Patient on Larch Ward, University Hospital Lewisham

12 Patient experience
Improving patient experience

"We work closely with local people and patient representatives to make improvements for visitors and service users."

Sophie Gayle, Associate Director of Patient Experience and Quality Improvement

Meeting the needs and expectations of patients and stakeholders

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

Jan Ferrari, Chair of the Patient Welfare Forum, explains the difference their feedback and ideas make says: "During the past year PWF members have visited all of the wards and outpatient clinics in University Hospital Lewisham, talking to over 200 patients and carers (and also staff) about their experience. Working with the Trust's Patient Experience Team, our feedback to the Trust has contributed to a range of improvements – such as clearer appointment letters, better information about waiting times in clinics and improved signage to help patients and visitors find their way around. Some of our members also attend Trust-wide committees, including patient experience, complaints and catering, to represent the voice of the patient."

Judy Lyons from the Patient User Group describes how they ensure suggestions from patients are acted on: "The past year has seen a steady growth in the number of PUG volunteers which allowed us to complete more observations not only of wards but also outpatients at Queen Elizabeth Hospital. Perhaps more importantly it means we have been able to revisit sites to check that promised actions and commitments have been fulfilled thus completing the 'quality circle' ensuring a better experience for both patients and visitors. We continue to work collaboratively with the Trust's Patient Experience Team and have assisted with a number of audits including wheelchairs, information leaflets and public seating."

New visiting hours

As a result of seeking patients' views, we have changed the visiting hours at both University Hospital Lewisham and Queen Elizabeth Hospital to reflect the needs of vulnerable patients and promote the benefits of contact with family and friends.

The key changes to visiting are:

- Open visiting for up to two named immediate family members or carer as identified in the patient's care plan.
- The Trust has signed up to 'John's Campaign'. This initiative calls for the right of patients with dementia to have their carers available to support them in hospital for as many hours as they are needed, and as they are able to give, providing the comfort or wellbeing of other patients is not compromised.
- Introduction of a carers' passport so that carers of vulnerable patients can be identified and have open visiting access. This allows carers to continue to be involved in aspects of the patients care such as meal times, personal care and to stay with them overnight. We will try to accommodate visitors who wish to stay overnight as long as the wellbeing or comfort of other patients is not compromised.
- Visiting hours from 3.00-8.00pm for all other family and friends, limited to two people at any one time.

Sophie Gayle explains: "Our revised policy aims to provide a consistent approach to visiting across our adult inpatients areas and reflect the needs of vulnerable patients. We recognise that contact with family and friends is an important part of the patient's day and this promotes wellbeing."

Visiting hours in areas where patients receive specialist care, such as the intensive care unit and children's ward, are tailored to suit the needs of the patients. The visiting hours for these areas can be found on the Trust's website (www.lewishamandgreewnich.nhs.uk) or from the individual unit.

Of course, in special cases, such as when a patient is terminally ill, we are flexible about when patients can see visitors.

"For me only one word to describe the nurses. ANGELS!"

Patient on Ward 4 Queen Elizabeth Hospital

The care and attention has been second to none. Staff have been friendly and informative throughout.

Patient on Ward 3 Queen Elizabeth Hospital

Improving services for people with dementia

The Trust is introducing lots of ways to improve how our services are experienced by people with dementia. This has included providing additional training to help staff develop their understanding of the challenges faced by people with dementia, so that we take this into account when we are providing care.

Over 2016/17, with our encouragement, over 200 staff became "dementia friends" – gaining a better understanding of dementia and encouraging staff to volunteer and help people this condition. We also introduced "dementia clocks" on our wards, which display the date and time much more clearly than normal clocks – to help patients and visitors with dementia to keep track of the time.

In February 2017, the Trust opened a new "sensory room" on one of the older people's wards at University Hospital Lewisham. Ginnie Adamson, dementia nurse, describes it: "The sensory room is quite unlike your standard hospital environment: it has a laser sky projector that displays moons and stars on the ceiling, there's a bubble wall and sensory lighting and a tactile wall. A sensory magic computer is used for reminiscence, relaxation and music. This room really helps people with dementia by reducing stress and anxiety, and helps to lift patients' moods. Families also enjoy time in in it away from the hustle and bustle of the ward. Following the successful opening of this sensory room at UHL, we are developing one for patients at QEH to open later in 2017."

Helping intubated patients with communication

The Trust's Speech and Language Therapy team is using the latest technology to help patients who cannot talk because they are intubated or have a cuffed tracheostomy to communicate.

Hospital patients can use "eWriter" tablets to write messages for their family or hospital staff. Or patients can pre-record messages to play when they are unable to speak. Speech and Language Therapist Beth Shakespeare explains what a difference this makes: "In the past staff got by with picture and alphabet cards. These new high-tech aids, paid for by the Trust's charitable funds, make so much difference to our patients and hopefully relieve many of the frustrations that patients feel when they cannot talk."

PALS and complaints

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

During 2016/17 we received 743 complaints, which was over 500 fewer than in the previous year (when we received 1,250 complaints).

Complaint themes over 2016/17

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

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

We have made a range of improvements as a result of complaints, such as:

- Open visiting is now in place on all adult inpatient wards
- Comments boards with ideas boxes are in place at UHL, and we plan to for install them at QEH site over 2017/18. These provide further opportunity for patients to share their ideas or comments with us.
- Buying a number of recliner chairs for wards so that, where appropriate, family members can stay with our patients.

13 Developing our workforce
Improving staff experience

"We have introduced a range of initiatives to support our staff who go the 'extra mile' every day."

Janet Lynch, Director of Workforce and Education

Staff wellbeing programme

We have launched a new programme over 2016/17 to improve the health and wellbeing of staff. Fay Blackwood, Associate Director of Workforce and Education, describes what we offer: "We have been working with staff to put together a comprehensive wellbeing programme. This includes activities led by staff, including Pilates classes, a running club, Aquafit, mindfulness sessions, football – to name just a few. These are in addition to other activities which were already underway, such as the regular staff health and wellbeing roadshows and the staff physiotherapy service." We also have an excellent suite of face-to-face training programmes and online resources to expand and support mental wellbeing.

The Trust also offers an employee assistance programme, offering all staff confidential advice and counselling.

New staff benefits scheme

We have launched a new partnership with Connected Benefits, one of the UK's leading providers of innovative employee benefits schemes. Lisa Brown, Workforce Programme and Projects Manager, explains: "We are delighted to have made this agreement with Connected Benefits. The new web platform offers our staff access to a range of benefits and discounts, including on cars, electrical goods, cycles and childcare vouchers. We are also working hard to promote local discounts and offers for NHS staff."

Celebrating our staff

We celebrate staff who go the extra mile through our annual staff awards. In 2016, the awards were funded by generous donations from the Trusts' partners: Abbey Travel, Capsticks, Interserve, ISS World, Meridian Hospital Community, Muffin Break and Vinci Facilities.

Staff at the Safari Children's Inpatient Ward at Queen Elizabeth Hospital (QEH) were named winners of the "Healthcare Heroes" award. They were nominated by Sonia Sankoli, aged 32 from Bexley, who said: "My son, Dhian Hari Singh Sankoli, was diagnosed as having a life limiting genetic condition when he was 10 days old. When he was four months' old, he was admitted to the Safari Children's ward with bronchitis and we remained there for eight weeks before he sadly passed away.

"The care was extraordinary. He was seen by 22 nurses, and each went the extra mile, often staying late to check we were all ok. I always had help for tasks like giving Dhian a bath and so I never felt alone; before long the staff were like an extension of our family.

"Everyone went the extra mile for us – putting us in touch with a local hospice, other families and giving us training on feeding equipment. One of the nursing team suggested we put Dhian in a special seat to help with his support and breathing. I cannot tell you how happy this seat made my son; some of my best memories I have of him are sitting in that chair."

Since Dhian Hari Singh Sankoli passed away, Sonia and her husband Sandeep have been raising money for QEH to develop a new sensory room that will aid other children who have complex needs with their development skills. They started fundraising in May 2016 have already raised £18,500.

Elizabeth Butler, Chair of Lewisham and Greenwich NHS Trust, said: "Sonia and Sandeep Sankoli are special people and we cannot thank them enough for the support they continue to give to our hard working and dedicated staff. Dhian made a lasting impression upon everyone who met him, and the development of a sensory room will be a wonderful legacy to him."

"You cannot control when you fall ill, and we are working to ensure that patients get the best treatment 24/7, so that you do not have to wait until Monday for your investigations or specialist review."

Dr Elizabeth Aitken, Medical Director

It is important that patients receive the best care possible 24/7, including outside normal working hours and at weekends, when research shows there can be higher mortality rates for patients across the NHS. During 2016/17, we continued working towards meeting national standards around seven day working. Across England four priority clinical quality targets for seven day working must be met by NHS Trusts for all patients by 2020, as follows:

Standard 2: Time to consultant review

All patients admitted as an emergency must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time they arrive at hospital.

Standard 5: Access to diagnostics

Hospital inpatients must have scheduled seven-day access to diagnostic services such as X-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and their reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients.

Standard 6: Access to consultant-directed interventions

Hospital inpatients must have 24-hour access, seven days a week, to consultant-directed interventions either on-site or through formally agreed networked arrangements with clear protocols, such as:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery.

Standard 8: Ongoing review

All patients on the Acute Medical Unit, Surgical Admissions Unit, Intensive Care Unit and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care, consultants should be working multiple day blocks.

Once transferred from the acute area of the hospital to a general ward, patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

There is a national requirement to audit performance against these standards twice a year to review progress in April and September.

The Trust has integrated the plans to deliver 7 day working within our wider improvement plan and we continue to make incremental improvements to delivery as we work towards full achievement by March 2018. Progress during 2016/17 demonstrated an improvement in Time to Consultant review (Standard 2) and Ongoing review (Standard 8).

Our improvement plans at both hospitals are addressing workforce and equipment issues to enable us to deliver the required standard for Access to diagnostics.

September 2016 figures showed that across South East London some patients were not always able to get an MRI scan quickly enough at evenings and weekends; these gaps are being addressed by the Trust and our partners through the Urgent and Emergency Care Network.

At the time of writing we are waiting for the results of our April 17 audit, and continue to review at each hospital to ensure we are making progress against our plans.

15 Better use of technology
Bringing new benefits to patients and staff

"We are enabling staff to work more efficiently, including being able to access records on the move, and we're working with GPs and other health and care organisations to provide a secure but easily accessible shared care record which will improve patient care."

Dr John O'Donohue, Consultant in Gastroenterology and Clinical Lead for IT

Free patient and staff Wi-Fi

In November 2016 we implemented free staff and public Wi-Fi access at both Queen Elizabeth Hospital (QEH) and University Hospital Lewisham (UHL). We will be extending Wi-Fi to the Kaleidoscope children's centre and Waldron Health Centre, which we run in the Lewisham community, by May 2018. We are also planning the introduction of free Wi-Fi across our other sites in the community.

Using new technology

The Trust is working to help clinicians to carry out their clinical duties faster and more easily using convenient and accessible digital tools. Dr John O'Donohue explains how new technology helps: "On the wards, doctors and other clinical staff may want to look at records and test results at the patient's bedside, not just at a workstation. We have introduced a new app – called LGT Portal – which enables our staff to use their own mobile devices for this. This is highly secure and will help frontline staff to focus on patient care."

Introducing new ways of working for community staff

We have also introduced a more responsive and flexible mobile working system for 150 of our community staff. Mobile technology is scheduled to be completed for other staff in the community over 2017.

Meredith Deane, Divisional Manager for Acute and Emergency Medicine and Programme Lead for Mobile Working, says: "In the past, many staff were finding that they were having to travel back to the office to write up patient notes, and they couldn't access patient records when they were with patients. We have given staff laptops which they can use to access records any time – enabling them to spend more time on patient care and less on admin."

We are looking at options to extend mobile working to both clinical and non-clinical staff to support more flexible ways of working.

Improving access to patient notes

Whilst the Trust has introduced electronic systems for patient records, we still have lots of written medical notes, and getting hold of these can take some time. So we will be introducing a new system to help staff access medical records much quicker, significantly reducing admin for healthcare professionals and support staff. By introducing Radio Frequency Identification (RFID) technology later in 2017, we will make records faster to file and retrieve.

Reducing our carbon footprint

Introduction

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

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

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

Sustainable Development Management Plan

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

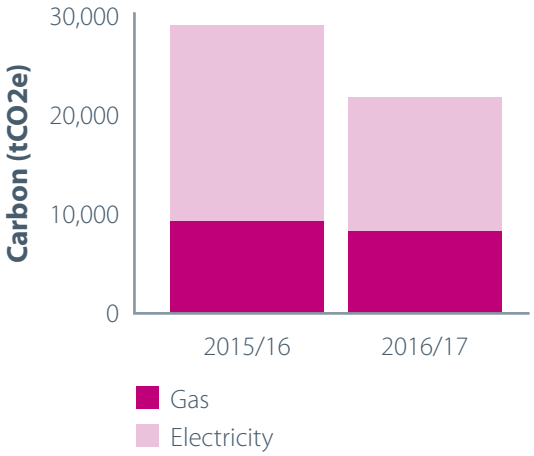
As an organisation we acknowledge our responsibility towards creating a sustainable future. To help us achieve that goal we run awareness campaigns that promote the benefits of sustainability to our staff.

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

Energy use over 2016/17

Lewisham and Greenwich NHS Trust spent £4,062,624 on energy in 2016/17, which is 1.6% less than we spent on energy last year.

Carbon emissions – energy use



Travel

We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public who use our services.

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.

17 Building for the future
Trust objectives

Trust objectives 2017/18

We aim to get it right for every patient, every time.

We have developed a trust wide Safety and Quality Improvement Plan and our trust objectives for 2017/18 are focused on delivering that plan at pace.

1. **Deliver all aspects of our Emergency Care Improvement Plan. Our key objectives include:**
   - Improving the flow of patients through our emergency care pathways at both of our hospitals
   - Developing the frailty pathway further to meet the needs of our older patients
   - Improving the discharge experience for all our patients.

2. **Improve the safety and quality of our care and actively respond to identified risks ensuring we are focused on getting the best results for patients every time by:**
   - Delivering the key national performance standards, such as the 4-hour A&E standard, the 18 week referral to treatment standard and the national cancer targets
   - Improving the safety of our patients in critical care through improved multi-disciplinary working and governance processes
   - Fostering a continuous learning environment through regularly reviewing how we can improve
   - Working with our staff and patients to make safety and quality the focus of all improvements and change.

