Bundle ULH Annual Public Meeting 11 September 2024

1 Welcome, Chair's opening remarks, apologies for absence
2 To receive the minutes of the 2023 Annual Public Meeting
    Minutes APM Sept 2023
3 To receive the Annual Report and Accounts 2023/24
    United Lincolnshire Hospitals NHS Trust Annual Report and accounts 2023-24
4 Looking ahead to 2024/25
5 Questions

Minutes of the United Lincolnshire Hospitals NHS Trust
Annual Public Meeting

Held on 18 September 2023

Via MS Teams Live Stream

Present

Voting Members
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Dr Karen Dunderdale, Director of Nursing
Mr Barry Jenkins, Director of Finance and Digital
Mrs Rebecca Brown, Non-Executive Director
Ms Michelle Harris, Chief Operating Officer

Non-Voting Members
Mrs Sarah Buik, Associate Non-Executive Director
Dr Sameedha Rich-Mahadkar, Director of Improvement and Integration
Ms Claire Low, Director of People and OD

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Anna Richards, Associate Director of Communications and Engagement
Mr Andrew Simpson, Deputy Medical Director

Apologies
Dr Colin Farquharson, Medical Director
Dr Chris Gibson, Non-Executive Director
Mr Neil Herbert, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Mr Paul Dunning, Interim Medical Director

001/23	**Item 1 Welcome, Chair's opening remarks and apologies** The Chair welcomed members of the public and Trust Board members to the meeting noting that the Annual Public Meeting was an important milestone in the cycle of board business where the opportunity was taken to reflect and report on the previous year, April 2022 to March 2023.
002/23	The Chair noted that the meeting was an opportunity to not only celebrate successes but also to share plans with the public and wider stakeholders on areas where improvement was required.
003/23	Members of the public who had joined the meeting virtually were welcomed as the Trust Board considered the annual report and accounts of the 2022/23 year.
004/23	The Chair noted that there was an opportunity for those joining the meeting to ask questions which would be taken at the appropriate point of the agenda and advised that if there was insufficient time for these to be responded to during the meeting, a response these would be followed up once the meeting had concluded.
005/23	The Chair offered opening remarks noting that the 2022/23 year had been a challenging year for a number of reasons, including periods of industrial action by some staff groups and increased pressures both locally and nationally on NHS services.

006/23	Despite the challenges faced the Trust had been successful in a number of areas including improvements in National Staff Survey Results and the development of the new resuscitation department at Lincoln County Hospital as well as delivering a significant capital programme.
007/23	The Chair offered thanks to the Chief Executive and Executive Directors for the outstanding leaderships of teams across the Trust in resolving to improve patient safety and quality of care. Thanks were expressed to the Non-Executive Directors for the governance and pursuit of assurance.
008/23	The Chair noted the formal requirement to report changes to the Trust Board noting that during 2022/23 there had been a number of changes to the Board of Directors.
009/23	The Chair was delighted to confirm a number of incoming appointments and changes to roles including Mr Paul Dunning assuming the role of Acting Medical Director, covering the sickness absence of Dr Colin Farquharson from September 2022.
010/23	The appointment the Deputy Director of People and OD, Ms Claire Low, who had subsequently assumed the Interim Director of People and OD role in December 2022.
011/23	Outgoing Board members had been the Chief Operating Officer, Mr Simon Evans who left the Trust in January 2023 with Ms Michelle Harris assuming the Interim Chief Operating Officer position.
012/23	Mr Mark Brassington had, during the year, continued on secondment with NHS England however resigned on 31 March 2023 with the role of Director of Improvement and Integration continuing to be covered by Mrs Sameedha Rich-Mahadkar, who was on secondment to the Trust.
013/23	The Chair was delighted that Professor Karen Dunderdale had taken on the role of Director of Nursing for Lincolnshire Community Health Services NHS Trust on an interim basis, in addition to her substantive position with the Trust.
014/23	The Chair also noted the changes of Non-Executive Directors within the Trust advising that Ms Gail Shadlock and Mrs Sarah Dunnett had left the Trust during 2022/23 and that Mr Neil Herbert and Mrs Rebecca Brown had joined as Non-Executive Directors.
015/23	Mrs Vicki Wells and Mrs Sarah Buik had also joined the Trust in August 2022 as Associate Non-Executive Directors.
016/23	Thanks were offered to all Board members past and present for their commitment to the Board and the Trust.
017/23	The Chair also thanked the Board Secretary and secretariate without whom the public meetings and all other associated meetings would not function well.
018/23	The Chair noted the apologies for the Annual Public Meeting with apologies received from Dr Farquharson, Medical Director, Mr Paul Dunning, Interim

	Medical Director and Non-Executive Directors Professor Baker, Dr Gibson, Mr Herbert and Ms Cecchini.
019/23	**Item 2 Minutes of the last annual meeting held on 29 September 2022** The minutes were accepted as a true record of the annual public meeting held on the 29 September 2022.
020/23	**Item 3 Reflecting on 2022/23** The Chief Executive offered a summary of the year ending March 2023 and thanked those who were in attendance at the meeting.
021/23	The Chief Executive noted that the Trust was deemed to be an extra-large Acute Trust in the NHS on a scale of small, medium, large, extra large and supra larger, meaning that the Trust was one of the bigger organisations within the NHS providing acute and specialist services.
022/23	The Trust had an annual income of £758m and provides a range of services from the four acute hospitals in Lincolnshire as well as a variety of outpatient, day case and inpatient services from other locations.
023/23	The Chief Executive noted that during the 2022/23 year the Trust had treated over 140,000 patients in accident and emergency, over 640,000 outpatients, 134,000 inpatients and delivered around 4000 babies.
024/23	Looking back to the 2022/23 year the Chief Executive noted that this had again been a challenging year for the NHS both nationally and locally including the continued recovery from Covid-19 as well as recovery following a major fire at Lincolnshire Hospital in March 2022.
025/23	The Trust has also been impacted by a number of periods of industrial action by some staff groups in addition to the continued increasing demand in emergency care.
026/23	Despite the challenges the Trust had made progress on the improvement journey with a number of conditions lifted from the CQC registration of the Trust as well as being removed from the Maternity Safety Improvement Programme.
027/23	The Trust continued to work across the system to ensure the best outcomes for patients and it was recognised that further work was required to improve financial management as a system, which remained in the NHS System Oversight Framework Level 4.
028/23	During the 2022/23 year the Trust achieved a number of success including the development of a new resuscitation department at Lincoln, costing £5.6m and was able to submit a declaration of full compliance against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. The Trust was only one of a few in the country to have declared full compliance against the scheme during the year.
029/23	The Chief Executive was pleased to note the improvement in the NHS National Staff Survey results with the overall positive score increasing by 3.5% and the

	Trust being ranked second out of 65 acute Trusts for the level of improvement seen.
030/23	It was recognised that continued improvement was required to improve staff experience with the Trust continuing to be part of the NHS Culture and Leadership Programme and the launch of the Cultural Intelligence programme to improve equality, diversity and inclusion.
031/23	The Trust continued to build relationships with the University of Lincoln to further develop research and innovation and work had been undertaken with Lincolnshire Community Health Services NHS Trust in order to expand virtual wards.
032/23	The Chief Executive noted that there continued to be operational challenges within emergency care services due to increased attendances and emergency admissions. There had also been an increase in acuity which had impacted on increasing the waits in Emergency Departments.
033/23	Performance against key national target areas had not delivered to expected standards in the year due to a number of factors including the ongoing recovering from Covid-19, growth in demand for services at a greater rate than increase in capacity and difficulties in recruitment of sufficient staff numbers across all aspects of the urgent and elective pathways.
034/23	Despite the challenging year the Chief Executive was pleased that a number of improvements had been achieved and expressed gratitude to the staff who continued to work tirelessly and selflessly to keep patients safe and to rive forward the Trust's vision to provide outstanding care, personally delivered.
035/23	**Item 4 Receive the Annual Report and Accounts for 2022/23** The Director of Finance and Digital presented the Annual Report and Accounts for 2022/23 and noted that there had been a Lincolnshire system financial plan for the year to deliver a break-even position.
036/23	The Trust delivered a deficit of £13.6m following an agreed adjustment to the financial performance of the Trust. There had been achievement of £18.9m Cost Improvement Programme savings against planned savings of £29m.
037/23	During the year the Trust had maximised capital resources of £47.1m through investment in the estates infrastructure as well as improving and modernising digital and equipment assets.
038/23	The Director of Finance and Digital noted statutory duties with which the Trust had to comply and advised of the achievement of the external financing limit in addition to management of the capital resource of £47.1m.
039/23	There was a need to achieve the capital cost absorption rate of 3.5% which was achieved however the Trust had been unable to meet the Better Payment Practice Code of 95%. Work would continue throughout the year to improve the position.
040/23	The Chief Executive looked to the current year of 2023/24 noting that the Integrated Improvement Plan set out the Trust's commitment to continual improvement and mapped the stages of the improvement journey.