3. **Engage our workforce to deliver our Safety and Quality Improvement Plan by:**
   - Ensuring our workforce is resourced and deployed effectively to enable the Plan's delivery
   - Empowering staff to make the improvements they know are needed and to take responsibility for their personal practice
   - Improving staff experience to help us attract and retain staff and reduce our agency use
   - Improving the engagement of our clinical staff and increasing visibility of our clinical leaders
   - Implementing a Clinical Leadership Development Programme.

4. **Ensure the financial stability of the organisation:**
   - Making the best use of resources in the interests of safe and quality patient care
   - Taking part in the NHS Financial Improvement Programme and implementing plans for financial improvement, targeting a plan to return to financial balance.

5. **Commence the delivery of the Trust clinical service strategy with estate development as a key enabler. We will:**
   - Begin to implement the plans for our hospital sites to ensure that we make the best use of local NHS estate for the benefit of our patients
   - Deliver the planned improvements to our facilities, including starting the programme of infrastructure upgrades to improve the clinical facilities at QEH
   - Continue the work with partners in Lewisham to develop integrated care and new ways of working, including improvements to community facilities.

6. **Use information technology to support improvements to patient care by:**
   - Getting the right information to the right people, at the right time and place
   - Using information to help us plan and provide the most appropriate prevention and treatment programmes for our patients.

7. **Work effectively with partners to deliver the South East London Sustainability and Transformation Plan to optimise the resources available for patient care.**

Key risks to the Trust achieving our objectives

The key risks to the Trust achieving our objectives are outlined below.

Risks to improving the emergency pathway

At present, there are cramped facilities for emergency care, particularly at QEH where we do not have escalation areas. We are working to address this over 2017/18 by making necessary changes to the working environment through our safety and quality improvement plan (see section 5). We are also working to improve the flow of patients through our hospitals to free up hospital beds and enhance patient safety (section 5). In the longer term, we are also working to upgrade the emergency department at QEH (see section 18).

The infrastructure of the building at QEH is no longer fit for purpose. As a result, we have been awarded funding to start a major estates refurbishment programme over 2017/18 to make the necessary improvements (see section 18 for more information).

Risks to improving safety and quality

Recruitment and retention of staff

The national shortage in some roles, such as qualified nurses, means there is a risk that we will not be able to meet our staffing requirements. This could have implications on our ability to improve performance. It would also affect the Trust's financial position due to the cap which has been imposed on NHS Trusts around agency spend. To manage these risks, we will continue our recruitment drive and will also look for additional opportunities to address where there are staff shortages.

Staff morale

With the NHS facing significant pressures, there is a risk of low staff morale. We are developing our staff engagement programme to address this, and ensuring that we engage with staff about clear plans for the future. Through the Safety and Quality Improvement Plan (section 5), our aim is to empower staff to make the changes which are needed for our patients.

Risks to ensuring the financial stability of the organisation

Although we met our financial target in 2016/17, the Trust is still in financial deficit, and we need to take action to ensure our long term financial viability. In 2017/18, we have joined the national NHS programme to help with this work. In the longer term, our clinical service strategy is outlined in section 18.

Significant savings across the NHS in South East London need to be made through the Sustainability and Transformation Plan (STP) for the region. We are working with partners on this, and need to ensure that our plans for the future are aligned with the STP.

> **"The staff are all very pleasant and courteous. Nothing has been too much trouble for them, the level of care has been excellent – a real credit to this hospital."**
>
> Patient on Linden Ward,
> University Hospital Lewisham

18 Our vision and clinical service strategy

"We are developing exciting plans for the future, so we can support our staff and become a consistently high performing organisation."

Tim Higginson, Chief Executive

Background

We have a major Safety and Quality Improvement Plan in place (see section 5) and have been developing our clinical strategy, working on exciting plans for the organisation. Our focus is on supporting staff who are under pressure and becoming a consistently high performing organisation to deliver safe, high quality care to patients.

We have a major improvement plan in place

We know there is more to do and over the next five years we will be making significant improvements as part of our clinical strategy, investing in:

- Ambulatory care redevelopment at Queen Elizabeth Hospital (QEH) (see page 17)
- Reopening a day theatre at QEH and new operating theatres at University Hospital Lewisham (UHL) (see page 19)
- Significant investment in radiology equipment at both hospitals.
- New endoscopy facility at UHL and endoscopy suite upgrade at QEH (see page 31)
- Investment in maternity services at both hospitals
- Upgrade of our children's facilities at both hospitals
- Transforming how we deliver outpatient services at both hospitals
- Critical care development and expanded chemotherapy service at QEH.

We still face significant challenges

We know that our staff face significant challenges, which include:

- Increasing demand for our services, which we try to provide in cramped, sometimes even inadequate facilities, particularly at QEH
- Difficulty recruiting and retaining the staff we need
- A shortage of appropriate provision in the community for local people who need care, but not a hospital bed
- Financial challenges and limited capital funds to invest in major improvement schemes
- Growing national pressure to put NHS land and facilities to full use.

Our plans to deal with these challenges need to support the overall strategy for South East London

NHS organisations have been required to work together to develop Sustainability and Transformation Plans (STPs) for the next five years. The STP for SE London is not proposing major changes to hospitals in SE London. It clearly states that the aim is to manage future demand so we do not need to build a new hospital, rather than by closing an existing one.

Commissioners have confirmed that both our Emergency Departments are needed for the foreseeable future. We need to ensure we have the range of services at both UHL and QEH to support the emergency pathways.

The STP for SE London proposes improving community services through the development of "local care networks". These networks will bring together primary, community, mental health and social care colleagues to manage the health and care of local populations.

Our vision

Our vision is to be a consistently high performing and financially sustainable organisation. This means ensuring that all our services provide the right quality of care, and have the right staff in place to do so.

We believe our hospitals are broadly the right size to meet local need, provided that we can complete the improvement work we have begun, and that patients who no longer need our care can be transferred promptly to an appropriate setting. At present, this isn't happening, partly due to the way the system works, and partly due to shortages in the right out-of-hospital services.

The size of our hospitals will therefore remain broadly the same. In the community, we need to work with partners to develop and support the community based care strategy for Lewisham, where we provide the community service. In Greenwich and Bexley we will work closely with the providers of community services.

Our priorities

To make our vision a reality, our priorities must be:

- To make sure that that our hospital and community services have the right staff and the right facilities fit for the future
- Helping to solve not only our problems but those of our communities – with health and social care facilities, employment and housing
- Identifying sources of funding where these solutions need investment
- Having a sound understanding of our financial position and a plan to return it to balance.

Our clinical service strategy is designed to tackle these priorities.

Our clinical service strategy at QEH

We will start a major programme to improve the infrastructure

We have already secured significant national funding to sort out the longstanding infrastructure problems with the hospital buildings at QEH. This will tackle the areas you can't see, such as electrics, ventilation, water systems, generator capacity and more.

We are also planning significant improvements to the facilities we offer patients

We are developing plans to:

- Upgrade the emergency department, medical admissions unit, critical care, children's emergency assessment unit and emergency care areas
- Rebuild the endoscopy suite at the hospital and return day surgery to its intended use – so it is not used as an escalation area
- Improve the women's unit to provide increased capacity to meet growing demand.

We want to do more

Our plans also include the development of a care home at QEH and we have an exciting opportunity to develop our role in education and training – locating a Skills Academy across both of our hospital sites (see below for more information).

Our PFI partners will be developing a new front entrance for the hospital, which will be an extension to the current entrance. The new front entrance will include shops and places to eat, providing a more welcoming environment for visitors and staff. This will free up space to be developed for clinical use, allowing us to start our major clinical improvement plan.

Funding these developments

Some schemes are funded by our capital funding (ie endoscopy), PFI partners (new front entrance), and we have national funding for infrastructure works. But all the clinical improvements will be expensive, so we propose developing some housing to fund these plans. By using our estate more efficiently, we can develop housing and keep the clinical space we need.

> **The staff are very friendly. They have gone out of their way to make sure I get the treatment I need.**
>
> Gynaecology outpatient, University Hospital Lewisham

Our strategy at UHL

Our plans fit in with wider partnership work

Local partners in Lewisham are working together (through the Lewisham Devolution Pilot and One Public Estate project) for more local decision making and to make better use of resources across the public sector. Lewisham Health and Care Partners are working on the integration of adult care.

We want to develop services needed by local people

Local partners are considering the development of "local care network hub" on the north end of the UHL site. This would support primary care and community health teams.

We are working with South London and Maudsley NHS Foundation Trust (SLAM) to look at providing a more appropriate mental health inpatient facility on the UHL site to replace the Ladywell Unit, which is at the end of its life. SLAM is also exploring the opportunity to enhance community mental health provision in Lewisham by including some of their services in the network hub development.

We could also create community facilities for people who do not need hospital care and we have a range of options in mind which could include intermediate and step down beds and a care home.

We are also considering whether we could provide specialised rehabilitation facilities here for adults and children given the shortage of such facilities in the South East.

We have an opportunity to develop a Skills Academy across both our hospital sites (see below for more information).

Funding these developments

Affordability is key so these plans will also include some housing to fund the clinical service developments. We have the opportunity to do this by using our estate much more efficiently.

At UHL and QEH

The Skills Academy

The Skills Academy will enable us to extend the education and training we currently provide through our links to local universities, providing training for staff to develop the specialist skills which we will need in the future. We also have an opportunity to become a licensed apprentice training provider, working with local councils to offer training for local care workers to address the current shortage of trained staff.

Our strategy for Lewisham community

As the provider of community services in Lewisham, we are working with our partners in the Clinical Commissioning Group, SLAM and local authority to develop the community based care strategy for Lewisham – looking at how teams can work together, how technology can support new ways of working, and how we can make better use of our land and facilities.

Partners own or lease a lot of property in the borough. Some buildings are in good condition and well located, but could be used more efficiently. Indeed, partners plan to develop "local care network hubs" at the Waldron Health Centre and Downham Health and Leisure Centre.

Other buildings in the community do not offer a suitable environment and/or are not in the right locations. In some cases we need new facilities (eg the neighbourhood hub on the UHL site). We will need to fund new developments by selling any estate that we don't need. Our aim is to support improved care, work more efficiently, and retain our assets for health and care use in the borough.

Next steps

We will continue to progress our improvement programme, where we have agreed funding through our capital programme over the next five years.

We will start work on improving the infrastructure at QEH this year, and will start by building a clinical decant facility that can be used as each area is refurbished. More work is needed to finalise the rest of our plans with partners and we will need to follow the process for achieving planning permission for any building developments. As we develop these plans we will share this work with you through a range of community engagement events.

Accountability report

19 Directors' report

Role of the Trust Board

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

Trust Board members

Members of the Trust Board during 2016/17 are listed below. Co-opted members are non-voting members.

Ms Elizabeth Butler, Chair – leaving 31 May 2107

Mr John Ballard, Non-Executive Director

Prof Stuart Carney, Non-Executive Director – left on 31 January 2017

Ms Claire Champion, Director of Nursing and Clinical Quality

Mr John Hennessey, Director of Finance and Information

Mr Tim Higginson, Chief Executive

Mr Keith Howard, Director of Estates and Facilities – co-opted

Dr Elizabeth Aitken, Medical Director

Ms Janet Lynch, Director of Workforce and Education – co-opted

Ms Lynn Saunders, Director of Strategy, Business and Communications, co-opted

Mr Lee McPhail, Director of Service Delivery – co-opted

Ms Veronika Simons, Non-Executive Director

Ms Val Davison, Non-Executive Director

Mr Russell Manley, Non-Executive Director – left on 31 December 2016

Ms Sukhvinder Kaur-Stubbs, Non-Executive Director

Dr Julia Mundy (Non-Executive Director), from 1/6/2016

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 committee, which meets five times a year and approves the annual accounts and annual report. Over 2016/17, membership of the audit committee included:

- Mr John Ballard
- Mr Russell Manley
- Dr Julia Mundy.

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

Details of company directorships and other significant interests

The register of interests for Board members is in the table below:

Name	Declaration
Ms Elizabeth Butler	Self employed chartered accountant, some clients are NHS employees or businesses seeking to do business with the NHS. Co-opted member of the Audit and Risk Committee of the General Medical Council; Chair of the Audit and Risk Committee of the Royal College of Veterinary Surgeons
Mr John Ballard	Treasurer – Life and Deaf Association, not for profit body promoting mental health of deaf young people
Prof Stuart Carney	Member of Order of Malta/Orders of St John Care Trust Charity, which sponsors the Orders of St John Care Trust. The Trust undertakes development work with clinical commissioning groups. Head of School and Head of Division at King's London, School of Medical Education that undertakes medical education research with funding from the Guy's and St Thomas' Charitable Trust
Ms Claire Champion	Nil
Ms Val Davison	Director of Dulwich Consulting Ltd – Core Business is interim management/management consultancy for NHS organisations and for companies seeking to do business with the NHS. (No work undertaken in SE London). Currently undertaking interim Programme Manager role for Hertfordshire Community NHS Trust. Provision of ad hoc Management Consultancy to Ryhurst Ltd and Guideon Ltd.
Dr Elizabeth Aitken	Nil
Mr John Hennessey	Nil
Mr Tim Higginson	Nil
Mr Keith Howard	Nil
Ms Sukhvinder Kaur-Stubbs	MD and major shareholder of Engage-Us Ltd. Providing consultancy support to charities in social care and advice to Department of Health. May seek opportunities on personalisation and user involvement among independent care providers, local authorities and if relevant NHS.
Ms Janet Lynch	London Vice President – Healthcare People Management Association. Provides a professional HR voice in healthcare and aims to support and develop HR staff to improve the people management contribution in healthcare
Mr Russell Manley	Partner, P2G LLP, a social enterprise partnership that assists UK public sector organisations to deliver savings from existing PFI contracts. Currently working with several NHS Trusts.
Mr Lee McPhail	Nil
Dr Julia Mundy	Nil
Ms Lynn Saunders	Nil
Ms Veronika Simons	Nil

20 Protecting data

Information governance

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

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

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

For 2016/17, the Trust IG Toolkit score was 77%, achieving a satisfactory green pass rate in all IG controls. This provides the Trust Board with substantial assurance that appropriate controls are implemented and consistently applied to manage the information risks of the business.

Information governance incidents for 2016/17

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

During 2016/2017 the Trust had one serious incident at Level 2 and 135 incidents at Level 1. The level 2 incident was reported to the Department of Health, the Information Commissioner's Office and NHS Digital.

Level 2 incident

In March 2017, we received a complaint about a breach of patient confidentiality from one of our patients. We reported this as a level 2 incident. At the time of writing (April 2017), our investigation into the incident is still ongoing. This will help us identify what happened and identify any steps that need to be taken so that this does not happen again.

Level 1 incidents

A breakdown of the 135 incidents marked at Level 1 were categorised as follows:

Summary of other personal data related incidents in 2016/17

Category	Breach	Total
A	Corruption or inability to recover electronic data	2
B	Disclosed in error	56
C	Lost in transit	0
D	Lost or stolen hardware	1
E	Lost or stolen paperwork	13
F	Non-secure disposal hardware	0
G	Non-secure disposal of paperwork	22
H	Uploaded to website in error	0
I	Technical security failings (including hacking)	8
J	Unauthorised access/disclosure	12
K	Others	21
	Total	**135**

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

Remuneration policy for directors and senior managers

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

The remuneration report is subject to audit.

Salary and pension entitlements of senior managers – remuneration

Name	Title	Salary (bands of £5,000) £000s	Other remuneration (bands of £5,000) £000s	Bonus payments (bands of £5,000) £000s	Benefits in kind Rounded to the nearest £100	All pension related benefits (bands of £2,500) £000s	Salary (bands of £5,000) £000s	Other remuneration (bands of £5,000) £000s	Bonus payments (bands of £5,000) £000s	Benefits in kind Rounded to the nearest £100	All pension related benefits (bands of £2,500) £000s	Totals 2016/17 £000s	Totals 2015/16 £000s
1. Executive Directors													
Tim Higginson	Chief Executive	195-200	-	-	-	-	195-200	-	-	-	-	195-200	195-200
John Hennessey	Director of Finance, Information & Performance	155-160	-	-	-	25-27.5	155-160	-	-	-	22.5-25	180-185	175-180
Claire Champion	Director of Nursing & Clinical Quality and Deputy CEO	135-140	-	-	-	2.5-5	150-155	-	-	-	27.5-30	140-145	175-180
Elizabeth Aitken	Medical Director	95-100	90-95	-	-	25-27.5	10-15	10-15	-	-	17.5-20	215-220	45-50
2. Other Members of the Board													
Janet Lynch	Director of Workforce & Education	120-125	-	-	-	25-27.5	120-125	-	-	-	5-7.5	145-150	125-130
Lynn Saunders	Director of Strategy, Business and Communications	120-125	-	-	-	15-17.5	120-125	-	-	-	7.5-10	135-140	125-130
Keith Howard	Director of Facilities & Estates	120-125	-	-	-	12.5-15	120-125	15-20	-	-	7.5-10	130-135	140-145
Lee McPhail	Director of Service delivery	140-145	-	-	-	-	140-145	-	-	-	-	140-145	140-145
3. Chairman & Non Executive Directors													
ELizabeth Butler	Chairman	40-45	-	-	-	-	40-45	-	-	-	-	40-45	40-45
John Ballard	Non-Executive Director	5-10	-	-	-	-	5-10	-	-	-	-	5-10	5-10
Julia Munday	Non-Executive Director (F 01/06/16)	5-10	-	-	-	-	-	-	-	-	-	5-10	-
Veronika Simons	Non-Executive Director	5-10	-	-	-	-	5-10	-	-	-	-	5-10	5-10
Stuart Carney	Non-Executive Director (T 31/01/17)	5-10	-	-	-	-	5-10	-	-	-	-	5-10	5-10
Val Davison	Non-Executive Director	5-10	-	-	-	-	5-10	-	-	-	-	5-10	5-10
Russell Manley	Non-Executive Director (T 31/12/16)	0-5	-	-	-	-	0-5	-	-	-	-	0-5	0-5
Sukhvinder Kaur-Stubbs	Non-Executive Director	5-10	-	-	-	-	5-10	-	-	-	-	5-10	5-10
Charles Wolfe	Non-Executive Director (F 01/03/17 - T 31/03/17)	0-5	-	-	-	-	-	-	-	-	-	0-5	-

Salary and pension entitlements of senior managers – pension benefits

Name	Title	Real increase/(decrease) in pension at age 60 (bands of £2,500) £000s	Real increase/(decrease) in pension lump sum at age 60 (bands of £2,500) £000s	Total accrued pension at age 60 at 31 March 2017 (bands of £5,000) £000s	Total accrued pension lump sum at age 60 at 31 March 2017 (bands of £5,000) £000s	Cash Equivalent Transfer Value at 31 March 2017 £000s	Cash Equivalent Transfer Value at 31 March 2016 £000s	Real Increase in Cash Equivalent Transfer Value £000s	Employers Contribution to Stakeholder Pension £000s
Tim Higginson	Chief Executive	-	-	-	-	-	1,708	-	-
John Hennessey	Director of Finance, Information & Performance	0 - 2.5	5 - 7.5	40 - 45	120 - 125	829	761	68	-
Claire Champion	Director of Nursing & Clinical Quality and Deputy CEO	0 - 2.5	0 - 2.5	45 - 50	145 - 150	-	959	-	-
Elizabeth Aitken	Medical Director	0 - 2.5	0	50 - 55	90 - 95	763	716	47	-
Janet Lynch	Director of Workforce & Education	0 - 2.5	0 - 2.5	45 - 50	130 - 135	832	804	27	-
Lynn Saunders	Director of Strategy, Business and Communications	0 - 2.5	2.5 - 5	30 - 35	100 - 105	-	713	-	-
Keith Howard	Director of Facilities & Estates	0 - 2.5	2.5 - 5	25 - 30	75 - 80	-	529	-	-

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members in the table below.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Exit packages

Exit packages for staff leaving in 2016/17			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	#	#	#
<£10,000	0	7	7
£10,000 - £25,000	0	2	2
£25,001 - £50,000	0	0	0
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages	0	9	9
	£'s	£'s	£'s
Cost	0	55,054	55,054

Exit packages were paid for nine staff departures during the year at a cost of £55K.

Highest paid director and median pay of workforce

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

The banded remuneration of the highest paid director in Lewisham and Greenwich NHS Trust in the financial year 2016/17 was £195,000 (2015/16 £199,372). This was 5.71 times (2015/16 6.3 times) the median remuneration of the workforce, which was £34,154 (2015/16 £31,665). The director is the Chief Executive.

In 2016/17 one employee received remuneration in excess of the highest-paid director (none in 2015/16). Remuneration ranged from £15,081 to £209,912 (2015/16 £15,239 to £199,372).

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		
	2016/17	2015/16
Pay of highest paid director	£195,000	£199,372
Median pay	£34,154	£31,665
Median as multiple of highest paid director	5.71	6.30

Review of tax arrangements of public sector employees – Off-Payroll Engagements

Reporting bodies are required to disclose details in respect of the tax arrangements of public sector employees relating to off-payroll engagements under Treasury PES(2012)17.

The disclosure covers the following off-payroll engagements:

Details of all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months	Number
The total number of existing engagements as of 31 March 2017	1
The number that have existed for less than one year at time of reporting.	-
The number that have existed for between one and two years at time of reporting.	-
The number that have existed for between two and three years at time of reporting.	-
The number that have existed for between three and four years at time of reporting.	-
The number that have existed for four or more years at time of reporting.	1
Declaration that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance needs to be sought that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	1

The Trust has had no new off-payroll engagements that have reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day.

The Trust has had no off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017.

Our staffing profile

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

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

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

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

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

Table of staffing profile

Staff numbers				
	31/03/2017	31/03/2016	31/03/2017	31/03/2016
	Number	Number	£000	£000
Medical and dental	933	927	89,102	86,968
Ambulance staff	-	-	-	-
Administration and estates	1,428	1,426	53,085	51,108
Healthcare assistants and other support staff	1,002	1,018	27,076	30,208
Nursing, midwifery and health visiting staff	2,653	2,638	122,934	116,563
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	1,122	1,122	48,355	48,309
Social Care Staff	-	-	-	-
Healthcare Science Staff	-	-	-	-
Other	5	5	243	244
Total	7,143	7,136	340,795	333,400

Equality statement

We recognise that everyone has different needs in relation to public services, and that in both the workplace and as service users, certain individuals/groups of individuals can experience unfair and unequal outcomes. To help us understand and take action where necessary, the Trust continues to implement the Department of Health's Equality Delivery System (EDS) for the NHS and Workforce Race Equality Standard (WRES). Implementing these has helped us to meet the commitment set out above as well as the requirements of the Equalities Act 2010.

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

National NHS staff survey

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

Our top results were:

- Quality of non-mandatory training, learning and development
- The percentage of staff able to contribute towards improvement at work
- The percentage of staff reporting good communication between senior management and staff
- Quality of appraisals
- Effective use of patient/service user feedback.

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

- Percentage of staff working extra hours
- Percentage of staff appraised in last 12 months
- Percentage of staff reporting most recent experience of harassment, bullying or abuse
- Percentage of staff feeling unwell due to work related stress in the last 12 months
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month.

There are 16 findings which have shown some improvement since the 2015 survey, however nine have deteriorated and seven have shown no change. Our actions will focus on the key themes of:

- Equality and diversity
- Health and wellbeing
- Errors and incidents
- Working patterns
- Violence, harassment and bullying.

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

NHS pensions scheme

Past and present employees are covered by the provisions of the NHS pensions scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. For further detail, please refer to note 8.3 on page 73 of the annual accounts.

Staff sickness absence

Staff sickness		
	31 March 17	31 March 16
	Number	Number
Total days lost	51,760	51,524
Total staff years	5,600	5,555
Average working days lost	9.2	9.3

Annual accounts

23 Governance statement signed by accountable officer

1. Scope of responsibility

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

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

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

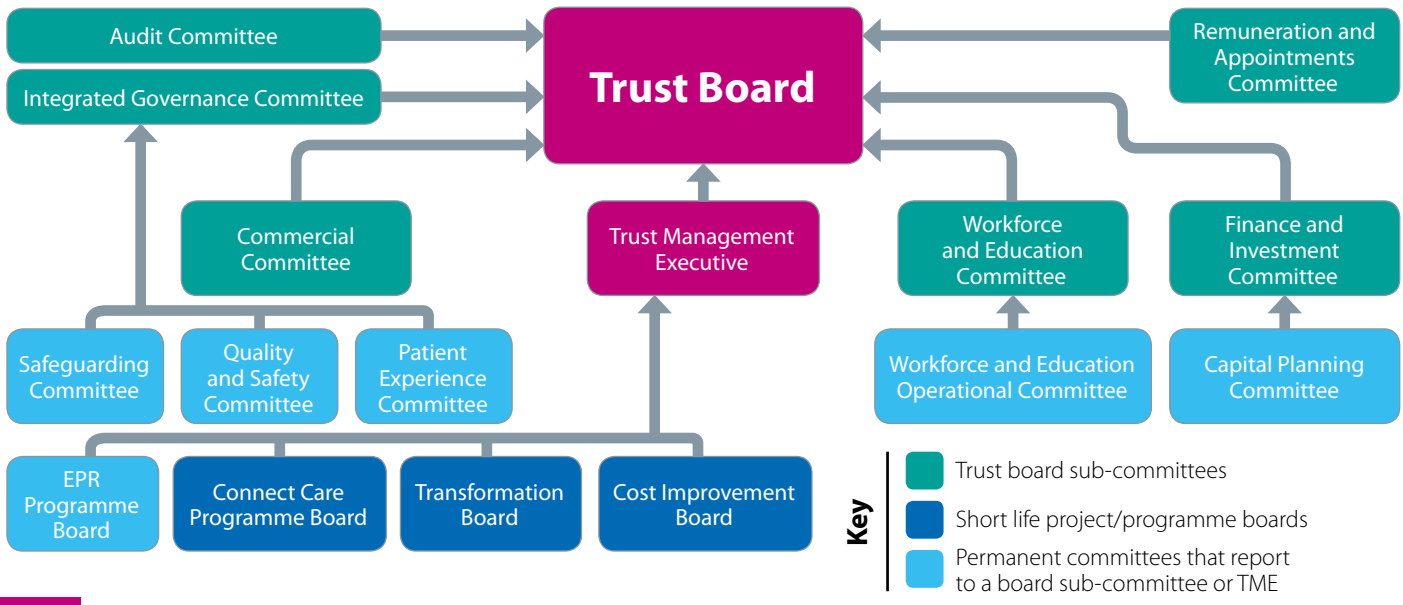
I also account to NHS Improvement – this body monitors the Trust and intervenes in performance management if the quarterly rating in its performance framework requires it or there is other adverse information of sufficient importance. I, and officers of the Trust, meet monthly with officers of NHS Improvement to discuss performance. I attend the Health and Adult Social Care Overview and Scrutiny Committees in relevant Council areas to account for the performance of the Trust to the local community and oversee the work of executive officers in the work programme of the Scrutiny Committees.

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

2. The governance framework of the organisation

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

Trust board assurance structure



2.1 The Trust Board

The Board consists of four voting executive directors, eight non-executive directors (including the Chair) and four non-voting executive directors. The Board meets ten times a year in public; Board minutes and papers are made freely available, including on the Trust website. The Board also meets ten times a year for "Board Seminars". Attendance by its members has been consistently high and I am confident that the Executive Team and Board members were suitably engaged and informed in both Board and Trust management during 2016/17. The Board has reviewed its effectiveness, using external expertise – the output was discussed at an away day in June 2016 and an action plan developed. The annual Board self–assessment is in progress and the results are due to be discussed at the April 2017 Board seminar. These reviews feed into a Board development programme. This is complemented by other actions that have been taken through the appraisal of Board members by either the Trust Chair or I, respectively.

During the year two Non-Executive appointments were made to the Board to replace leavers, including the University Nominated Non-Executive Director. Interviews are scheduled for 30th March 2107 to replace a Non-Executive Director who left in January 2017.