041/23	The Trust continued to work towards the strategic objectives which provided focus to our patients, our people, our services and our partners with the Trust pledging to put quality improvement, productivity and efficiency at the heart of what it did to support delivery of better patient outcomes and improve operational and financial sustainability.
042/23	The Chief Executive noted that challenges remained as the Trust moved in to the 2023/24 year with a focus on the recovery of elective waiting list, reducing waiting times and improving focus on A&E performance.
043/23	There would also be a focus on improving cancer standards, staff recruitment, retention and organisational culture and strengthening financial management across the system.
044/23	The Chief Executive also noted the implementation of the Group arrangement with Lincolnshire Community Health Services NHS Trust recognising the exciting opportunities that this would present not only for the organisations but for the population of Lincolnshire.
045/23	The Chair noted the formal duty of asking the Board members to receive the annual report and accounts for 2022/23. The Trust Board: • **Received the Annual Report and Accounts for 2022/23**
046/23	**Item 4 Public Questions** The Chair noted that there had been no questions received from members of the public prior to the meeting and noted that there had been no questions submitted during the course of the meeting to be responded to.
047/23	The Chair thanked Board members for participating in the meeting and members of the public for attending the meeting.
048/23	**Item 5 Any Other Notified Items of Business** There were no further items of business.
049/23	The APM for 2022/23 was closed.

NHS
United Lincolnshire Hospitals
NHS Trust

Annual Report and Accounts for the year ended 31 March 2024

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Contents

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This annual report and accounts are available at www.ulh.nhs.uk

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For further information about this report or the work of the Trust please contact the communications and engagement team at Lincoln County Hospital, Lincoln, LN2 4AX or by telephoning 01522 573986.

Chief Executive and Chair's Foreword

We are pleased to be able to share with you our Annual Report for the year 2023/24.

This report covers a year in which the NHS both locally and nationally has been under pressure, but where we have also shown real signs of improvement through the hard work of our staff and embracing innovation.

We are proud of colleagues across the Trust, who have worked so hard to help us continue to recover from the last few challenging years, reducing our elective waiting times and working collectively across our healthcare system to improve our performance around urgent and emergency care, for the benefit of our patients. We know we have more work to do, but it is really encouraging to see the progress that continues to be made.

We are also proud to be able to say that we lead an organisation that has demonstrated improved financial grip and control over the last year, delivering on our financial plan for the year and achieving and exceeding our target for cost improvement programmes (CIPs) in a very challenging financial climate.

We've seen some really positive developments on our capital programme during the year, including continuing work on the new Emergency Department for Pilgrim hospital, the expansion of the new Community Diagnostic Centre in Grantham and the long-awaited opening of the 24/7 Urgent Treatment Centre at Grantham and District Hospital.

Following a public consultation exercise we have also successfully secured the future of the comprehensive paediatric service at Pilgrim, after a number of years of uncertainty. This is a welcome outcome for the local population and for the committed members of staff who have worked hard to establish this service.

In addition, we've started to see a shift in our organisational culture and staff wellbeing. Whilst there is still a way to go, our annual National Staff Survey results have improved again over the last year, and we have been proud to receive a number of awards for how we support and train staff, including being proud recipients of the NHS Pastoral Care Quality Award in recognition of best

practice care for staff recruited and onboarded from overseas. We were also recipients of the Gold Award in the Defence Employer Recognition Scheme.

This year has also been a huge turning point for our organisation and how we work with partners, as agreement was reached that we would move towards a Group arrangement with Lincolnshire Community Health Services NHS Trust from Monday 1 April 2024.

This reflects the huge amount of positive progress that we have made over the last year in working together with partners, to improve the care that we provide to our patients in Lincolnshire.

We are so proud to lead this organisation, which is really making a difference for the people of Lincolnshire. Thank you to our colleagues for everything they do to

continue to provide safe and compassionate care for our patients and their communities.

Elaine Baylis, Chair

Andrew Morgan, Chief Executive

Performance Report

Overview

The purpose of this overview is to give context to the Annual Report. It outlines and summarises the Trust's performance over the past year, where we have made improvements and the areas in which we need to continue to improve.

Whilst we are required by law to include technical and financial detail, we have tried to make this overview as easy as possible to read and understand, whilst sharing with you information about our Trust and the services we provide for the residents of Lincolnshire and beyond. The Performance Report is a summary of what we provide, how we have performed against the national mandated standards for clinical care, what we achieved in 2023/24, and how your money was invested to improve services for patients.

The Accountability Report and the Financial Statements contain a range of other technical details, statements and financial information, which we are required to produce by Parliament and our legal regulators, NHS England (NHSE).

About Us

United Lincolnshire Hospitals Trust (ULHT) serves one of the largest geographical areas in England with a population of around 769,474 (Office of National Statistics).

Our services are provided by four core clinical divisions: Medicine, Surgery, Family Health and Clinical Support Services with support from Corporate Divisions.

We provide a comprehensive range of hospital based medical , surgical, paediatric, obstetric and gynaecological services and primarily operate from four hospital sites in Lincoln, Boston, Grantham and Louth.

We have a number of community hospitals providing additional capacity closer to our patients' homes; John Coupland at Gainsborough, Johnson Hospital at Spalding, Skegness and District Hospital and Community Diagnostic Centre at Grantham.

We have an annual income for 2023/24 of £740m. Our main contract is with NHS Lincolnshire Integrated Care Board (ICB)

In an average year, we treat more than 140,000 accident and emergency patients, over 600,000 outpatients and over 130,000 inpatients, and deliver around 4,000 babies.

For 2022/23 vs 2023/24 our attendances were as follows:

	2022/23	**2023/24**
Outpatient	640,532	679,357
A&E Attendances*	141,360	154,418
Inpatients	134,775	131,213

*Grantham ED changed to UTC 31 October 2023

Whilst the Trust is the largest provider of elective care for Lincolnshire ICB, Northern Lincolnshire and Goole NHS Foundation Trust and North West Anglia NHS Foundation Trust provide a significant share of elective care in East and South Lincolnshire respectively.

Trust Organisational Structure

The table below shows the services provided by the Trust and how they are managed through each of the four Trust divisions:

Division	Clinical Business Unit	Clinical Service
Family Health	Women's Health	Breast Obstetrics Gynaecology
	Children and Young People	Paediatrics Neonatology
Clinical Support Services	Diagnostics	Radiology Radiotherapy Medical Physics Pathology Audiology
	Therapies and Rehabilitation	Rehabilitation medicine Occupational Therapy Speech and Language Therapy Dietetics Physiotherapy
	Pharmacy	
	Outpatients	
	Cancer Services	
Surgery	Surgery	General Surgery Vascular Urology Head and Neck
	Orthopaedics and Opthalmology	Orthopaedics Opthalmology Orthoptics
	Theatres, Anaesthetics, Critical Care and Pain	Theatres Critical Care
Medicine	Urgent and Emergency Care	A&E Acute Medicine Cardiology (including cardiac physiology)
	Cardio Vascular	Diabetes Renal Stroke Endocrinology

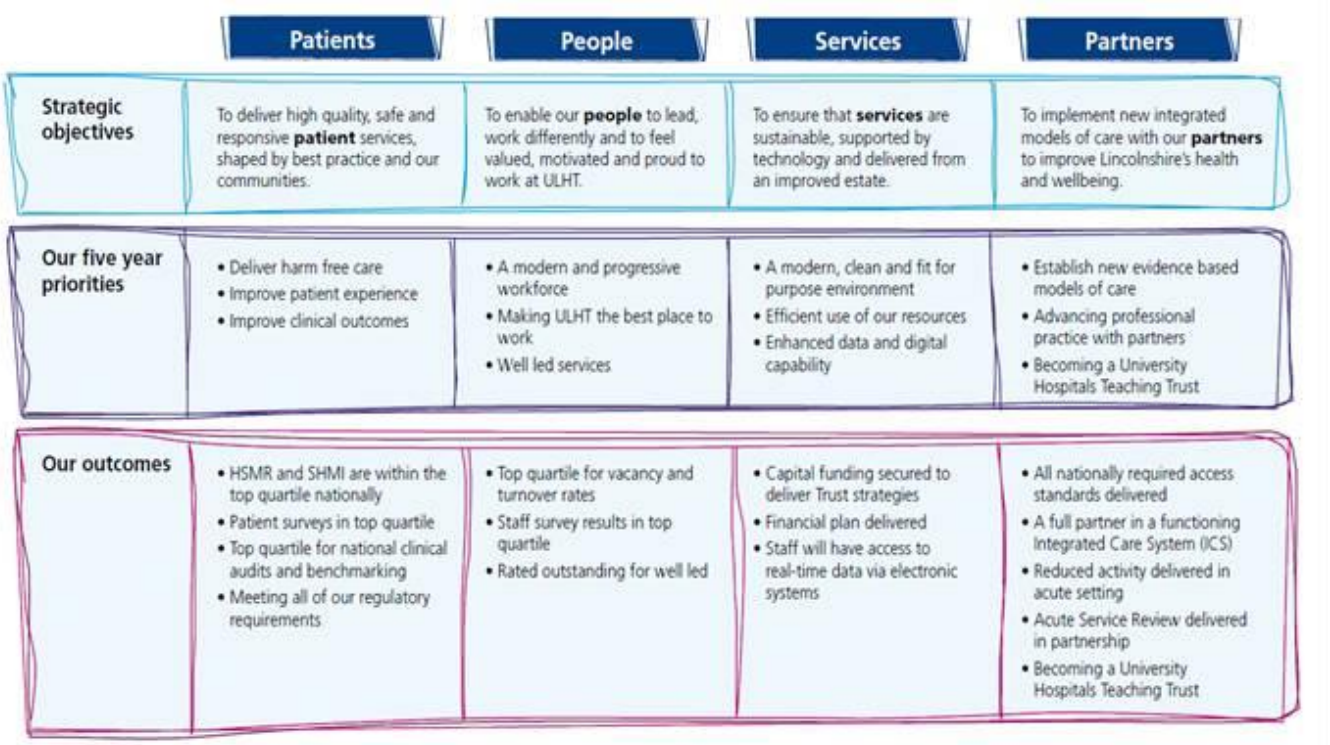
	Specialist Medicine	Dermatology Rheumatology Neurology Gastroenterology Respiratory Health care of the older person

The four Divisions were introduced to provide consistent structures with strengthened roles, clearer decision making closer to the front line of service delivery.