2.2 Summary of public Board activity and points of note

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

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

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

- Patients: via the Trust's Annual General Meeting and Q and A sessions before each Board meeting.
- Public/Voluntary Sector: The Trust has hosted a range of evening events for Trust Members and potential members to learn more about the Trust and to interact with Board and staff members. These include topic specific presentations on items of general health interest such as eating well in addition to sessions on becoming a dementia friend and end of life care.
- Staff: The Board is informed of staff views from the Staff Surveys, the staff Friends and Family test, from members of the Trust Management Executive and Clinical Leaders Group, on Board walkabouts and from discussions held by the Director of Workforce & Education with the Trust Joint Partnership Committee.
- GPs and Clinical Commissioners: The views of provider and commissioner GPs are of key importance to the Board. Through visits by the Director of GP Engagement and members of the Business Development team the Trust has engaged with local practices giving them the opportunity to discuss the Trust and its management.

2.3 Board committees

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

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

3. Risk assessment

Risk, or change in risk is identified, evaluated and controlled as described in the Trust's Risk Management Strategy. 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.

Risks are identified via a variety of mechanisms:

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

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

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

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

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. The Trust's Risk Register and issues logs are generated through the assessment process and reviewed on a regular basis to ensure that risks are being treated and risks can be added or deleted, as necessary.

Other methods of identifying risks are:

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

3.1 Capacity to handle risk

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

The Director of Nursing and Clinical Quality is the lead executive for the risk management structure and processes. The lead executive has continued to lead a holistic approach to risk management within the Trust by developing a new corporate risk and issues framework, strengthening reporting between the committees within the risk and governance structures, and upwards to the Trust Board.

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

The Audit Committee monitors and assesses both internal control issues and financial risk. The Audit Committee's responsibilities for Risk Management are clearly outlined in the Committee Terms of Reference. The Committee assures itself that risk management processes are robust through the work of the Integrated Governance Committee.

Audit managers from KPMG (internal auditors) and Grant Thornton (external audit) attend all Audit Committee meetings and are responsible for the development of the audit reports and findings and the Annual Report to those charged with Governance. The Committee approves the annual Internal Audit Plan. This Plan is based on the Trust's Assurance Framework. The Audit Committee receives details of all the reports of the Internal Auditors and monitors the implementation of recommendations. Reports that impact on clinical risks are also reported to the Integrated Governance Committee. The main purposes of the audit reports are to provide Management, the Audit Committee and the Trust Board with:

- An opinion of the adequacy of internal control;
- Information on significant audit findings and recommendations.

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

Risk issues are reported to the Board through the Integrated Governance Committee, which carries the Board's delegated authority for the close scrutiny of Risk Management and the Assurance Framework. In order to manage its extensive agenda, the Integrated Governance Committee has three formal reporting committees (Quality and Safety, Patient Experience and Safeguarding), which provide the Integrated Governance Committee with assurance regarding work within their respective remits. Each reporting committee has formal Terms of Reference and submits reports and minutes to the Integrated Governance Committee on a regular basis. The Integrated Governance Committee also seeks assurance that the Trust is conforming to best practice in corporate governance, health and safety and information governance and monitors the on-going work in these areas through the Quality and Safety Committee. The Integrated Governance Committee includes two lay members, who provide a valuable service-user perspective and an independent review of all Committee business. Mechanisms are in place to ensure that the Audit Committee and the Integrated Governance Committee communicate on shared issues. Financial risks are scrutinised by the Finance and Investment Committee (a Sub-committee of the Board), reflected in the Assurance Framework, and reported to the Audit Committee and the Board. Workforce and Educational risks are scrutinised by the Workforce and Education Committee (a Sub-committee of the Board) The key workforce risk continues to be the Trust's ability to recruit permanent staff to clinical roles, and the impact that this has on agency spend.

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

Management and ownership of risk is delegated to the appropriate level from 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, with exceptions reported to the Trust Management Executive.

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

Serious Incidents (SIs) are investigated through the Divisions involved, with reports generated by managers and signed-off by the Chief Executive. The Outcomes with Learning Group reviews all incidents after completion and monitors implementation of learning derived from each SI as well as delivery of action plans arising. Training in SI investigation and reporting has been carried out in 2016/17 to achieve an improvement in the timely completion of investigations and the preparation of SI reports. This will also assist the timely sharing of report outcomes and learning across the organisation.

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

4. Risk and control framework

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

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

In 2016/17 a new approach to the content and presentation of corporate level risks and issues was adopted. There is now a register of risks identified by senior Trust managers that have the potential to threaten the achievement of the Trust's Corporate Objectives. In addition there is a separate log of corporate level issues that have occurred and / or are currently being dealt with. Some risks will also have issues that have already materialised and the links between the Risk Register and Issues Log are indicated. The Corporate level Risk Register and Issues Log are complemented by similar documents held at Divisional / Departmental level which will contain risks and issues relevant to those areas. Divisions / Departments will apply to escalate relevant risks / issues to the corporate level if they can be shown to be a significant threat to the achievement of the Trust's corporate objectives. Further work is taking place to refine the calibration of risks on the register.

4.1 Board Assurance Framework

The Board Assurance Framework (BAF) is a key support to the Trust's system of internal control. It is separate from the Trust's risk register (although the Corporate Risk Register is linked to it) and provides a clear methodology for the focused management of risks to the delivery of the Trust's strategic objectives. In

2016/17 the format of the BAF was amended based on a template adopted by Monitor. The new format demonstrates clear links between the controls and assurances in place for delivery of the Strategic and Corporate Objectives. The Board is in the process of reviewing the risk appetite scores using the Good Governance Institute Risk Appetite for NHS Organisations (2012) matrix.

4.2 Care Quality Commission Registration

The Care Quality Commission (CQC) carried out an unannounced inspection of the emergency department and medical services at QEH in June 2016.

The CQC gave the emergency department and medical services an overall rating of "requires improvement". The report notes the progress made since the last CQC inspection in February 2014, when the emergency department in QEH was the only service rated as "inadequate".

In the June 2016 inspection, the CQC rated emergency department staff as "Good" in the "Caring" domain, for providing "a caring, kind, and compassionate service".

The Trust has developed a detailed plan of improvements to our emergency pathway. We are working with our health and social care partners to address the areas highlighted for improvement.

In March 2017, the CQC undertook a planned comprehensive inspection of all the Trust services, including our community services. The Trust has not received the CQC draft or final report at the time of writing this report.

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

The CQC have also told us that we need to make changes more quickly, particularly with regard to the emergency care pathway. With our partners, we have developed and are progressing the implementation of our safety and improvement plan which aims to address the areas of feedback provided by CQC.

We are working with our partners to deliver improvements across the health and social care system, and delivering the plan is our main priority as an organisation.

Internally, we have four workstreams, each led by an executive director:

- Improving patient flow
- Clinical engagement, leadership and changing practice
- Upgrading your working environment
- Monitoring safety and quality of care

The programme as a whole is overseen by Programme Directors who will be working with operational and clinical teams to ensure the necessary changes result in improved performance across the Trust.

4.3 Quality governance

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

The 2015/2016 Quality Account was reviewed by Internal audit who confirmed that based on the results of their procedures, nothing had come to their attention that caused them to believe that, for the year ended 31 March 2016, the Quality Account was not prepared in all material respects in line with the criteria set out in the Regulations.

4.4 The management of incidents and identification of clinical risk

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, and the investigation of Serious Incidents and Never Events. The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the Trust. The responsibility for risk management is clearly mapped to all

staff, the Trust Board, NEDs and Executive Directors, department heads, managers and senior clinicians. Risks are identified reactively and proactively. All risks are assessed against one standard tool. All risks are managed through Divisional Governance meetings; oversight is maintained by the relevant Trust Board sub-committee. High level risks are reported to and reviewed by the Trust Board quarterly.

4.5 Clinical audit

The Trust has an established clinical audit programme as detailed in the Trust's Quality Account. The programme aims to drive continuous improvement of services and quality of care. The Clinical Audit programme priorities in 2016/2017 were the National Clinical Audit and Confidential Enquiries Programme Mandatory Audits, NICE Guidance and Quality Standards, Trust Wide Governance and Risk Audits and local Clinical Specialty level Audits. The internal monitoring and reporting of Clinical Audit activity within the Trust is established through a range of structures, systems and processes. The overall monitoring and reporting of all Clinical Audit activity is led by the Clinical Effectiveness Department supported by Directorate Level Governance and Audit Meetings, Divisional Level Governance and Risk Meetings and is overseen by the Clinical Audit and Guidelines Group

4.6 Information governance/data security

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

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

In March 2017, the Trust received a complaint about a breach of patient confidentiality from a patient. This has been reported as a level 2 incident and the investigation into the incident is still ongoing. This will help us identify what happened and identify any steps that need to be taken so that this does not happen again.

4.7 Data quality

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

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

The risks that exist around the accuracy of waiting time data relate to the accuracy of the extracts available from the systems, the accuracy of the data recorded by staff, the availability of the required data to support pathway validation and the resources available to complete the validation actions prior to data submission. All of these risks are mitigated through the actions detailed above.

In May 2016 the Audit Committee received an internal Audit Report on the systems of data quality in place around cancer waiting times to ensure the accuracy of data. This had been

an area of weakness identified by management for review and received a rating of 'Partial Assurance with improvements required'. All recommended actions would be completed by the end of April 2017.

4.8 Counter fraud

The anti-fraud, bribery and corruption work carried out during the financial year 2016/17 is currently being assessed by the Trust against the NHS Protect Standards for Providers 2016/17 - Fraud, Bribery and Corruption/NHS Standard Contract. Following the annual Self-Review Toolkit return on 31st May 2016, changes to the standards were incorporated into the 2016/17 annual Counter Fraud plan to improve ratings not assessed as green. Where there was evidence of activity carried out but the Trust could not yet demonstrate that the activity had been assessed for effectiveness, the standard was rated amber.

4.9 Other aspects

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. As such processes are established to manage concerns when they are identified. As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

5. Review of effectiveness

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

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.
- Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.
- The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.
- External auditors provide me with assurances through their opinion on the financial statements, their value for money conclusion and the external auditor's report on the annual Quality Account.
- Other external organisations, including NHS Improvement, Care Quality Commission, MHRA, other agencies of the Department of Health and our commissioners, have provided me with reports about controls, compliance with standards, financial management and performance in delivering targets.

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

- Failure to maintain Emergency Department performance because of lack of capacity in health system to manage winter pressures has a significant impact on the Trust's ability to deliver high quality care and meet national performance targets.
- Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquidity position.

The Head of Internal Audit Opinion for 2016/17 has been received and is summarised below:

Our overall opinion for the period 1 April 2016 to 21 March 2017 is that: 'significant with minor improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

6. Significant issues

6.1 Quality and safety

The Trust's most significant issues relating to quality of services have been linked to capacity and unprecedented levels of emergency activity. This has had significant financial impact throughout the year as the Trust called on bank and agency staff to ensure that safe staffing levels were maintained throughout peak periods of activity and to open escalation areas. The sustained national activity position had a similar effect on the Trust's Emergency Department standards and elective activity which affected the achievement of standards in the second half of the financial year.

Following the Trust-wide inspection from the CQC in March, a Safety and Quality Improvement Programme has been developed to make changes more quickly, particularly with regard to the emergency care pathway. With our partners, we are looking urgently at ways in which we can make the necessary improvements for our patients. We have commissioned an external review of our governance arrangements, particularly in relation to the way we manage our risk registers.

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

6.2 Finance

The Trust reported a deficit of £41.0m in 2016/17 broadly in line with its submitted Plan, which included receipt of £16.6m for Sustainability and Transformation Funding. With the application of technical adjustments for Interest Payments for PFI contracts, the reported deficit was reduced to £20.1m, marginally less than the control total of £20.2m. For 17/18 the Trust will no longer benefit from the technical adjustment, but still expects to deliver the NHSI Financial Plan Control Total of £22.7m, an improvement of £10.3m on the 2016/17 performance prior to the technical adjustment. The 2017/18 plan also includes the Trust receiving £16.7m for Sustainability and Transformation Funding in 2017/18. To achieve the 2017/18 plan, the Trust is planning for a £47.8m Cost Improvement Programme (CIP) which has three main components:

- £16.7m of savings will come from joint work with other SE London Trusts and come from efficiencies gains from working together and consolidation of some corporate services;
- £10.1m of savings from Transformation programmes with SE London Commissioners. These savings will come from changes in patient pathways and reductions in length of stay delivered through transformation schemes; and
- £20.0m of savings from Trust specific schemes that will be delivered across the Trust while ensure the quality of patient services. This equates to approximately 3.7% of the Trust's turnover.

The main themes for the Trust CIP Programme will be collaborative working with others in SE London, reduction in Agency spend, and procurement savings.

6.3 Liquidity

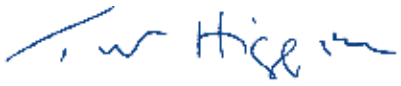
The Trust has historically operated on extremely low levels of cash; both formerly as Lewisham Healthcare Trust and Lewisham and Greenwich NHS Trust following the merger with Queen Elizabeth Hospital, Greenwich in October 2013.

However, underlying liquidity has declined sharply since the merger in terms of nominal cash balances held compared with the near doubling of turnover. Clearly, the financial deficit position since FY14/15 has also had a significant impact on liquidity.

Despite the receipt of sizeable amounts of revenue deficit cash support over the past two years, the Trust has experienced increasing difficulty in paying its creditors; which has led to a significant decline in performance against the better payment practice code target and a corresponding marked deterioration in relations with suppliers.

7. Concluding statement

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



Tim Higginson, Chief Executive
30 May 2017

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

We have audited the financial statements of Lewisham and Greenwich NHS Trust (the "Trust") for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014 (the "Act"). The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. 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, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the "2016/17 GAM") and the requirements of the National Health Service Act 2006.

We have also audited the information in the Accountability Report that is subject to audit, being:

- the single total figure of remuneration for each director;
- CETV disclosures for each director;
- the table of exit packages;
- the analysis of staff numbers and costs; and
- the table of median pay and highest paid director (pay multiples) disclosure.

This report is made solely to the directors of Lewisham and Greenwich NHS Trust, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. 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.

Respective responsibilities of directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Act to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report by exception where we are not satisfied.

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.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Introduction and Background, the Performance Report and the Accountability Report to

identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria 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 2017, 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.

Opinion on financial statements

In our opinion:

- the financial statements give a true and fair view of the financial position of Lewisham and Greenwich NHS Trust as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006.

Emphasis of matter – going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.1 to the financial statements concerning the Trust's ability to continue as a going concern. The Trust incurred a deficit of £20 million during the year ended 31 March 2017.

The directors are seeking additional support from NHS Improvement for 2017/18 up to the level of the planned deficit of £22.7 million. NHS Improvement has not, at the date of our report, formally confirmed this support. This indicates the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Opinion on other matters

In our opinion:

- the parts of the Accountability 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 Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Act because we had 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.

On 30 May 2017 we referred a matter to the Secretary of State under section 30b of the Act in relation to Lewisham and Greenwich NHS Trust's breach of its break-even duty for the three year period ended 31 March 2017.

We are required to report to you if we are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified value for money conclusion

The Trust made a planned deficit of £20 million in 2016/17, which is in line with the Trust's control total. This is the third consecutive year in which the Trust has been in deficit. The Trust's cumulative deficit is £49.5 million as at 31 March 2017.

The Trust has also set deficit budgets for 2017/18 and 2018/19. The Trust is working with partners in the local health economy through the Sustainability and Transformation Plan (STP), which aims to develop a plan which will return the health economy to a sustainable financial position. Pending the development of this, the Trust currently does not have a medium term financial plan to return to a balanced financial position.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified value for money conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2016, except for the effects of the matter reported in the Basis for qualified value for money conclusion paragraphs above, we are satisfied that, in all significant respects, Lewisham and Greenwich NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Other matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have made a written recommendation to the Trust under section 24 of the Act in the course of, or at the conclusion of the audit.

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

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 Act and the Code of Audit Practice.

Darren Wells
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

2nd Floor
St Johns House
Crawley
RH10 1HS
30 May 2017

25 Statements of the Chief Executive's and directors' responsibilities

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

I confirm that, 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 trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Tim Higginson, Chief Executive
30 May 2017

Statement of directors' responsibilities in respect of the accounts

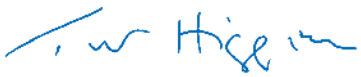
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised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

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

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

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

By order of the Board



Tim Higginson, Chief Executive
30 May 2017

John Hennessey, Finance Director
30 May 2017

Year ended 31 March 2017

Statement of Comprehensive Income for year ended 31 March 2017	Note	2016/17 £000s	2015/16 £000s
Gross employee benefits	8.1	(339,550)	(330,713)
Other operating costs	6	(210,207)	(198,570)
Revenue from patient care activities	3	471,881	468,508
Other operating revenue	4	67,361	50,439
Operating surplus/(deficit)		**(10,515)**	**(10,336)**
Investment revenue	10	34	50
Other gains and (losses)	11	(46)	0
Finance costs	12	(24,393)	(19,115)
Surplus/(deficit) for the financial year		**(34,920)**	**(29,401)**
Public dividend capital dividends payable		(6,105)	(7,345)
Transfers by absorption - gains		0	0
Transfers by absorption - (losses)		0	0
Net Gain/(loss) on transfers by absorption		**0**	**0**
Retained surplus/(deficit) for the year		**(41,025)**	**(36,746)**
Other Comprehensive Income			
Impairments and reversals taken to the revaluation reserve		0	0
Net gain/(loss) on revaluation of property, plant & equipment	*	(22,521)	21,875
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Other gain/(loss) (explain in footnote below)		0	0
Net gain/(loss) on revaluation of available for sale financial assets		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Other pension remeasurements		0	0
Reclassification adjustments			
On disposal of available for sale financial assets		0	0
Total comprehensive income for the year		**(63,546)**	**(14,871)**
Financial performance for the year			
Retained surplus/(deficit) for the year		(41,025)	(36,746)
Prior period adjustment to correct errors and other performance adjustments		0	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**	20,685	14,608
Impairments (excluding IFRIC 12 impairments)	***	178	(819)
Adjustments in respect of donated gov't grant asset reserve elimination		108	90
Adjustment re absorption accounting		0	0
Adjusted retained surplus/(deficit)		**(20,054)**	**(22,867)**

* The net loss on revaluation of £22,521K arises from the update of land and building fair values in accordance with DH guidance - See Note 14.1 Property Plant and Equipment.

** The IFRIC 12 adjustment of £20,685K is the revenue impact of PFI assets treated as on-balance under International Financial Reporting Standards (IFRS) and is reversed out for the purposes of the financial "breakeven" performance measure.

*** This adjustment of £178K is the Non-IFRIC 12 element of total impairments (£6,421K) included in Note 6 (Operating Expenses) and is reversed out for the purposes of the financial performance "breakeven" measure.

The notes on pages 61 to 97 form part of this account.

Statement of Financial Position as at 31 March 2017	Note	31 March 2017 £000s	31 March 2016 £000s
Non-current assets			
Property, plant and equipment	14	335,568	378,533
Intangible assets	15	27,323	19,450
Investment property		0	0
Other financial assets		0	0
Trade and other receivables	19.1	2,482	2,988
Total non-current assets		**365,373**	**400,971**
Current assets			
Inventories	18	5,670	6,179
Trade and other receivables	19.1	50,649	41,670
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	20	5,457	2,064
Sub-total current assets		**61,776**	**49,913**
Non-current assets held for sale		0	0
Total current assets		**61,776**	**49,913**
Total assets		**427,149**	**450,884**
Current liabilities			
Trade and other payables	21	(52,989)	(64,460)
Other liabilities		0	0
Provisions	25	(1,876)	(2,122)
Borrowings	22	(5,830)	(3,673)
Other financial liabilities		0	0
DH revenue support loan	22	0	0
DH capital loan	22	(787)	(787)
Total current liabilities		**(61,482)**	**(71,042)**
Net current assets/(liabilities)		**294**	**(21,129)**
Total assets less current liabilities		**365,667**	**379,842**

	Note	31 March 2017 £000s	31 March 2016 £000s
Non-current liabilities			
Trade and other payables	21	(657)	(707)
Other liabilities		0	0
Provisions	25	(3,919)	(3,975)
Borrowings	22	(107,170)	(110,611)
Other financial liabilities		0	0
DH revenue support loan	22	(78,042)	(29,676)
DH capital loan	22	(12,198)	(12,985)
Total non-current liabilities		**(201,986)**	**(157,954)**
Total assets employed:		**163,681**	**221,888**
Financed by			
Public Dividend Capital		188,005	182,666
Retained earnings		(162,410)	(121,448)
Revaluation reserve		138,086	160,607
Other reserves		0	63
Total Taxpayers' Equity:		**163,681**	**221,888**

The notes on pages 61 to 97 form part of this account.

The financial statements on pages 57 to 97 were approved by the Board on 30 May 2017 and signed on its behalf by

Tim Higginson, Chief Executive
30 May 2017

Statement of Changes in Taxpayers' Equity for year ended 31 March 2017	Public dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2016	**182,666**	**(121,448)**	**160,607**	**63**	**221,888**
Changes in taxpayers' equity for 2016/17					
Retained surplus/(deficit) for the year		(41,025)			(41,025)
Net gain / (loss) on revaluation of property, plant, equipment			(22,521)		(22,521)
Transfers between reserves		63	0	(63)	0
Reclassification adjustments					
Temporary and permanent PDC received - cash	5,339				5,339
Temporary and permanent PDC repaid in year	0				0
Net recognised revenue/(expense) for the year	**5,339**	**(40,962)**	**(22,521)**	**(63)**	**(58,207)**
Balance at 31 March 2017	**188,005**	**(162,410)**	**138,086**	**0**	**163,681**

Balance at 1 April 2015	**183,014**	**(84,702)**	**138,732**	**63**	**237,107**
Changes in taxpayers' equity for the year ended 31 March 2016					
Retained surplus/(deficit) for the year		(36,746)			(36,746)
Net gain / (loss) on revaluation of property, plant, equipment			21,875		21,875
Transfers between reserves		0	0	0	0
Reclassification adjustments					
New PDC received - cash	6,348				6,348
PDC repaid in year	(6,696)				(6,696)
Net recognised revenue/(expense) for the year	**(348)**	**(36,746)**	**21,875**	**0**	**(15,219)**
Balance at 31 March 2016	**182,666**	**(121,448)**	**160,607**	**63**	**221,888**

Statement of Cash Flows for the year ended 31 March 2017	Note	2016/17 £000s	2015/16 £000s
Cash flows from operating activities			
Operating surplus/(deficit)		(10,515)	(10,336)
Depreciation and amortisation	6	23,433	21,049
Impairments and reversals	16	6,421	1,853
(Increase)/decrease in Inventories		509	(517)
(Increase)/decrease in Trade and Other Receivables		(8,167)	1,190
Increase/(decrease) in Trade and Other Payables		(11,507)	6,384
Provisions utilised		(1,354)	(700)
Increase/(decrease) in movement in non cash provisions		1,052	382
Net Cash Inflow/(Outflow) from Operating Activities		**(128)**	**19,305**
Cash flows from investing activities			
Interest received		34	50
(Payments) for property, plant and equipment		(9,554)	(12,299)
(Payments) for intangible assets		(4,932)	(4,817)
Net cash inflow/(outflow) from investing activities		**(14,452)**	**(17,066)**
Net cash inflow / (outflow) before financing		**(14,580)**	**2,239**
Cash flows from financing activities			
Gross temporary and permanent PDC received	*	5,339	6,348
Gross temporary and permanent PDC repaid		0	(6,696)
Loans received from DH - new revenue support loans	**	51,581	65,500
Loans repaid to DH - capital investment loans repayment of principal		(787)	(787)
Loans repaid to DH - working capital loans/revenue support loans	**	(3,215)	(35,824)
Capital element of payments in respect of finance leases and On-SoFP PFI and LIFT		(4,141)	(2,301)
Interest paid		(24,393)	(19,115)
PDC dividend (paid)/refunded		(6,411)	(8,327)
Net cash inflow/(outflow) from financing activities		**17,973**	**(1,202)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**3,393**	**1,037**
Cash and cash equivalents (and bank overdraft) at beginning of the period		**2,064**	**1,027**
Cash and cash equivalents (and bank overdraft) at year end	20	**5,457**	**2,064**

** PDC Received of £5,339K relates to DH funded IT capital investment at QEH (£1,643K) and Trust internal capital funding (£3,696K) brought forward from 2015/16.

** The Trust received revenue cash support during the year totalling £48,366; this being the sum of new support loans (£51,581K) less support loans repaid (£3,215K). The support received comprised Revenue Support Loans (RSL) totalling £21,481K and cash drawn down against the DH approved Revolving Working Capital Facility totalling £26,885K.

Notes to the accounts

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016/17 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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.

1.2 Going concern

IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern.

The directors are seeking additional support from NHS Improvement for 2017/18 of £22,700,000. As disclosed in note 1.2 to the financial statements, NHS Improvement has not, at the date of our report, formally confirmed this support.

Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the 2016/17 Department of Health Group Accounting Manual the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

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

1. The Trust has used component lives information provided by an independent valuer to depreciate buildings on a component basis.
2. Land and buildings have been valued on a Modern Equivalent Asset (MEA) basis using the existing site methodology in preference to an alternative location approach. This choice was predicated on the overriding practical requirement for the Trust's two hospitals to be situated in the same geographical area as the populations they serve. Therefore, the existing locations were considered the most appropriate for valuation purposes. The valuer applied the latest DH Group Accounting Manual (Dec 2016) guidance; which allows for VAT to be

excluded when considering the value of PFI buildings. This approach has resulted in a significant reduction in the overall valuation of the Riverside Building (UHL) and Queen Elizabeth Hospital (QEH) site.

1.3.2 Key sources of estimation uncertainty

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

1. Property, Plant and Equipment (PPE) – PFI buildings are on the Statement of Financial Position at current value as determined by an independent professional valuer on the basis of depreciated replacement cost (DRC). The associated liability has been included using the Department of Health (DH) Universal Model.
2. The value of assets and liabilities at the year end are based on opening values with changes applied to reflect acquisitions, reclassifications, disposals, revaluations, impairments and transfers during the year as appropriate.
3. Outstanding Legal Claims – The value of reported 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.
4. The Trust has estimated provisions for pensions relating to former staff using information provided by the NHS Pensions Agency at the time of the members' early retirement. These are updated annually and changes made where notification is received of the death of a member and resulting cessation of any continuing liability or it becomes apparent that the provision is no longer sufficient to meet the liability.
5. The useful economic life of plant and machinery and IT equipment has been estimated on a probable life basis; consistent with actual experience inside the Trust and across similar NHS provider organisations.
6. QEH Managed Equipment Service (Toshiba) Residual Interest adjustment (Note 28 Impact of IFRS Treatment in Current Year): The build up of any liability or deferred asset is based on:
   - the projected carrying Net Book Value (NBV) of existing assets plus future additions at the end of the contract.
   - less the estimated expiry payment for the equipment which the Trust has elected to acquire at the end of the contract in line with the formula agreed under the contract deed of variation (DoV) signed during the year.

1.4 Revenue

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

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

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

1.5 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies

to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS 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.

1.6 Other expenses

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

Alternative open market valuations are routinely sought where operational assets are scheduled for imminent closure and subsequent disposal.

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

Subsequent expenditure

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

1.8 Intangible assets

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 £5000.

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

Measurement

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments

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

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

The following summarises the remaining useful lives applied by asset category respectively over which depreciation has been calculated:

- Buildings (excluding Dwellings): 1 to 56 years
- Plant and Machinery: 1 to 9 years
- Transport: Nil years (fully depreciated)
- Information Technology: 1 to 7 years
- Furniture and fittings: 1 to 8 years
- Internally Generated Software Licences: 2 to 10 years.

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

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

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.10 Donated assets

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

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

1.13 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.

The Trust as lessee

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

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

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

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

The Trust as lessor

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 so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the 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 on a straight-line basis over the lease term.

1.14 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

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

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the

minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

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

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

However, replacement under the QEH PFI Equipment contract have been capitalised on the following basis:

- Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.
- The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.
- Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

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

Other assets contributed by the Trust to the operator

The Trust did not contribute any assets to the operator before the PFI building came into use.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.16 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.

1.17 Provisions

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015/16: positive 1.37%) in real terms.