Vision, ambitions and strategies for 2020-2025

As a Trust Board in February 2020 we committed to delivering our 5 year Integrated Improvement Plan (IIP) reaching year four of delivery in 2023/24. At this time little did we know that we would be experiencing a global pandemic that disrupted healthcare delivery as we knew it. As a result the first two years of our plans were severely affected.

The following strategic framework was agreed to shape our plans for 2020-2025:



The Integrated Improvement Plan sets out the Trust commitment to continual improvement and a map for the next stages of the improvement journey.

The Trust has five values which demonstrate what we stand for and how we behave.

The strategic objectives are simple and focus on our patients, our people, our services and our partners. The annual Integrated Improvement Plan detailed the work to progress and the actions to be taken during the year under the key objectives.

The Trust pledged to put quality improvement, productivity and efficiency at the heart of what it does to support delivery of better patient outcomes, improve operational and financial sustainability.

Achievements During 2023/2024

To monitor progress during 2023/24 the Trust identified 18 metrics as part of an executive score card (displayed in the tables below).

For our patients we have;

- Invested £15m capital into Lincoln Emergency Department to improve flow
- Between October 2023 and January 2024 there was a reduction of 18% in people waiting over 12 hours in our Emergency Departments
- You Care We Care To Call initiative active on 45 wards
- Developed therapy services at the front door to enable earlier access to treatment for patients

Patients Objectives	No	Measurement	Measurement Definition	2023/24 Tolerance	2023/24 Ambition	2023/24 M01 Actual	2023/24 M12 Actual
1a: Deliver high quality care which is safe, responsive and able to meet the needs of the population	1	Medication incidents resulting in harm	Percentage of medication omitted or delayed doses incidents report without a reason	1%	15%	24%	12.00%
			Percentage of medication incidents reported as causing harm (low, moderate, severe or death) Per 1,000 OBD	1%	10.70%	12.8%	14.1%
	2	DKA incidents resulting in harm	The total number of DKA incidents reported as causing harm (moderate, severe or death) per 1,000 OBD	0.1	0	0	0
	3	Incidents occurring in ED resulting in harm	Total number of incidents in ED reported as causing harm (moderate/severe/ death) number of incidents	0	0	N/A	4
	4	Falls incidents resulting in harm	The total number of fall incidents reported as causing harm (moderate/severe/death) per 1,000 OBD	0.1	0.19	0.04	0.08

	5	Deteriorating patient	SEPSIS screening (bundle) compliance in A&E (adult)	>90% (Green) 80-89% (Amber) <79% (Red)	95%	91%	91%
			SEPSIS screening (bundle) compliance in A&E (child)	>90% (Green) 80-89% (Amber) <79% (Red)	90%	92.5%	91.20%
			Time to IV antibiotics within 1 hour of Sepsis in A&E (adult)	>90% (Green) 80-89% (Amber) <79% (Red)	98%	97%	95.50%
			Time to IV antibiotics within 1 hour of Sepsis in A&E (child)	>90% (Green) 80-89% (Amber) <79% (Red)	90%	87.5%	75.00%
1b: Improve patient experience	1	Enhanced Patient experience	Total number of wards enrolled in 'You care, we care to call'	1	38	5	8 (YTD 45)
			Number of avoidable complaints where a complaint or PALS enquiry states that there was difficulty in getting through to the ward, phone not being answered or relative being informed (participating wards)	3	67	3	2 (YTD 51)
1c: Improve clinical outcomes.	1	Quality Accreditation	Number of clinical areas achieving the Diamond award	1	8	1	0 (YTD11)
	2	Compliance with clinical effectiveness	Rate of compliance with best practice, NICE guidance	1%	Proposed 95%	93%	95%
	3	Echocardiography	Number of patients waiting more than 6 weeks for an Echocardiogram	100	0 June 2024	5,650	799
	4	Stroke Length of Stay	The average length of stay for patients diagnosed as having a stroke (in days)	0.5	10	12.98	10.56

For our people we have

- Invested more that £2.8m in additional learning, providing a range of learning opportunities above statutory and mandatory training
- Staff Turnover has improved from 13.23% in April 2023 to 11.36% in December 2023

- Implemented the first ever Staff Menopause Service in the NHS
- We have employed over 630 more staff in the past year

People Objectives	No	Measurement	Measurement Definition	2023/24 Tolerance	2023/24 Ambition	2023/24 M01 Actual	2023/24 M12 Actual
2a: A modern and progressive workforce.	1	Vacancy rate	Total vacancy rates including all staff groups	1%	4%	7.69%	6.76%
	2	Sickness rate	Total sickness rates including all staff groups	1%	4.50%	5.57%	5.40%
	3	Staff turnover	Total turnover rates including all staff groups	1%	11.50%	13.23%	10.62%
	4	Apprentice Levy – utilisation	Percentage of apprenticeship levy utilised by ULHT	2%	90%	78%	76%
	5	Apprentice Levy – gifted	Amount of apprenticeship levy gifted to System partners	£20,000	£203,571	£17,811 (Month) £17,811 (Rolling)	£204,590
2b: Making ULHT the best place to work.	1	Statutory Mandatory Training (Essential)	Overall core learning including all staff groups	2%	95%	90.17%	93.77%
	2	Appraisal compliance	Total appraisal rates excluding medical and dental staff	5%	90%	67.19%	72.24%
	3	Pulse Survey results (quarterly Staff Survey)	Percentage of people recommending the Trust as a place of work to Friends and Family	5%	55%	Completed	47.80%

	4	Pulse Survey results (quarterly Staff Survey)	Percentage of people agreeing that they are treated with kindness compassion and respect	1%	4.5%	Awaited	67.20%
2c: Well-led services.	1	Pulse Survey results (quarterly Staff Survey)	Percentage of people happy with the standard of care provided by the organisation and would recommend it as a place to receive care to Friends and Family	5%	53%	Completed	45.90%

For our services we have

- Delivered savings of £32m through our improvement programmes
- Fully implemented the digital solution for electronic prescribing and medicines administration
- Committed to investing £76m over the next 10 years for a new Electronic Patient Record
- Achieved 5.8% of patients discharged or moved to a Patient Initiated Follow Up pathway which exceeds the national target of 5%

Services Objectives	No	Measurement	Measurement Definition	2023/24 Tolerance	2023/24 Ambition	2023/24 M01 Actual	2023/24 M12 Actual
3a: A modern, clean and fit-for-purpose environment.	1	Pilgrim ED	Pilgrim ED project plan milestones (Contractor handover December 2025)	N/A	On a plan with building works to be completed in February 2026	Building work commenced	Building work commenced
	2	Stroke	Stroke Project plan milestones	N/A	Business Case approved	On track	Further evaluation
	3	Mortuary Refurbishment	Mortuary refurbishment Project plan milestones	N/A		On track	Design challenges being overcome at LCH
	4	Green Plan	Compliance with the Green Plan	N/A	TBC in M03 report	On track	On track
3b: Efficient use of our resources.	1	Financial plan	Variance against Trust financial plan	£0	£0		-£2,611k (YTD +£2,k)

	2	Cost Improvement Plans	Progress against Cost Improvement Plan Trajectories	£0	£28.1m		£2,763m (YTD £34,218m)
	3	Capital Plan	Variance against Trust Capital plan	N/A	£40m		£31,831.5k (YTD £62,452k)
3c: Enhanced data and digital capability.	1	Enabling Technologies	Percentage of infrastructure technology investment that has been delivered (this is multiyear, therefore, ambition is not 100%)	0	On Plan	On Plan	On Plan
	2	Electronic Patient Record (ePR)	Percentage of Electronic Patient Record Project frontline digitalisation approach and procurement complete	0	On Plan	On Plan	On Plan
	3	Electronic Prescribing Medicines Administration System (ePMA)	Percentage of wards live on the e-prescribing system	0	On Plan	On Plan	Complete
	4	Digital Capability and Skills	Compliance with formal learning as part of Digital Implementation Team programmes and projects	0	On Plan	On Plan	On Plan
3d: Reducing unwarranted variation in urgent, planned care and cancer service delivery through transformation programmes and ensuring we meet all constitutional standards.	1	4 hours in ED	Number of patient ED attendances transferred, admitted or discharged within 4 hours of arrival	2%	75%	59.50%	60.56%
	2	Aggregated time of arrival, greater than 12 hours in ED	Number of patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendance	5.00%	1.00%	12.43%	21.35%
	3	65 Week Waits Shifted to 52 Week Waits and to Population Health Pillar.	Number of patients waiting 65 weeks or more (Referral to Treatment pathways)	0	0	2,122	306