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

- A short term rate of negative 2.70% (2015/16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015/16: negative 1.00%) for expected cash flows over five years up to and including 10 years
- A long term rate of negative 0.80% (2015/16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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

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

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 25 Provisions.

1.19 Non-clinical risk pooling

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

1.20 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.21 Contingencies

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

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

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

1.22 Financial assets

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

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and

loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.23 Financial liabilities

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

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

Financial guarantee contract liabilities

The Trust had no guarantee contract liabilities in place during the year.

Financial liabilities at fair value through profit and loss

The Trust had no derivative based financial liabilities.

Other financial liabilities

Financial liabilities against the Trust are classified as 'Other'.

1.24 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.

1.25 Foreign currencies

The Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 34 to the accounts.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.28 Losses and special payments

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

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

1.29 Subsidiaries

The Trust has no subsidiaries.

The Department of Health Group Accounting Manual requires consolidation of the Trust's charitable accounts where the IFRS10 (Consolidated Financial Statements) control criteria are satisfied. However, as the total assets of the Charity are less than 0.2% of those of the Trust, and its total income is less than 0.13% of that of the Trust, the total amounts are immaterial. IAS 1 (Presentation of Financial Statements) states that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material, and on this basis, the Trust has not consolidated its charitable funds.

1.30 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating segments

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

3. Revenue from patient care activities

Revenue from patient care activities	Note	2016/17 £000s	2015/16 £000s
NHS Trusts		372	414
NHS England		53,462	68,803
Clinical Commissioning Groups	*	392,012	363,427
Foundation Trusts		7,879	5,402
Department of Health		13	10
NHS Other (including Public Health England and Prop Co)		0	463
Additional income for delivery of healthcare services		0	15,524
Non-NHS:			
Local authorities		15,088	11,576
Private patients		75	130
Overseas patients (non-reciprocal)		2,030	1,407
Injury costs recovery		861	1,293
Other non-NHS patient care income		89	59
Total Revenue from patient care activities		**471,881**	**468,508**

4. Other operating revenue

Other operating revenue	Note	2016/17 £000s	2015/16 £000s
Recoveries in respect of employee benefits		3,167	3,235
Patient transport services		1,562	1,564
Education, training and research		21,744	20,693
Non-patient care services to other bodies		4,944	3,977
Sustainability & Transformation Fund Income	**	16,746	0
Income generation (Other fees and charges)		1,668	2,571
Rental revenue from operating leases		1,530	2,699
Other revenue	***	16,000	15,700
Total other operating revenue		**67,361**	**50,439**
Total operating revenue		**539,242**	**518,947**

* This includes £10,500K (£16,800K in 2015/16) revenue support for the continuing financial implications of the QEH merger and its recognised exceptional running costs. Unlike last year (£5,200K), no funding was received for additional operational services and reconfiguration.

** This includes £16,746K Sustainability and Transformation Funding (STF) from DH.

*** The £16,000K (£15,700K in 2015/16) is financial support received under the SLHT dissolution agreement to off-set the additional cost imposed by the QEH PFI building - Reference the TDA document "Securing sustainable healthcare for the people of South East London as part of the SLHT dissolution".

5. Overseas visitors disclosure

Overseas visitors disclosure	2016/17 £000s	2015/16 £000s
Income recognised during 2016/17 (invoiced amounts and accruals)	2,030	1,407
Cash payments received in-year (re receivables at 31 March 2016)	1,013	607
Cash payments received in-year (iro invoices issued 2016/17)	1,017	800
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	0	0
Amounts added to provision for impairment of receivables (iro invoices issued 2016/17)	1,028	568
Amounts written off in-year (irrespective of year of recognition)	312	330

6. Operating expenses

Overseas Visitors Disclosure	2016/17 £000s	2015/16 £000s
Purchase of healthcare from non-NHS bodies	394	427
Trust Chair and Non-executive Directors	84	85
Supplies and services - clinical	83,096	84,183
Supplies and services - general	3,966	3,252
Consultancy services	1,762	710
Establishment	3,968	5,355
Transport	4,069	3,728
Service charges - ON-SOFP PFIs and other service concession arrangements	17,895	19,132
Business rates paid to local authorities	3,239	3,489
Premises	31,855	29,851
Hospitality	81	81
Insurance	45	25
Legal Fees	161	123
Impairments and Reversals of Receivables	2,338	1,753
Inventories write down	76	79
Depreciation	20,543	19,162
Amortisation	2,890	1,887
Impairments and reversals of property, plant and equipment	6,421	1,853
Internal Audit Fees	232	149
Audit fees	122	122
Other auditor's remuneration	12	0
Clinical negligence	24,643	21,743
Education and Training	1,462	1,290
Change in Discount Rate	315	(9)
Other	538	100
Total Operating expenses (excluding employee benefits)	**210,207**	**198,570**
Employee benefits		
Employee benefits excluding Board members	338,513	329,642
Board members	1,037	1,071
Total employee benefits	**339,550**	**330,713**
Total operating expenses	**549,757**	**529,283**

7. Operating leases

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

7.1 Lewisham and Greenwich NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2016/17 Total £000s	2015/16 £000s
Payments recognised as an expense					
Minimum lease payments				2,245	2,250
Contingent rents				0	0
Sub-lease payments				0	0
Total				**2,245**	**2,250**
Payable:					
No later than one year	58	2,133	60	2,251	2,274
Between one and five years	232	111	32	375	463
After five years	940	163	0	1,103	1,198
Total	**1,230**	**2,407**	**92**	**3,729**	**3,935**
Total future sublease payments expected to be received:				0	0

7.2 Lewisham and Greenwich NHS Trust as 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.

	2016/17 £000s	2015/16 £000s
Recognised as revenue		
Rental revenue	1,530	2,699
Contingent rents	0	0
Total	**1,530**	**2,699**
Receivable:		
No later than one year	1,530	2,932
Between one and five years	6,120	6,120
After five years	10,710	10,710
Total	**18,360**	**19,762**

8. Employee benefits

8.1 Employee benefits

	2016/17 £000s	2015/16 £000s
Employee benefits – gross expenditure		
Salaries and wages	284,820	283,263
Social security costs	27,295	21,769
Employer contributions to NHS BSA - Pensions Division	28,680	28,341
Other pension costs	0	0
Termination benefits	0	27
Total employee benefits	**340,795**	**333,400**
Employee costs capitalised	**1,245**	**2,687**
Gross employee benefits excluding capitalised costs	**339,550**	**330,713**

8.2 Retirements due to ill-health

	2016/17 Number	2015/16 Number
Number of persons retired early on ill health grounds	5	3
	£000s	**£000s**
Total additional pensions liabilities accrued in the year	180	153

8.3 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Alternative pension Scheme "NEST"

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

The specific characteristics of NEST are as follows:

- Contributions to NEST are based on 1% for employees and 1% for employers.
- Retirement age within this scheme is set at 65.
- Pensions are based on investment and growth funds.
- Employees can pay into these funds directly to top up their pension.
- Pensions can be drawn from age 55.
- At retirement employees can choose how they receive their funds – based on pension pot value.
  - Cash only – cash payment up to 25% value will be tax free
  - Retirement income
  - Cash and retirement income – cash payment up to 25% will be tax free
  - Transfer pension – open market
- Survivor's pensions are included as well as death benefits.
- Employees can choose to opt out of the scheme.
- From October 2017 employers will contribute 2%
- From October 2018 employers will contribute 3%

Contributions will be reviewed in 2017.

9. Better payment practice code

9.1 Measure of compliance

	2016/17 £000s	2016/17 £000s	2015/16 £000s	2015/16 £000s
Non-NHS payables				
Total non-NHS trade invoices paid in the year	115,841	317,919	98,945	223,921
Total non-NHS trade invoices paid within target	17,987	200,585	36,865	140,660
Percentage of NHS trade invoices paid within target	**15.53%**	**63.09%**	**37.26%**	**62.82%**
NHS payables				
Total NHS trade invoices paid in the year	3,096	17,489	3,353	17,673
Total NHS trade invoices paid within target	760	5,373	1,348	9,487
Percentage of NHS trade invoices paid within target	**24.55%**	**30.72%**	**40.20%**	**53.68%**

9.2 The late payment of commercial debts (interest) Act 1998

	2016/17 £000s	2015/16 £000s
Amounts included in finance costs from claims made under this legislation	5	2
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**5**	**2**

10. Investment revenue

	2016/17 £000s	2015/16 £000s
Interest revenue		
Bank interest	34	50
Total investment revenue	**34**	**50**

11. Other gains and losses

	2016/17 £000s	2015/16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	(39)	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	(7)	0
Total	**(46)**	**0**

12. Finance costs

	Note	2016/17 £000s	2015/16 £000s
Interest			
Interest on loans and overdrafts		1,488	890
Interest on obligations under finance leases		12	0
Interest on obligations under PFI contracts:			
main finance cost	*	15,186	11,679
contingent finance cost		7,637	6,464
Interest on late payment of commercial debt		5	2
Total interest expense		**24,328**	**19,035**
Provisions - unwinding of discount		65	80
Total		**24,393**	**19,115**

* This includes £1,753K from the reversal of the prepayment held in 2015/16. See Note 27.

13. Auditor disclosures

13.1 Other auditor remuneration

	2016/17 £000s	2015/16 £000s
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	12	12
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	0	0
Total	**12**	**12**

14.1. Property, plant and equipment

	Land £000s	Buildings excluding dwellings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
Cost or valuation:								
At 1 April 2016	**35,985**	**314,448**	**7,869**	**67,188**	**8**	**14,789**	**1,492**	**441,779**
Additions of assets under construction	0	0	4,883	0	0	0	0	4,883
Additions purchased	0	2,841	0	1,696	2	118	0	4,657
Additions leased (including PFI/LIFT)	0	0	0	2,857	0	0	0	2,857
Reclassifications	0	568	(6,941)	0	0	535	0	(5,838)
Disposals other than for sale	0	0	0	(62)	0	(1)	(207)	(270)
Revaluation	292	(44,905)	0	0	0	0	0	(44,613)
At 31 March 2017	**36,277**	**272,952**	**5,811**	**71,679**	**10**	**15,441**	**1,285**	**403,455**
Depreciation								
At 1 April 2016	**0**	**0**	**0**	**52,145**	**8**	**10,063**	**1,030**	**63,246**
Reclassifications	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	(35)	0	(1)	(195)	(231)
Revaluation	117	(22,209)	0	0	0	0	0	(22,092)
Impairments/reversals charged to operating expenses	(117)	6,538	0	0	0	0	0	6,421
Charged during the year	0	15,671	0	3,513	0	1,202	157	20,543
At 31 March 2017	**0**	**0**	**0**	**55,623**	**8**	**11,264**	**992**	**67,887**
Net Book Value at 31 March 2017	**36,277**	**272,952**	**5,811**	**16,056**	**2**	**4,177**	**293**	**335,568**
Asset financing:								
Owned - purchased	**36,277**	**109,557**	**5,811**	**8,468**	**2**	**4,176**	**293**	**164,584**
Owned - donated	0	580	0	65	0	1	0	646
Owned - government granted	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	590	0	0	0	590
On-SOFP PFI contracts	0	162,815	0	6,933	0	0	0	169,748
PFI residual interests	0	0	0	0	0	0	0	0
Total at 31 March 2017	**36,277**	**272,952**	**5,811**	**16,056**	**2**	**4,177**	**293**	**335,568**

Revaluation reserve balance for property, plant and equipment

	Land £000s	Buildings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
At 1 April 2016	**20,597**	**138,228**	**0**	**1,652**	**2**	**97**	**31**	**160,607**
Movements (specify)	175	(22,696)	0	0	0	0	0	(22,521)
At 31 March 2017	**20,772**	**115,532**	**0**	**1,652**	**2**	**97**	**31**	**138,086**

Additions to assets under construction in 2016/17

	Assets under construction & payments on account £000s
Land	0
Buildings excl dwellings	4,456
Dwellings	9
Plant and machinery	418
Balance as at YTD	**4,883**

14.2. Property, plant and equipment in previous year

2015/16	Land £000s	Buildings excluding dwellings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
Cost or valuation:								
At 1 April 2015	**36,092**	**306,024**	**14,793**	**63,982**	**75**	**12,986**	**1,492**	**435,444**
Additions of assets under construction	0	0	5,920	0	0	0	0	5,920
Additions purchased	0	1,389	0	2,986	0	770	0	5,145
Reclassifications	0	1,452	(12,844)	250	0	1,033	0	(10,109)
Disposals other than for sale	0	0	0	(30)	(67)	0	0	(97)
Revaluation	(107)	5,583	0	0	0	0	0	5,476
At 31 March 2016	**35,985**	**314,448**	**7,869**	**67,188**	**8**	**14,789**	**1,492**	**441,779**
Depreciation								
At 1 April 2015	**0**	**0**	**0**	**48,751**	**75**	**9,037**	**864**	**58,727**
Reclassifications	0	15	0	(15)	0	0	0	0
Disposals other than for sale	0	0	0	(30)	(67)	0	0	(97)
Revaluation	0	(16,399)	0	0	0	0	0	(16,399)
Impairments/reversals charged to operating expenses	0	1,853	0	0	0	0	0	1,853
Charged during the year	0	14,531	0	3,439	0	1,026	166	19,162
At 31 March 2016	**0**	**0**	**0**	**52,145**	**8**	**10,063**	**1,030**	**63,246**
Net Book Value at 31 March 2016	**35,985**	**314,448**	**7,869**	**15,043**	**0**	**4,726**	**462**	**378,533**
Asset financing:								
Owned - purchased	**35,985**	**117,108**	**7,869**	**8,965**	**0**	**4,724**	**462**	**175,113**
Owned - donated	0	382	0	123	0	2	0	507
Owned - government granted	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	196,958	0	5,955	0	0	0	202,913
PFI residual interests	0	0	0	0	0	0	0	0
Total at 31 March 2016	**35,985**	**314,448**	**7,869**	**15,043**	**0**	**4,726**	**462**	**378,533**

14.3. Property, plant and equipment

Revaluation

Land and buildings

Summary

Following the full "fair value" revaluation carried out last year, 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 2016/17 in order to update the fair value of land and buildings for this year.