	4	28-Day Cancer Target	Number of patients diagnosed within 28 days or less, of referral as a percentage of total cancer pathways	5%	75%	57.80%	73.5% Forecast
	5	62-Day Cancer Target	Number of patients waiting 62 days or less of referral as a percentage of total cancer pathways	5%	85%	57.30%	59.3% Forecast
	6	Implementation of SAFER Bundle – LOS > 7 Days pathway 0 Move to Population Health Pillar.	Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients	1%	9%	12.3%	10.14%
	7	Bed Occupancy	Percentage of adult general and acute bed occupancy – National ask 92% or below	0%	92%	93.87%	92.04%
	8	Elective Activity	Achievement of 116% ERF. Please note, this is a YTD cumulative calcuation.	0%	116%	69%	108% (figure taken from finance row)
	9	Day cases	Number of Day cases – National ask, 116% increase on 2019/20 figures. Please note, this is a YTD cumulative calcuation.	0%	116%	83%	108% (figure taken from finance row)
	10	Outpatient procedures and first appointments	Number of Outpatient procedures and first appointments – National ask, 116% increase on 2019/20 figures. Please note, this is a YTD cumulative calcuation.	0%	116%	78%	115% (figure taken from finance row)

	11	Outpatient follow-up	Percentage of outpatient appointments that were follow-up appointments – National ask, 25% reduction. Please note, this is a YTD cumulative calcuation and it does not include all specialties.	5%	<75%	67%	84%
	12	6-week Diagnostic (DM01)	Percentage of patients receiving diagnostic tests within 6 weeks – National ask, increase in 2023/24 and ambition of 95% by 2025	5%	80%	61.76%	73.74%
	13	Diagnostic activity (Figures based on the D&C model as of 29/03/2023, and trajectories are the difference/4 and may fluctuate in the year)	Imaging diagnostic activity levels – National ask, increase in 2023/24 and ambition of 110% by 2025 (Please note: This relates to the Radiology D&C and is inclusive of CDC impact and is the Direct Access and Direct Imaging whilst an Outpatient)	0%	110%	YTD Performance from April 2023 to October 2023 as per DM01 activity: Magnetic Resonance Imaging = 137.44% Computed Tomography = 134.67% Non-obstetric ultrasound = 165.44% DEXA scan = 127.29%	

For our partners

- Developed a Group model with LCHS and established LCHG on 1 April 2024
- Invested £2.4m in medical education facilities at Pilgrim and Lincoln
- Invested £41m in three community diagnostics centres across Lincolnshire
- Working with LCHS improved virtual ward utilisation

Partners Objectives	No	Measurement	Measurement Definition	2023/24 Tolerance	2023/24 Ambition	2023/24 M01 Actual	2023/24 M12 Actual
4a: Establish collaborative models of care with our partners	1	Health Inequalities and Core20PLUS Indicators - Tobacco Cessation Moved into Pillar 5.	Percentage of inpatients for smoke, signposted to the Tobacco Cessation Service	1%	8%	0	0
	2	Non-elective admissions	Total number of non-elective admissions	5%	68,286	4,808	5,487 (YTD 62,203)
4b: Becoming a University Hospital Teaching Trust	1	Clinical Academics	Number of Clinical Academics in post	2	6	0	0
	2	Collaborative Research projects	Total number of collaborations that are developed to support research grants	1	4	2	6
4c: Successful delivery of the Acute Services Review	1	Speciality-level clinical service strategies Different KPI.	Number of completed Specialty Clinical Service Strategies	1	10	0	YTD 10
	2	Partnership Strategy	Quarterly output report, demonstrating progress against partnership strategy	N/A	Ambition will be determined from the baseline	A baseline will be determined from the Q3 report	Partnership Strategy Development

Our key risks and issues

Workforce

During 2023/24, we maintained our efforts to recruit to vacant posts. However recruitment and retention of medical and nursing staff remains one of our key risks. The Trust continues to focus on staff and engagement and the restructuring of development pathways and alternative workforce models to mitigate the risk to service provision and poor patient experience.

Results in the NHS National Staff Survey continue to show improvements with the Trust ranked 56 out of 62 Acute Trusts the highest position in the last five years. Whilst improvement could be seen key themes were identified which the Trust formulated actions in response to covering compassionate leadership, compassionate and inclusive communications, bespoke interventions to support teams and staff engagement.

The Trust remains part of the NHS Culture and Leadership programme with seven key actions:

- Prioritise investment in our leaders and their development;
- Engage staff in resetting our organisational values and better using them as part of our recruitment and appraisal processes to hold people to account;
- An overhaul of the appraisal process;
- Ensuring our organisational priorities resonate with staff;
- Further development of work already underway to improve our organisational culture;
- Look at more opportunities to engage and involve staff directly in improving patient care and services;
- Introduce an employee assistance programme.

CQC Improvements

In March 2022 the Trust was delighted to be able to announce that it was no longer considered to be in quality and financial special measures.

The outcome from the most recent inspection in 2021 was ‘requires improvement’ however the widespread improvements made in quality and

safety of services was reported by the CQC across a number of domains. The Trust ratings for being effective and well led went from requires improvement to good. The safe and responsive domains remain requires improvement and caring remains good.

The Trust was the subject of two section 31 notices under the Health and Social Care Act 2008, which impose conditions on the registration of the Trust as a provider in respect of regulated activities. During 2022/23 the Trust were able to demonstrate the necessary progress in addressing these issues and the notices were removed.

Within the 2022 CQC report there were 5 “Must Do” areas for improvement identified and 38 “Should Do” areas for improvement. These improvement initiatives were built into improvement plans.

In summary, the CQC report showed the ratings following the 2021 inspections as follows:

Title	Rating
Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well Led	Good
Overall	Requires Improvement

It is our ambition to continue to improve the CQC rating to ‘good’ at our next inspection.

Performance challenges

The Trust’s A&E services continue to operate under pressure with more attendances and emergency admissions. Increased acuity and demand for Emergency Care combined with delays in discharging continued to create increased waiting times. A number of schemes were put in place over the

winter months but complexity of patients seen and industrial action meant that these were not able to meet the underlying demand and additional growth.

Work continues with the Lincolnshire health and social care system with the aim of reducing the burden on the emergency departments.

There has been growing concern nationally over acute care providers ability to release ambulance crews due to high demand in emergency departments and lack of hospital flow. Clinical and operational leaders have worked with system leaders to ensure there is management of patient flow out of the hospital setting.

Development of the Lincolnshire Community and Hospitals NHS Group

In 2022-23, our health and care system leaders commissioned an independent review of the Lincolnshire NHS provider landscape. The intention was to identify how providers could organise health and care to better meet the considerable service and financial challenges. The review said that Lincolnshire health and care system leaders should strengthen their ability to enable shared strategic and operational decision making to improve the delivery of integrated high-quality health and care.

Greater integration between Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT) was one of the key recommendations. The review recommended establishing an NHS Trust Group arrangement between LCHS and ULHT, with the close engagement of other NHS partners.

Leaders felt that moving to a Group model would most effectively address the issues of opportunity and urgency, and was the best model of provider collaboration to adopt because it would enable us to:

- Balance greater organisational integration with the potential degree of disruption.
- Maximise the potential to integrate services and resources for the benefit of patients and to do this at pace.
- Address the most pressing patient harm issues and care integration opportunities.
- Supporting better use of resources and value for money.

Through the 2023/2024 progression to the group model has been at pace, commencing with establishing a steering group at the end of quarter one, bringing both Trust Boards together in September through to the end of the year in a series of workshops to agree and define governance, financial, legal, digital and people workstreams. In November 2023 monthly board in common development sessions commenced to maintain the quoracy and sovereignty of both trust boards.

The quality committees in both trusts were identified to be the first board assurance committee to form a committee in common in shadow form from January 2024. Through these workshops and collaborative discussions template agendas, terms of reference and workplans were agreed. In quarter four the quality committee in common met each month receiving assurance from both trusts, enabling thematic review of complex patient safety, clinical effectiveness and patient experience and involvement risks, issues and good practice. Both trusts continue to maintain legal and regulatory compliance and assurance reporting, although coming together in a group model has enabled reduction in integrated urgent and emergency care treatment times, increased pace through collaboration of referrals between acute and community and improved and strengthened risk identification, mitigation and management across aligned portfolios and joint executive leadership.

The Future: Looking ahead to our vision, ambitions and strategies for 2024/25

By coming together as Lincolnshire Community and Hospitals NHS Group, we are looking at the ways we can work more effectively for our patients and our people. We firmly believe that this will bring great benefits to both United Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust, and more importantly to our patients. Both organisations have lots to be proud of and have achieved many impressive things in recent years. Being part of a Group enables us to build on this and go further faster, for the benefit of our patients.

Our fundamental drivers are improving how we deliver services for our patients, improving the population health of the many communities we serve

and making it easier for our people to deliver the care they want to provide. Our shared commitment to delivering these benefits as a Group will keep us focused as the organisations implement the changes over the coming months.

This year is our 'transition' year as we look to integrate more closely with the two trusts. Our Group Strategy describes the key strategic aims and objectives that we are collectively working towards.

In the coming months, we will work across Lincolnshire Community and Hospitals NHS Group to co-create our longer-term strategy with our patients, people and key external stakeholders.

We have engaged across the whole organisation to help co-create our 2024/25 Group Strategic Plan. We have achieved this through several workshops and strategic thinking sessions held with our Trust Board, Executive Leadership Team, Divisional Leadership Teams and our senior teams.

Going Concern

In preparing these Financial Statements, all organisations are required to consider whether it is appropriate to prepare financial statements on a 'going concern basis'.

HM Treasury's Financial Reporting Manual provides the following interpretations of going concern in the public sector context:

- For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.
- DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

On-going service provision by the United Lincolnshire Hospitals NHS Trust is confirmed. It is therefore appropriate to prepare the Annual Financial Statements on a Going Concern basis.

There is an expectation the Trust will continue in operation for the foreseeable future and will be able to realise assets and discharge liabilities in the normal course of operations.

Performance Analysis

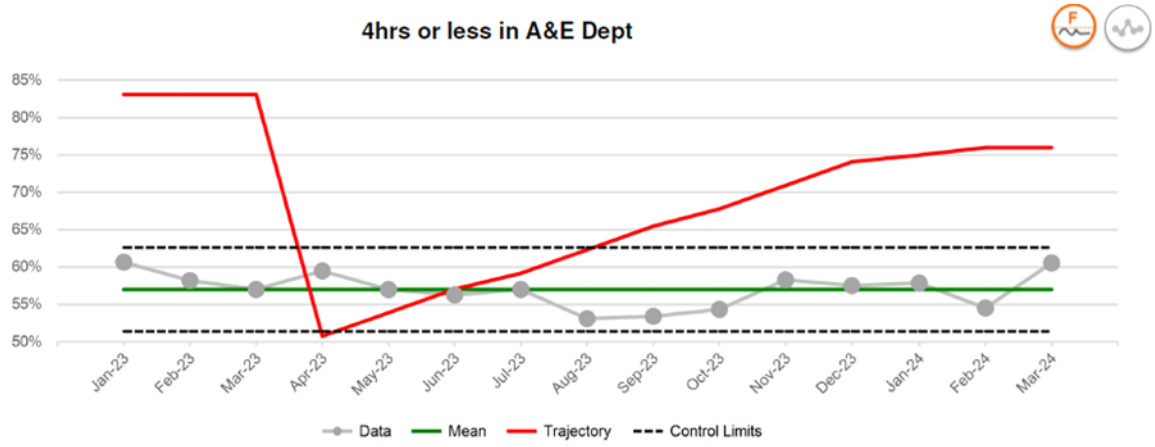
Overview

The Trust produces a monthly Integrated Performance Report (IPR) which is considered at the Board committees covering finance, performance, quality and workforce. The report is then presented to Trust Board with relevant matters for escalation.

We have kept our focus on infection control and constitutional standards. During the year, compliance with infection control practices continued to be strong as evidenced by site visits and compliance with the Infection Prevention and Control Board Assurance Framework.

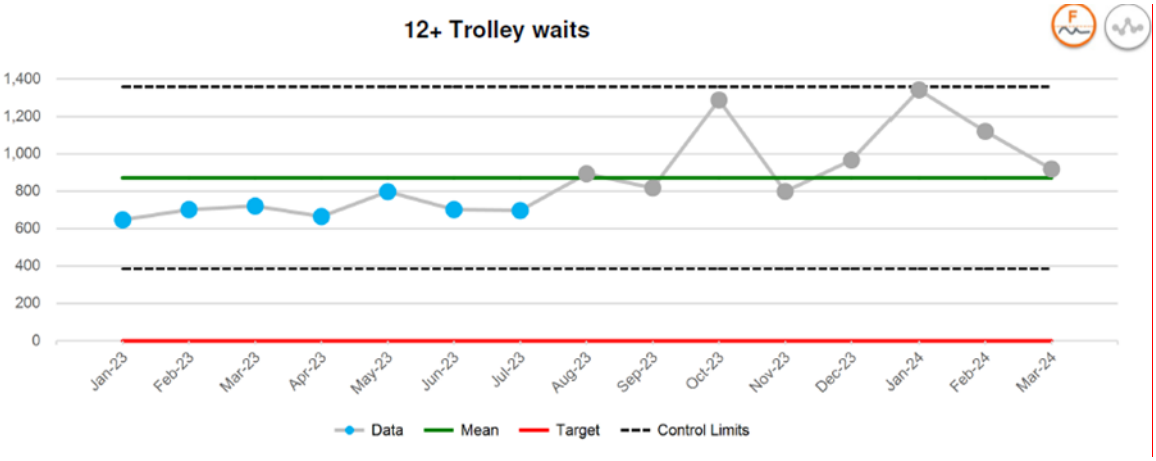
The Trust's performance in its key national target areas of referral-to-treatment (RTT), cancer waiting times, A&E waiting times, and diagnostics have not been delivered to the standard we would expect this year. The poor position against the constitutional standards is well understood. It is driven by a number of factors including:

- growth in demand for services that has increased at a greater rate than we have been able to increase capacity;
- difficulties with recruiting sufficient numbers of staff across all parts of the urgent and elective care pathways.

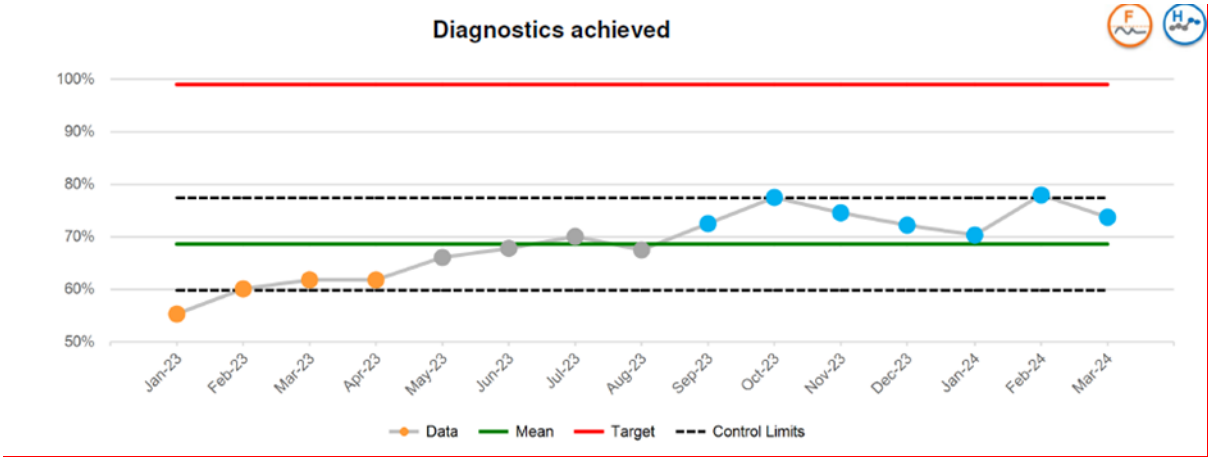


The national 4-hour standard means that we should expect to see 95% of patients in A&E within 4 hours. The agreed trajectory for compliance for ULHT is set at 76%.

The 4-hour transit target performance for March 2024 Type 1 (24/7) ED activity was 60.56%.



There is a zero tolerance for greater than 12-hour trolley waits (time from decision to admit to admission or discharge). These events are reported locally, regionally, and nationally. In March 2024 the Trust saw 919 12-hr trolley wait breaches. This equates to 9% of all type 1 attendances for March.



Percentage of Diagnostics tests undertaken in under 6 weeks. We are currently at 73.74% against the 99.00% target.

Percentage of patients on an incomplete pathway waiting less than 18 weeks. There is a backlog of patients on incomplete pathways.

March 2024 saw RTT performance of 50.01% against an 84.1% target.

In 2023/24 the Trust had 17,501 patients who waited longer than 65 weeks for treatment.