In drafting their report ME have made their assessment on Modern Equivalent Asset (MEA) basis. ME have also applied the latest DH Group Accounting Manual (Dec 2016) guidance; which allows for VAT to be excluded when considering the value of PFI buildings. This approach has resulted in a significant reduction in the overall valuation of the Riverside Building (UHL) and Queen Elizabeth Hospital (QEH) site.

As the report constituted a form of "interim valuation" ME did not inspect the properties on this occasion.

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 Application 1 – Valuation for Financial Reporting;
- IVSC: International Valuation Application 3 – Valuations for Public Sector Assets for Financial Reporting;
- RICS: Valuation Standard VPS4 – Bases of Value;
- RICS: Valuation Standard UKVS1 – Valuation of Real Property for Financial Statements;
- RICS: UK Guidance Note UKGN2 – Depreciated Replacement Cost Method of Valuation for Financial Reporting.

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

- Market Value for assets where a market exists and comparisons can be considered;
- Existing Use Value where the property is not specialised and is owner occupied;
- Existing Use Value for Social Housing where the property provides residential staff accommodation;
- Depreciated Replacement Cost where no market exists for a property, which may be rarely sold or it is a specialised asset.

Montagu Evans noted that the Trust portfolio does not include any investment properties or assets held for sale and, as such, the Market Value basis of valuation has not been used on this occasion. Similarly the Trust does not own any key worker accommodation and as such, the Existing Use Value for Social Housing has not been used. However, the remaining two basis of valuation, which are summarised below, are relevant to the nature of the Trust's portfolio and have been adopted where appropriate.

(a) Depreciated replacement cost (DRC) - Specialised Assets

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

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

Valuations based on DRC are only to be used for valuing specialised property that is owner occupied for inclusion in financial statements. We have used DRC as the basis of valuation for all of the specialised assets owner occupied by the Trust.

(b) Existing Use Value (EUV) - Non Specialised Assets

Within the RICS Valuation – Professional Standards (January 2014 edition) Existing Use Value is defined as;

The estimated amount for which an asset or liability should exchange on the valuation date between a willing buyer and a willing seller in an arm's length transaction after proper marketing and where the parties had each acted knowledgeably, prudently and without compulsion – assuming

that the buyer is granted vacant possession of all parts of the asset required by the business, and disregarding any potential alternative uses and any other characteristics of the asset that would cause its market value to differ from that needed to replace the remaining service potential at least cost.

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

"In reporting EUV capital values, we have stated the valuation on a gross basis, namely before deduction of any purchaser's costs or disposal costs that may be traditionally incurred in a sale of the asset. This is in keeping with the requirements of the FReM and IFRS."

Modern Equivalent Assets

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 on the basis of the existing hospital locations.

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 (15%) and Royal Borough of Greenwich (18%) have been applied.

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

"Over the period since our last valuation we have seen continued upward movement in build costs, albeit the rate of growth has slowed notably from that in previous years. In contrast the locational weightings have reduced significantly since our last valuation by 10% in both boroughs, primarily as a result of reducing labour costs."

Accounting outcomes

The outcome of the valuation report from ME is that the value of land and buildings reduced by £22,521K ; which has created the following accounting changes:

- A net downward revaluation of £28,942K.
- A net £633K reversal of past impairments resulting from increases in value during the year.
- A net impairment charge to expenditure of £7,055K from reductions in the value of assets not matched by positive revaluation reserve balances.
- A net decrease to the revaluation reserve of £22,521K.

Asset disposals

A number of aged and low value assets have been disposed of during the year due to obsolescence or being surplus to requirement.

These had a Net Book Value of £46K. No sale receipts were received for any of the assets disposals.

Donated assets

No donated assets were received during the year.

15. Intangible non-current assets

	2016/17			2015/16		
	IT - in-house & 3rd party software £000s	Intangible assets under construction £000s	Total £000s	IT - in-house & 3rd party software £000s	Intangible assets under construction £000s	Total £000s
At 1 April 2016	**26,540**	**0**	**26,540**	**11,614**	**0**	**11,614**
Additions of assets under construction	0	2,936	2,936	0	0	0
Additions purchased	1,996	0	1,996	4,817	0	4,817
Reclassifications	3,313	2,525	5,838	10,109	0	10,109
Disposals other than by sale	(9)	0	(9)	0	0	0
At 31 March 2017	**31,840**	**5,461**	**37,301**	**26,540**	**0**	**26,540**
Amortisation						
At 1 April 2016	**7,090**	**0**	**7,090**	**5,203**	**0**	**5,203**
Reclassifications	0	0	0	0	0	0
Disposals other than by sale	(2)	0	(2)	0	0	0
Charged during the year	2,890	0	2,890	1,887	0	1,887
At 31 March 2017	**9,978**	**0**	**9,978**	**7,090**	**0**	**7,090**
Net Book Value at 31 March	**21,862**	**5,461**	**27,323**	**19,450**	**0**	**19,450**
Asset Financing: Net book value at 31 March comprises:						
Purchased	21,862	5,461	27,323	19,450	0	19,450
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Finance leased	0	0	0	0	0	0
On-balance sheet PFIs	0	0	0	0	0	0
Total at 31 March	**21,862**	**5,461**	**27,323**	**19,450**	**0**	**19,450**
Revaluation reserve balance for intangible non-current assets						
At 1 April 2016	**0**	**0**	**0**	**0**	**0**	**0**
Movements (specify)	0	0	0	0	0	0
At 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**

16. Analysis of impairments and reversals recognised in 2016/17

	2016/17 Total £000s
Property, plant and equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to departmental expenditure limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	6,421
Total charged to annually managed expenditure	**6,421**
Total impairments of property, plant and equipment changed to SoCI	**6,421**
Total impairments charged to SoCI - DEL	**0**
Total impairments charged to SoCI - AME	**6,421**
Overall total impairments	**6,421**
Donated and gov granted assets, included above	
PPE - Donated and government granted asset impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and government granted asset impairments: amount charged to SOCI - DEL	0

	Property plant and equipment	Intangible assets	Financial assets	Non-current assets held for sale	Total £000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	0	0	0	0	0
Over-specification of assets	0	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0	0
Total charged to departmental expenditure limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0	0	0
Loss as a result of catastrophe	0	0	0	0	0
Other	0	0	0	0	0
Changes in market price	6,421	0	0	0	6,421
Total charged to annually managed expenditure	**6,421**	**0**	**0**	**0**	**6,421**
Total impairments of property, plant and equipment changed to SoCI	**6,421**	**0**	**0**	**0**	**6,421**
Donated and gov granted assets, included above					
PPE - Donated and government granted asset impairments: amount charged to SOCI - DEL					0
Intangibles - Donated and government granted asset impairments: amount charged to SOCI - DEL					0

17. Commitments

17.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	1,042	1,957
Intangible assets	0	661
Total	**1,042**	**2,618**

The Trust has made contractual agreements for property, plant and equipment with external providers totalling £1,042K for Ambulatory care at QEH (£624K), Backlog Maintenance - OPD Roof (£243K) and UHL Renal Unit (£175K).

18. Inventories

	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s
Balance at 1 April 2016	**2,332**	**3,669**	**0**	**178**	**0**	**0**	**6,179**
Additions	38,057	19,949	0	2,460	0	0	60,466
Inventories recognised as an expense in the period	(37,967)	(20,428)	0	(2,504)	0	0	(60,899)
Write-down of inventories (including losses)	(76)	0	0	0	0	0	(76)
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0
Balance at 31 March 2017	**2,346**	**3,190**	**0**	**134**	**0**	**0**	**5,670**

19.1. Trade and other receivables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
NHS receivables - revenue	13,513	20,784	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	26,262	10,350	0	0
Non-NHS receivables - revenue	10,680	5,491	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	2,625	3,857	2,482	2,988
PDC Dividend prepaid to DH	1,587	1,281	0	0
Provision for the impairment of receivables	(5,615)	(4,001)	0	0
VAT	1,513	2,107	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income excluding PFI lifecycle	0	1,753	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	84	48	0	0
Total	**50,649**	**41,670**	**2,482**	**2,988**
Total current and non current	**53,131**	**44,658**		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services and, as such, no credit scoring of them is considered necessary as the debt is low risk.

19.2. Receivables past their due date but not impaired

	31 March 2017 £000s	31 March 2016 £000s
By up to three months	8,974	16,179
By three to six months	1,451	4,438
By more than six months	7,439	7,166
Total	**17,864**	**27,783**

19.3. Provision for impairment of receivables

	Note	31 March 2017 £000s	31 March 2016 £000s
Balance at 1 April 2016		**(4,001)**	**(2,589)**
Amount written off during the year		724	341
Amount recovered during the year		0	0
(Increase)/decrease in receivables impaired	*	(2,338)	(1,753)
Transfers to NHS Foundation Trust on authorisation as FT		0	0
Transfers (to)/from other public sector bodies under absorption accounting		0	0
Balance at 31 March 2017		**(5,615)**	**(4,001)**

* Receivables impaired during the year total 2,338K and relates entirely to outstanding sales ledger invoices. There was no movement in Injury Cost Recovery balances notified by the Compensation Recovery Unit (Department of Work and Pensions).

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

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

Outstanding Injury cost recovery balances have been impaired at 22.94% of total notified income in line with DH guidance; which is up 0.95% on last year (21.99%).

20. Cash and cash equivalents

	Note	31 March 2017 £000s	31 March 2016 £000s
Opening balance		**2,064**	**1,027**
Net change in year	*	3,393	1,037
Closing balance		**5,457**	**2,064**
Made up of			
Cash with government banking service		5,445	2,050
Commercial banks		0	0
Cash in hand		12	14
Liquid deposits with NLF		0	0
Current investments		0	0
Cash and cash equivalents as in statement of financial position		**5,457**	**2,064**
Bank overdraft - government banking service		0	0
Bank overdraft - commercial banks		0	0
Cash and cash equivalents as in statement of cash flows		**5,457**	**2,064**
Third party assets - bank balance (not included above)		26	48
Third party assets - monies on deposit		0	0

* The increase in cash held at the yearend relates to Trust internal capital funding not utilised in year and being carried forward to 2017-18 with the approval of DH.

21. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
NHS payables - revenue	5,834	6,174	0	0
NHS payables - capital	0	0	0	0
NHS accruals and deferred income	6,454	6,855	0	0
Non-NHS payables - revenue	22,068	29,182	0	0
Non-NHS payables - capital	714	728	0	0
Non-NHS accruals and deferred income	10,462	14,656	657	707
Social security costs	3,807	3,024		
PDC Dividend payable to DH	0	0		
Accrued Interest on DH Loans	94	84		
VAT	0	0	0	0
Tax	3,377	3,230		
Payments received on account	0	0	0	0
Other	179	527	0	0
Total	**52,989**	**64,460**	**657**	**707**
Total payables (current and non-current)	**53,646**	**65,167**		

22. Borrowings

	Note	Current		Non-current	
		31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Bank overdraft - government banking service		0	0		
Bank overdraft - commercial banks		0	0		
Loans from Department of Health - revenue	*	0	0	78,042	29,676
Loans from Department of Health - capital	**	787	787	12,198	12,985
Loans from other entities		0	0	0	0
PFI liabilities - main liability	***	5,726	3,673	106,701	110,611
LIFT liabilities - main liability		0	0	0	0
Finance lease liabilities	****	104	0	469	0
Other (describe)		0	0	0	0
Total		**6,617**	**4,460**	**197,410**	**153,272**
Total other liabilities (current and non-current)		**204,027**	**157,732**		

	31 March 2017		
	DH £000s	Other £000s	Total £000s
0-1 Years	787	5,830	6,617
1 - 2 Years	1,574	8,778	10,352
2 - 5 Years	2,361	10,395	12,756
Over 5 Years	86,305	87,997	174,302
TOTAL	**91,027**	**113,000**	**204,027**

* This is new and existing Revenue Support Loan (RSL) and Revolving Working Capital Facility (RWCF) funding as follows:

- RSL of £29,676K relating to revenue cash support received in 2015/16 - as detailed in the Statement of Cash Flow (SoCF) comparator (£65,000K less £35,824K repaid).
- RSL of £21,481K relating to revenue cash support received in year - as detailed in the Statement of Cash Flow (SoCF).
- RWCF of £26,885K relating to revenue cash support received in year - as detailed in the Statement of Cash Flow (SoCF).

** This existing Capital Investment Loan (CIL) funding as follows:

- CIL of £8,883K relating to the construction of the Urgent Care Centre completed in April 2012.
- CIL of £4,102K relating to the creation of additional "Winter Pressure" ward capacity in 2014-15.

*** The liabilities relate to PFI assets including the Riverside building on the Lewisham Hospital site and QEH buildings.

**** Finance lease liabilities relate to Pathology equipment contracts.

23. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Opening balance at 1 April 2016	**5,413**	**4,505**	**707**	**777**
Deferred revenue addition	5,761	5,413	0	0
Transfer of deferred revenue	(5,413)	(4,505)	(50)	(70)
Current deferred Income at 31 March 2017	**5,761**	**5,413**	**657**	**707**
Total deferred income (current and non-current)	**6,418**	**6,120**		

24. Finance lease obligations as lessee

Amounts payable under finance leases (other)	Minimum lease payments		Present value of minimum lease payments	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Within one year	127	0	104	0
Between one and five years	381	0	310	0
After five years	196	0	159	0
Less future finance charges	(131)	0		
Minimum lease payments/present value of minimum lease payments	**573**	**0**	**573**	**0**
Included in:				
Current borrowings			104	0
Non-current borrowings			469	0
			573	**0**
Finance leases as lessee				
Future sublease payments expected to be received			0	0
Contingent rents recognised as an expense			0	0

25. Provisions

	Total £000s	Early Departure Costs £000s	Legal Claims £000s	Restructuring £000s	Other £000s	Redundancy £000s
Balance at 1 April 2016	**6,097**	**3,772**	**1,439**	0	886	**0**
Arising during the year	1,237	0	523	0	500	214
Utilised during the year	(1,354)	(569)	(651)	0	(134)	0
Reversed unused	(565)	0	(565)	0	0	0
Unwinding of discount	65	54	0	0	11	0
Change in discount rate	315	257	0	0	58	0
Balance at 31 March 2017	**5,795**	**3,514**	**746**	0	1,321	**214**
Expected timing of cash flows:						
No later than one year	1,876	331	746	0	585	214
Later than one year and not later than five years	1,508	1,319	0	0	189	0
Later than five years	2,411	1,864	0	0	547	0

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:						
	£000s					
As at 31 March 2017	**419,768**					
As at 31 March 2016	**374,797**					

Early departure "pensions" costs relating to other staff are on-going and none are capitalised.