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Feb-24	Mar-24	Apr-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.45%	0.40%	0.33%	0.33%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	76.00%	54.55%	60.56%	63.22%	63.22%	76.00%	F	H
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1,120	919	693	693	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	66.57%	64.17%	75.97%	75.97%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,027	2,768	3,033			2,027	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	399	306			0	F	L
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	50.24%	50.01%			84.10%	F	
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	69,818	70,216			N/A	F	L
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	74.56%	73.53%			75.00%	F	H
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	53.90%	59.90%			85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	70.10%	69.60%			93.00%	F	H

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Feb-24	Mar-24	Apr-24	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	42.30%	46.50%			93.00%	F	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	89.60%	92.70%			96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	94.20%	90.60%			98.00%	F	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	75.00%	66.70%			94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	92.40%	93.90%			94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	38.50%	71.40%			90.00%	F	
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	77.30%	68.30%			85.00%	F	

Challenges do remain as we move into 2024/25, with a strong recovery focus on elective waiting lists and reducing waiting times; and an improvement focus on A&E and cancer standards. These areas are underpinned by system-wide action plans in collaboration with our health and social care partners. With activity levels increasing, improved efficiency and increased productivity are key. However, targeted investment and successful recruitment will also be required in order to meet the demand upon our services.

Delivery of financial plan

The Lincolnshire system financial plan for the year 2023/24 was to deliver a £15.4m planned deficit. The Integrated Care System enacted the NHS England protocol agreement after month 9 and agreed a £27.4m deficit. The Trust delivered an agreed adjusted financial performance deficit of £20.8m. Cost Improvement Programmes savings of £34.2m were delivered against planned savings of £28.1m

The financial performance of the Trust is scrutinised on a monthly basis by the Finance, Performance and Estates Committee to gain assurance in respect of financial delivery.

The Trust fully maximised the capital resources of £62.5m available to it in 2023/24 through investment in its Estate infrastructure and improving and modernising its Digital and Equipment assets.

Performance against national targets

A&E performance

The Trust's performance in urgent care during the 2023/24 financial year did not meet the improvement target of 76%, achieving a combined performance of 70.74% for Type 1 and Type 3, which was a decrease from 72.52% in the previous year (22/23). In March, all trusts' performances were specifically reviewed, and Lincolnshire showed a 2% improvement, achieving 72.5% compared to the previous year.

Several factors contributed to this underperformance:

- There was a significant increase (9.40%) in emergency services attendances at both Type 1 and Type 3 facilities.

- The number of ambulance conveyances across the three acute sites rose by 15.26% compared to 22/23.

- The Trust faced ongoing challenges in staffing, particularly in Medical and Nursing roles, notably at Pilgrim and Lincoln.

- High acuity levels and increased demand for admissions, along with suboptimal discharges, resulted in consistently high bed occupancy rates, exceeding 95% against core stock or 90% when additional beds were opened at the expense of other resources.

- Multiple exit blocks led to delayed discharges and flow issues across the hospitals.

As a result of these factors, bed occupancy within the hospital sites remained consistently high throughout the year, often exceeding 96% during the winter. This situation caused delays in admitting patients to the hospital beds and resulted in overcrowded emergency departments, leading to delays in ambulance handovers.

To address these challenges, key actions were undertaken during 2023/24:

- Continued expansion of the Same Day Emergency Care (SDEC) services and assessment areas (TAU/OAU/GAU).

- Maximization of Right to Reside information to facilitate timely and effective discharges for all pathway zero patients.

- Implementation of system flow and discharge improvements focusing on safe, timely effective and equitable care through programs such as SAFER and Monthly MADE events.

- Execution of the Care Closer to Home program, aiming to provide more care and treatment to patients in their homes.

- Continuation of the Breaking the Cycle initiatives with Boarding/Plus one patients, focusing on reducing unnecessary delays in patient care.

Diagnostic performance

MRI, CT and Dexa were affected by the fire in Lincoln at the end of March 2022 which significantly impacted overall Diagnostic performance. 23/24 has seen a improvement in performance as these services recovered, although performance is still below national targets. Inpatient, Urgent and Cancer demand is always prioritised meaning elective scanning can sometimes be impacted and this has been further exacerbated in 23/24 by the prioritisation of 65/78 week patients, particularly in Audiology.

Whilst echocardiography has long been the trusts largest diagnostic risk, continued month on month improvement has now put the service in a more stable position, with other modalities now being in a more pressured position. Dexa deterioration has been driven by long term absence and is expected to recover, but MRI deterioration has been driven by demand. Work is ongoing within the system to identify where the peaks in demand are so an improvement plan can be developed and implemented. Additional capacity from the CDCs will support recovery.

Cancer

Cancer performance within the Trust was below the national standard for 28 day and 62-day during 2023/24. 31 day first treatments also remained below the national standard for the same period. 31-day subsequent chemotherapy and radiotherapy were not achieved. 31-day subsequent surgery performance did not achieve the standard during this period.

This was partly due to the challenges with recruiting to consultant posts across a number of specialties, the impact of industrial action, and the impact of continuing capacity challenges for first outpatient and theatre capacity.

Actions undertaken to improve performance

During the course of 2023/24 a programme of improvement has been undertaken within the Trust, with support from ICS colleagues, in order to improve the timeliness of assessment, diagnosis and treatment of patients on cancer pathways.

18 weeks referral to treatment (RTT)

There is a backlog of patients on incomplete pathways. The Trust's performance in March 2024 was 50.01%, in March 2023 it was 50.29%, a decrease of 0.28%. Focussed efforts were placed on reducing very long waiting patients, eliminating 78 and 104 week waiter, with the Trust exiting March 2024 with 5 patients waiting over 78 weeks (position for March 2023 was 257).

Priority remains focussed on clinically urgent and cancer patients. National focus remains on patients that are over 65 weeks with a target to be zero by September 2024 (March 2024 position was 358). There are two main improvement programmes focussed on elective recovery. Productive theatres and the Outpatient improvement group. These programmes contain schemes designed to deliver improvement. Schemes focused on elective recovery are

- Validation programme
- Outpatient clinic utilisation
- Theatre untilisation
- Hybrid mail
- Outsourcing/Insourcing
- Use of ISPs
- Missing outcomes

Health Inequalities Statement

There has been progression in the use of health inequalities tools within the Trust in 2023/24. This has come through the development of new areas of reporting, for example, the introduction of a Health Inequalities Dashboard which allows the Trust to monitor and record patients in the Emergency Department and open 18 week wait pathways by a multitude of health inequalities segments, including: age, gender, deprivation, and ethnicity. Another major development for the Trust is the implementation of a Population Health Management Reporting Suite. This actively supports the Trust's ability

to identify specific cohorts of the population when undertaking service developments. Other active workstreams underpinned by ULHT's health inequalities approach include: ophthalmology , cardiology, and understanding the Lincolnshire population's future need for PET scan provision. The Trust is committed to building on its existing population health management approach in order to further improve patient experience, equity of access and clinical outcomes for the diverse communities it services.

Sustainability

The Trust's Green Plan seeks to embed sustainability and low carbon practice in the way vital healthcare services are offered and help the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions.

The climate crisis is also a health crisis. Rising temperatures and extreme weather will disrupt care and impact the health of patients and the public, especially the most vulnerable in society.

People with mental health issues may experience a higher degree of 'climate anxiety', and there may be co-morbidities associated with the physical impacts of climate change and a deterioration in mental health.

Then Trust has a central role to play in reducing health inequalities and helping the NHS to reach net zero.

The Trust's Green Plan serves as the central document for ULHT's sustainability agenda and provides the rationale for sustainability at the Trust. Through this Green Plan, ULHT will work with staff, patients and partners to take powerful sustainable development and climate action as part of the Trust's commitment to offer the highest quality care to the Lincolnshire community.

Task force on Climate-related Financial Disclosures (TCFD)

The GAM has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM

Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance pillar 2023-24. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the ARA and in other external publications.

The Trust monitors climate related issues through the approved Green Plan. Reporting on activities, achievements, targets and developments to the Trust committee on a quarterly basis formally. Issues or updates can be raised at the Trust Leadership Team forum, held monthly.

Additionally climate related issues are measured through the Trusts overall Integrated Improvement Plan, where the Green Plan forms a part of the overall Trust strategy. Key performance indicators are listed and monitored through the plan and is reported monthly to the Trust Board.

Additional reporting metrics, flow through to the board via ERIC, PAM and the Greener NHS Data Collection which all are signed off by the Trust board annually.

Climate related issues are largely but not exclusively monitored through the Estates and Facilities directorate, and encompass many of the management structures within.

- The Estates management structure has specific responsibility for sustainability, energy usage and reduction. The dedicated sustainability manager holds the responsibility under the Trust board within the Estates and Facilities directorate for all climate related issues.
- The capital management structure incorporates the latest climate related legislation, guidance and good practice in any new build or major refurbishment within the design phases.
- The Facilities management has specific responsibility for the Trusts travel plan where a range of initiatives covering vehicular usage, EV use, cycle schemes and wider schemes such as those relating to landscaping, through natural wild gardens and tree planting for new capital schemes.

All management structures report weekly into the Estate and Facilities senior management team, this is then reported through the Finance Performance and Estates Committee into the Trust Board, on a bi monthly basis. On a monthly basis the Estate and Facilities senior management team meet to discuss the Green Plan, decarbonisation programme, energy efficiency and sustainability.

Internally the Trust has a weekly communication strategy, via email and Intranet available to all staff members which updates collectively on relevant climate related issues, progress on our net zero carbon strategy and regularly promotes energy reduction initiatives.

Emergency Preparedness

In 2023/24 the Trust is fully compliant with 51 of the 62 Emergency Preparedness Resilience and Response (EPRR) core standards. This means that the Trust has an overall compliance of 82% which makes the Trust partially compliant overall. It should be noted that to achieve substantial compliance the Trust will need 89% compliance.

Training and Exercising:

- 4 Strategic Commanders were trained.
- 7 Tactical Commanders were trained.
- The Trust Mandatory Major Incident training (ESR) averaged 88%.
- The Trust took part in the 7 regional and national exercises: and delivered 4 tabletop exercises.

Incidents:

- During January 2023 the Trust faced the following challenges:
  - Rising Covid-19 and Influenza A rates in staff and patients.
  - Rising rates of Step A in children
  - Unprecedented numbers of self-presenting patients to our Emergency Departments
  - 24 Hour Industrial Actions by East Midlands Ambulance Service (EMAS).
- Junior Doctors and Consultant Industrial Action throughout the year.
- Lincolnshire Police declared a Critical Incident, due to a number of people who attended a go-karting track in Lincoln that day. Some had subsequently suffered the symptoms of carbon monoxide poisoning.

- A cross organisation failure of IT Systems occurred at 05:30 hours on 15th December 2023. Systems affected included EPMA, Bleep System, Web V, Care Portal. Both ULHT and LCHS were affected. It was later identified that the failure occurred as a result of a system reboot.

Lessons and Learning:

- Full reports (with associated action logs) were produced for the Critical Incident and Carbon Monoxide Incident.
- Regular debriefs have been undertaken at Strategic and Tactical level, post Industrial Actions.
- A structured debrief for the IT failure was carried out.

Additional Assurance Processes

- The EPRR workplan and assurance documents were reviewed on a monthly basis.
- The risk register was reviewed via Datix for EPRR risks on a monthly basis.
- The Major Incident Plan, Command and Control Policy and Critical Incident SOP were combined into a single Incident Response Plan. This was in response to feedback from the 2022 NHS England Core Standards review.
- The Snow and Adverse Weather Plan and Heatwave Plan were combined into a single Adverse Weather Plan (again as per NHS England feedback).
- A new CBRN Plan for Lincoln and Pilgrim was written which reflects the different decontamination procedures required for their ‘decontainers’.
- The Industrial Action plan was updated.
- The evacuation plans for Lincoln, Grantham and Pilgrim hospitals were updated and approved by the Operational Lead Nurse.
- An Incident Control Centre (ICC) setup guide was written and published.
- The Pandemic plan was updated to include recommendations from the previous core standards audit.
- Chemical, Biological, Radiological and Nuclear (CBRN) decontamination equipment inspections were undertaken at all three hospitals.
- The designated ICC areas for Lincoln, Grantham and Pilgrim hospitals were inspected to ensure that they remain fit for purpose.
- The A&E staff at Lincoln, Grantham and Pilgrim were randomly selected and given a verbal test of their knowledge of Major Incident and CBRN procedures.
- The CBRN maintenance, storage and servicing of the CBRN equipment at the Lincoln, Grantham and Pilgrim sites were checked by the EP team.

- A formal Audit of CBRN capability was carried out by EMAS with no remedial actions required.
- ULHT representatives attended the Local Resilience Forum and Health Emergency Planning Operations Group meetings.

Overseas Visitors

The National Health Service provides NHS funded healthcare to people who are ordinarily resident in the United Kingdom. When a person who is not ordinarily resident in the UK (an “overseas visitor”) needs NHS treatment they will be subject to the National Health Service (Charges to Overseas Visitors) Regulations 2017 (the “Charging Regulations”) and may incur a charge for treatment.

In accordance with the Charging Regulations the Trust has a legal obligation to make and recover charges for NHS treatment in relation to any person who is not ordinarily resident in the United Kingdom.

Operational requirements

In order to enforce our legal responsibilities the Trust is required to have systems and staff in place who possess the appropriate skills to:

I. Identify, without discrimination, and at the earliest possible opportunity, all patients who may be liable to charges;
II. Interview patients to establish if they are ordinarily resident or not, and if not, whether they are exempt from or liable for charges;
III. Make and recover charges from individuals who are not covered by an exemption category, providing them with a written statement of why charges apply, the level of charge/s and how they can pay.

The Trust must ensure that it’s human rights obligations are not compromised by the application of the patient eligibility assessment, failure to provide immediately necessary treatment may be unlawful under the Human Rights Act 1998. In situations where the patient is not eligible for NHS funded care, but where treatment is immediately necessary, the Trust will seek to begin the recovery of treatment fees as soon as the patient is well enough.

Similarly, treatment which is not immediately necessary, but is classed as urgent by clinicians (in that it cannot wait until the patient can be reasonably

expected to return home), should also be provided, although in these instances payment would be sought ahead of treatment.

The Overseas Visitors Team are responsible for delivering training to all relevant front line staff in order to ensure they have an awareness of the requirements for assessment of overseas patient eligibility. This training includes examples of baseline questions that are used in the assessment process and examples of documentation that can be used to assess patient eligibility.

The Overseas Visitors team have access to a national support network ensuring that legislative changes and ways of working are continuously refreshed where appropriate.

Signed……..

Chief Executive Date:

Accountability report

The purpose of the accountability section of the annual report is to meet key accountability requirements to Parliament. The requirements are based upon those dealt with in a Directors' Report, under the Companies Act 2006 and adapted for the public sector context.

The Trust external auditors have reviewed the accountability report for consistency with other information in the financial statements. Specific items which have been audited are marked as such.

The accountability report contains two sections:

- The corporate governance report.
- The remuneration and staff report.

Corporate Governance Report

Directors' report

The Trust Board

The Board is responsible for setting the overall policy and strategy for the organisation and for ensuring the effective implementation of that strategy. It establishes a committee structure that supports it in driving the delivery of the principal objectives through a process of risk management, control and assurance. The Trust Board met bi-monthly during 2023/24. The Assurance Committees of the Board met monthly. Further information relating to attendance at the Trust Board and these committees can be found in their annual reports on the Trust website at Board meetings - United Lincolnshire Hospitals (ulh.nhs.uk)

Board membership comprises the chair and chief executive, together with a mix of other executive and non-executive directors. Collectively, the members bring a diverse range of skills and senior experience to the Board and are accountable for the delivery of the organisational strategic objectives.

Further background on Board members can be found at https://www.ulh.nhs.uk/about/trust-board/

The non-executive directors are independent people, drawn from the local community and appointed by NHS England on behalf of the Secretary of State for Health and Social Care.

The chief executive and executive directors are full time employees of the Trust, appointed through open competition. The selection process includes an interview panel involving the chair, non-executive directors and independent advice.

The remuneration of executive directors is determined by the Remuneration and Terms of Service Committee. During 2023/24, this committee consisted of the chair and the non-executive directors.

An externally facilitated review of leadership and governance has been completed within the last 5 years by Mighty Waters. Mighty Waters has no connection with the Trust or any individual director.

Board Changes

During the year there were the following changes to the Trust Board membership and the status of director secondments as described below :

Mr Paul Dunning assumed the role of Acting Medical Director from the 22 September 2022 until 30 September 2023 covering the sickness absence of Dr Colin Farquharson.

Ms Claire Low continued in the Interim Director of People and OD role from December 2022.

Mr Paul Matthew Director of Finance and Digital left the Trust in April 2023. The Director of Finance role was covered on an interim basis by Mr Barry Jenkins between May 2023 and October 2023. From October 2023 the Director of Finance role was covered by Mr Jonathan Young.

The Interim Chief Operating Officer Ms Michelle Harris left the Trust in March 2024 when Ms Julie Frake-Harris assumed the Interim Chief Operating Officer

role. Ms Frake-Harris already held the role of Chief Operating Officer for Lincolnshire Community Health Services NHS Trust and retained this role.

Dr Sameedha Rich-Mahadkar was substantively appointed into the role of Trust Wide Lead for Integration and Planning and continues to cover the role of Director of Improvement and Integration on an interim basis.

Professor Karen Dunderdale continued in the role of Director of Nursing/ Deputy Chief Executive for Lincolnshire Community Health Services NHS Trust on an interim basis in addition to her role as Director of Nursing/Deputy Chief Executive at the Trust.

During 2023/24 there were no changes to the make up of the non executive director posts making up the Trust Board.

A full list of directors who have served during the year is shown within the remuneration report on page XX.

Audit and Risk Committee

Audit and Risk Committee membership should comprise four non-executive directors, one of whom should possess considerable financial expertise.