Legal claims (£746K) are based on an assessment of all outstanding cases by solicitors acting on behalf of the Trust.

Other provisions (£1,321K) comprise injury benefits of £795K and employee, public liability claims of £26K which are handled by the NHS Litigation Authority.

26. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	0	0
Employment tribunal and other employee related litigation	0	0
Redundancy	0	0
Other	(56)	(28)
Net value of contingent liabilities	**(56)**	**(28)**
Contingent assets		
Contingent assets	0	0
Net value of contingent assets	**0**	**0**

The contingent liability of £56K (2015/16 £28K) relates to employee and public liability claims handled by the NHS Litigation Authority.

27. PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts.

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	Total 2016/17 £000s	Total 2015/16 £000s
Total charge to operating expenses in year - Off SoFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	17,895	19,132
Total	**17,895**	**19,132**
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No later than one year	17,683	17,698
Later than one year, no later than five years	72,734	70,869
Later than five years	224,889	240,829
Total	**315,306**	**329,396**

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due	Total 2016/17 £000s	Total 2015/16 £000s
No later than one year	25,774	21,912
Later than one year, no later than five years	93,303	91,126
Later than five years	273,214	299,751
Subtotal	**392,291**	**412,789**
Less: interest element	(279,864)	(298,505)
Total	**112,427**	**114,284**

Queen Elizabeth Hospital building	QEH	
	2016/17 £000s	2015/16 £000s
No later than one year	16,105	15,625
Later than one year, no later than five years	67,365	64,963
Later than five years	164,588	181,064
Subtotal	**248,058**	**261,652**
Less: interest element	(181,840)	(193,249)
Total	**66,218**	**68,403**

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

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

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

Riverside building	UHL	
	2016/17 £000s	2015/16 £000s
No later than one year	6,132	6,287
Later than one year, no later than five years	25,938	26,163
Later than five years	108,626	118,687
Subtotal	**140,696**	**151,137**
Less: interest element	(96,303)	(105,256)
Total	**44,393**	**45,881**

The existing PFI contract for the Riverside building was entered into in July 2004 and had a term of 33 years (3 years construction and 30 years operational). Ownership of the Riverside building will transfer to the Trust at the end of the contract term.

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

QEH managed equipment service - Toshiba	QEH MES	
	2016/17 £000s	2015/16 £000s
No later than one year	3,537	0
Later than one year, no later than five years	0	0
Later than five years	0	0
Subtotal	**3,537**	**0**
Less: interest element	(1,721)	0
Total	**1,816**	**0**

	QEH MES prepayment	
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	**1,753**

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

The prepayment of £1,753K held in 2015/16 has been reversed and charged to I&E as an additional interest cost in respect of possible slippage against the planned equipment replacement programme (ERP) at the end of contract in September 2017 – see note 12 Finance Costs.

The new obligation of £1,816K relates to additional equipment replaced under the MES contract as part of the Deed of Variation agreed in April 2015. This provided for the purchase of an additional £2,500K of equipment under the contract.

At the end of the contract with Toshiba the Trust can 1) renew the contract with Toshiba, 2) novate the contract to a new contractor or 3) reprovide the medical equipment itself.

1. In this case the Trust would have a liability to Toshiba of £2,414k of which £1,816 is provided in the accounts above, ie a net liability of £598k.

2. In this case the Trust would have a liability through unitary charges for the equipment transferred from Toshiba to the new contractor of £2,414k, assuming Toshiba pass across to the new contractor a credit of £2060k set out in the Deed of Variation between Toshiba and the Trust.

3. In this case the Trust would need to reprovide new equipment with an estimated net book value of £7,949k at 30th September 2017.

Present value imputed "finance lease" obligations for on SOFP PFI contracts due	Total	
	2016/17 £000s	2015/16 £000s
Analysed by when PFI payments are due		
No later than one year	5,726	3,673
Later than one year, no later than five years	18,730	17,075
Later than five years	87,971	93,536
Total	**112,427**	**114,284**
Number of on SOFP PFI contracts		
Total number of on PFI contracts	3	3
Number of on PFI contracts which individually have a total commitments value in excess of £500m	0	0
Number of off SOFP PFI contracts		
Total number of off PFI contracts	0	
Number of off PFI contracts which individually have a total commitments value in excess of £500m	0	

28. Impact of IFRS treatment – current year

The information below is required by the Department of Heath for budget reconciliation purposes.

In accounting for finance leases the Trust incurred net additional costs which would not apply under UKGAAP. The additional costs come about largely because the residual interest charge from I&E to capital does not apply under IFRS and the depreciation charge to I&E being greater, as a rule, than the annual debt repayment element that it replaces.

All PFI schemes	2016/17 £000s	2015/16 £000s
Revenue costs of IFRS: arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	9,125	8,888
Interest expense	22,822	18,143
Impairment charge - AME	6,243	2,672
Impairment charge - DEL	0	0
Other expenditure	17,895	19,132
Impact on PDC dividend payable	2,596	3,118
Total IFRS expenditure (IFRIC12)	**58,681**	**51,953**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	37,996	37,345
Net IFRS change (IFRIC12)	**20,685**	**14,608**
Capital consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2015/16	2,230	2,004
UK GAAP capital expenditure 2015/16 (reversionary interest)	4,940	4,253

Queen Elizabeth Hospital building	QEH 2016/17 £000s	QEH 2015/16 £000s
Revenue costs of IFRS: arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	5,628	5,879
Interest expense	13,419	12,389
Impairment charge - AME	6,243	2,672
Impairment charge - DEL	0	0
Other expenditure	13,668	15,240
Impact on PDC dividend payable	1,706	2,254
Total IFRS expenditure (IFRIC12)	**40,664**	**38,434**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	27,657	26,756
Net IFRS change (IFRIC12)	**13,007**	**11,678**
Capital consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2015/16	0	0
UK GAAP capital expenditure 2015/16 (reversionary interest)	1,616	1,616

Riverside building	UHL 2016/17 £000s	UHL 2015/16 £000s
Revenue costs of IFRS: arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	2,245	1,782
Interest expense	4,619	4,701
Impairment charge - AME	0	0
Impairment charge - DEL	0	0
Other expenditure	2,352	2,110
Impact on PDC dividend payable	667	630
Total IFRS expenditure (IFRIC12)	**9,883**	**9,223**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	7,435	7,328
Net IFRS change (IFRIC12)	**2,448**	**1,895**
Capital consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2015/16	0	0
UK GAAP capital expenditure 2015/16 (reversionary interest)	1,024	1,024

QEH managed equipment service - Toshiba	QEH MES 2016/17 £000s	QEH MES 2015/16 £000s
Revenue costs of IFRS: arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	1,252	1,227
Interest expense	4,784	1,053
Impairment charge - AME	0	0
Impairment charge - DEL	0	0
Other expenditure	1,875	1,782
Impact on PDC dividend payable	223	234
Total IFRS expenditure (IFRIC12)	**8,134**	**4,296**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	2,904	3,261
Net IFRS change (IFRIC12)	**5,230**	**1,035**
Capital consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2015/16	2,230	2,004
UK GAAP capital expenditure 2015/16 (Reversionary Interest)	2,300	1,613

* This includes £1,753K from the reversal of the prepayment held in 2015/16. See Note 12 Finance Costs.

Revenue costs of IFRS12 compared with ESA10	2016/17 IFRIC12 £000s	2015/16 IFRIC12 £000s
IFRS12		
Depreciation charges	9,125	8,888
Interest expense	22,822	18,143
Impairment charge - AME	6,243	2,672
Impairment charge - DEL	0	0
Other Expenditure		
Service charge	17,895	19,132
Contingent rent	0	0
Lifecycle	0	0
Impact on PDC dividend payable	2,596	3,118
Total revenue cost under IFRIC12 vs ESA10	**58,681**	**51,953**
Revenue receivable from subleasing	0	0
Net revenue cost/(income) under IDRIC12 vs ESA10	**58,681**	**51,953**
ESA10		
Service charge	37,996	37,345

29. Financial instruments

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 risks 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 than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS organisation has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

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.

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.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care Trusts, 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.

29.2. Financial assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0	0	0	0
Receivables - NHS	0	13,513	0	13,513
Receivables - non-NHS	0	5,149	0	5,149
Cash at bank and in hand	0	5,457	0	5,457
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**24,119**	**0**	**24,119**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	20,784	0	20,784
Receivables - non-NHS	0	1,538	0	1,538
Cash at bank and in hand	0	2,064	0	2,064
Other financial assets	0	0	0	0
Total at 31 March 2016	**0**	**24,386**	**0**	**24,386**

29.3 Financial liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0	0	0
NHS payables	0	5,834	5,834
Non-NHS payables	0	22,961	22,961
Other borrowings	0	91,027	91,027
PFI & finance lease obligations	0	113,000	113,000
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**232,822**	**232,822**
Embedded derivatives	0	0	0
NHS payables	0	6,174	6,174
Non-NHS payables	0	30,437	30,437
Other borrowings	0	43,448	43,448
PFI & finance lease obligations	0	114,284	114,284
Other financial liabilities	0	0	0
Total at 31 March 2016	**0**	**194,343**	**194,343**

30. Events after the end of the reporting period

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

31. Related party transactions

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 any material transactions with the Trust.

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

For example:

Department of Health
HM Revenue and Customs
National Health Services Pension Scheme
NHS Litigation Authority
Bexley CCG
Bromley CCG
Croydon CCG
Dartford, Gravesham and Swanley CCG
Greenwich CCG
Lambeth CCG
Lewisham CCG
Southwark CCG
Tower Hamlets CCG
West Kent CCG
NHS England
Barts Health NHS Trust
Dartford and Gravesham NHS Trust
Guy's and St Thomas' NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Oxleas NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
St George's University Hospitals NHS Foundation Trust
London Borough of Bexley
Royal Borough of Greenwich
London Borough of Lewisham
Health Education England
Community Health Partnerships
NHS Property Services
NHS Blood and Transplant
London Specialised Commissioning

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
- Transaction with an entity identified in the Trust Registers of Interest exceeds £25K.

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:

	2016/17 £	2015/16 £
Patient education and welfare	72,089	174,038
Staff education and welfare	37,158	39,584
New equipment	227,451	327,261
Governance	31,322	43,813
	368,019	**584,696**

32. Losses and special payments

	Total value of cases £s	Total number of cases #
2016/17		
Losses	1,309,584	7,411
Special payments	26,223	54
Total losses and special payments and gifts	**1,335,807**	**7,465**
2015/16		
Losses	887,032	6,744
Special payments	75,123	53
Total losses and special payments	**962,155**	**6,797**

Details of cases individually over £300,000

There were no individual cases over £300K.

33. Financial performance targets

The figures given for periods prior to 2009/10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

33.1 Breakeven performance

	2006/07 £000s	2007/08 £000s	2008/09 £000s	2009/10 £000s	2010/11 £000s	2011/12 £000s	2012/13 £000s	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s
Turnover	172,464	171,106	174,246	188,109	222,366	229,184	241,470	382,097	517,522	518,947	539,242
Retained surplus/(deficit) for the year	2,042	3,771	(3,929)	(1,156)	(347)	44	(7,010)	74,377	(20,750)	(36,746)	(41,025)
Adjustment for:											
Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	0
Prior period adjustments	0	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	4,230	6,372	0	0	7,163	4,933	3,216	1,853	6,421
Adjustments for impact of policy change re donated/government grants assets						0	23	(6)	95	90	108
Consolidated budgetary guidance - adjustment for dual accounting under IFRIC12*				1,537	1,405	1,383	1,574	3,059	8,957	11,936	14,442
Absorption accounting adjustment							0	(82,121)	0	0	0
Other agreed adjustments	0	0	0	0	0	0	0	0	0	0	0
Breakeven in-year position	**2,042**	**3,771**	**301**	**6,753**	**1,058**	**1,427**	**1,750**	**242**	**(8,482)**	**(22,867)**	**(20,054)**
Breakeven cumulative position	**(13,409)**	**(9,638)**	**(9,337)**	**(2,584)**	**(1,526)**	**(99)**	**1,651**	**1,893**	**(6,589)**	**(29,456)**	**(49,510)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006/07 £000s	2007/08 £000s	2008/09 £000s	2009/10 £000s	2010/11 £000s	2011/12 £000s	2012/13 £000s	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s
Materiality test (ie is it equal to or less than 0.5%):											
Breakeven in-year position as a percentage of turnover	1.18	2.20	0.17	3.59	0.48	0.62	0.72	0.06	(1.64)	(4.41)	(3.72)
Breakeven cumulative position as a percentage of turnover	(7.77)	(5.63)	(5.36)	(1.37)	(0.69)	(0.04)	0.68	0.50	(1.27)	(5.68)	(9.18)

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

33.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

33.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016/17 £000s	2015/16 £000s
External financing limit (EFL)	49,245	25,267
Cash flow financing	45,384	25,203
Finance leases taken out in the year	627	0
Other capital receipts	0	0
External financing requirement	46,011	25,203
Under/(over) spend against EFL	**3,234**	**64**

The undershoot on the EFL target of £49,245K by £3,234K is attributable to unutilised Trust internal capital funding totalling £3,393K being carried forward, with approval from DH, as part of the increased year end cash balance (£5,457K from £,2,064K last year).

33.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016/17 £000s	2015/16 £000s
Gross capital expenditure	17,329	15,880
Less: book value of assets disposed of	(46)	0
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	0	0
Charge against the capital resource limit	**17,283**	**15,880**
Capital resource limit	22,418	15,911
(Over)/underspend against the capital resource limit	**5,135**	**31**

The undershoot on the CRL of £22,418K by £5,135K comprises the £3,393K unutilised capital funding referenced in the above note; together with delayed equipment purchases (£357K) and slippage on schemes across theatres (£485K) and endoscopy (£494K).

34. Third party assets

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

	31 March 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust	26	48

27 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.

How you can get a copy of this report and accounts

If you would like a hard copy of the report or accounts, please email communications.lg@nhs.net or call 020 8333 3297 and we will send you a copy. Alternatively, you can write to:

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