For 2023/24, Audit and Risk Committee membership was as follows:

Neil Herbert, Chair (November 2022 – ongoing)

Philip Baker (July 2021 – ongoing)

Daniela Cecchini (January 2022 – ongoing)

Rebecca Brown (October 2022 – ongoing)

Declarations of interest for each member of the Trust Board can be found on the Trust website

https://www.ulh.nhs.uk/about/trust/declarations-of-interest/

Code of Governance for NHS Provider Trusts

Statement of compliance with the Code of Governance

The Code of Governance for NHS Provider Trusts was most recently revised in October 2022, to take effect from 1 April 2023. The Audit Committee has been charged by the Board of Directors to maintain ongoing oversight of the Trust`s compliance with the Code of Governance and to identify to the Board of Directors any emergent areas of significant non-compliance. A specific set of disclosures is required to meet the Code of Governance. The following table lists the disclosures and details where the relevant information can be found in the annual report.

Ref	Criteria	Compliance	Evidence
Board Leadership and Purpose			
A2	**The role of the Board of Directors**		
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Compliant	Annual Report – Performance Report Overview
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Compliant	Annual Report – Remuneration and Staff Report
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements	Compliant	Annual Report – Performance Overview and Remuneration and Staff Report

Ref	Criteria	Compliance	Evidence
Division of responsibilities			
B2	**Appointments to the Board**		
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why	Compliant	Annual Report – declarations of interest
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Compliant	Annual Report – Corporate Governance Report Directors Report – Link to website

Ref	Criteria	Compliance	Evidence
Composition, succession and evaluation			
C4	**Appointments to the Board**		
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Compliant	Annual Report – Corporate Governance Report – Link to Trust website
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made	Compliant	Annual Report - Corporate Governance Report

	about any connection it has with the trust or individual directors.		
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Compliant	Annual Report – Corporate Governance Report and Remuneration Report – Links to Trust website

Ref	Criteria	Compliance	Evidence
Audit, Risk and Internal Control			
D2	**Annual Reporting**		
D2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services	Compliant	Annual Report – Financial statements
D2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Compliant	Annual Report – Statement of Accounting Officer's responsibilities
D2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report	Compliant	Annual Report – Performance Overview and Annual

			Governance Statement
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Compliant	Annual Report – Annual Governance Statement
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	Compliant	Annual Report – Going Concern Statement in Performance Overview

Ref	Criteria	Compliance	Evidence
Remuneration			
E2	**Remuneration**		
E2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Compliant	Annual Report – Remuneration Report

Declaration: Audit of the Trust Annual Report and Accounts 2023/24

The Trust Board collectively and Directors individually confirm that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; have taken "all the steps that ought to have taken" to make themselves aware of any such information and to establish that the auditors are aware of it.

Statement of accounting officer's responsibilities

The NHS England, in exercise of powers delegated by the Secretary of State for Health and Social Care, has designated that the Chief Executive should be

the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

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

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

Signed.....Chief Executive

Date.....

Annual Governance Statement

Scope of Responsibility

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

The Purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of United Lincolnshire Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive, as the Accountable Officer (AO) for the Trust, is responsible for:

- The establishment and maintenance of effective corporate governance and internal control arrangements; and

- Being open and communicating effectively about the Trust's management of risks, both internally and externally.

The Director of Nursing/ Deputy Chief Executive, as the executive lead for risk management is responsible for:

- Establishing and maintaining a Risk Register Confirm and Challenge Group authorised to monitor the consistent application of the policy throughout the Trust through supportive, multi disciplinary scrutiny of significant risks on a monthly basis
- Reporting on the effectiveness of the Risk Policy to the Audit and Risk Committee
- Retaining a suitable level of professional risk management expertise to support the effective implementation of the Policy.

Members of Divisional and Corporate teams are responsible for:

- The consistent application of the Policy within their areas of accountability;
- The management of specific risks that have been assigned to them and are recorded in the risk register, in accordance with the criteria set out in the policy; and
- Reporting on risk management matters as required to ensure that risk management performance can be monitored, assurance provided and risks escalated to a more senior level of management where appropriate.

All members of staff are responsible for:

- Applying this policy to any relevant risk management activity undertaken in the course of their duties
- The completion of any risk management-related mandatory Core Learning relevant to their role

The Trust's Risk Management Policy provides staff with clear and unambiguous criteria for evaluating risks, and the essential requirements of the risk management process have been designed into the Datix Risk Management System to provide a supportive structure and guidance for those with responsibility for managing risks.

The risk and control framework

The basic principle at the heart of the Trust's risk management approach is that an awareness and understanding of risk should be used to inform decision making at all levels. This requires not only the active engagement of all staff with risk management activity in practice, but also the integration of risk management principles and techniques within the formal governance arrangements of the organisation. This approach will enable major strategic, policy and investment decisions to be made with a full and reliable appreciation of the risks associated with them as well as any existing risks that those decisions may serve to mitigate.

The Board Assurance Framework (BAF) is an important document that enables the Trust Board to maintain effective oversight of strategic risk management within the organisation. The Trust Board identifies and defines strategic risks to its objectives and assigns each of those risks to a lead non-executive assurance committee for routine review and evaluation. The Trust Board continued to consider the board assurance framework at each of its meetings

The role of each Board committee is to consider evidence provided by members of the Executive Team and the reporting assurance groups in relation to relevant corporate risks, to enable the committee to make an informed judgement as to the level of assurance that can be provided to the Trust Board and assess the overall extent of strategic risk exposure at that time.

The role of the Audit and Risk Committee is to consider the appropriateness and effectiveness of the BAF as a key component of the Trust's internal control arrangements.

A strategic risk is defined as a risk that is Trust-wide in scope and extreme in terms of its potential severity. These are the risks that would fundamentally destabilise the organisation if they were to materialise.

During their most recent well led review the Care Quality Commission (CQC) recognised the effectiveness of the BAF. The Head of Internal Audit (HOIA) Opinion found that the Trust had reasonable and effective risk management, control and governance processes in place. The overall opinion was that

reasonable assurance could be given that there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently. However some weaknesses in the design and/or inconsistent application of controls , put the achievement of particular objectives at risk.

There are 4 key strategic objectives defined within the 2023/24 BAF underpinned by more detailed underlying objectives with metrics and deliverable outcomes. Strategic objectives are owned by the Trust Board, with responsibility for regular oversight of these and the risks to achievement being delegated to appropriate assurance committees. Relevant metrics were identified in relation to each strategic risk in the BAF. Reporting against these metrics was included in regular management reports that provide the lead committees with evidence that associated corporate risks are being managed effectively. Lead assurance committees reviewed and challenged each corporate risk that is included in the BAF, to provide guidance and set expectations to support Trust management teams in developing and delivering their risk treatment strategies.

The Trust Board has reviewed its risk appetite statement in year during a facilitated Board Development session. The risk appetite statement is now under review as part of the revised arrangements to become a group and will be published on the Trust website. The risk appetite statement is currently under review.

Compliance with the CQC registration requirements are considered both by the Trust Board and Quality Governance Committee and the Audit and Risk Committee.

Risks to data security are specifically highlighted within the 2023/24 BAF. The treatment of these risks is through a cyber security plan and digital strategy which are reviewed through Digital Hospital Group in to the Finance Performance and Estates Committee.

The key strategic risks to the organisation during 2023/24 that were the focus of consideration by the Trust Board and Executive were:

- Patient flow through Emergency Departments;
- Recovery of planned care admitted pathways;

• Recovery of planned care non admitted pathways;

• Recovery of planned care cancer pathways;

• Reliance on paper medical records;

• Reliance on manual prescribing processes;

• Potential for serious patient harm due to a fall;

• Processing of echocardiograms;

• Learning lessons from previous patient safety incidents;

• Recovery of children's community diabetes service

• Epilepsy service provision in Paediatrics

• Gaps in tertiary advice and support for children and young people with complex epilepsy

- Recruitment and retention of staff
- Workforce culture (Trust-wide)

• Disruption to services due to potential industrial action (Trust-wide)

• Pharmacy staffing levels and workload demands

• Haematology workforce capacity and service configuration

- Potential for a major fire
- Compliance with fire safety standards, assessed by Lincolnshire Fire and Rescue Service;
- Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- Reliance on agency/locum medical staff in Urgent and Emergency Care
- SARs compliance and access to health records in accordance with statutory compliance
- Medical air plant(medical gases)

Managed and mitigated through:

- Clinical service structures & resources;
- Clinical governance arrangements at Trust, directorate & service levels;

- Clinical policies, procedures, guidelines, pathways, supporting documentation, audit programme & training;
- Clinical staff recruitment, induction, mandatory training, registration & re-validation;
- Quality & safety improvement planning process & plans;
- Defined safe staffing levels;
- Health, safety & security policies, guidance, monitoring and training;
- Patient experience policies, procedures, training and services; and
- Infection, prevention & control management framework;
- Emergency Planning Protocols.

And outcomes assessed through:

- Number & severity of patient safety incidents;
- Number of Never Events;
- Number & severity of Healthcare Acquired Infections (HCAIs);
- Number & severity of safeguarding incidents;
- Number & severity of medication safety incidents;
- Harm free care rate;
- Hospital Standardised Mortality Ratio (HSMR);
- Number & type of complaints;
- Number & severity of health & safety incidents;
- Delivery of constitutional standards.

Reporting to the Audit and Risk Committee has been maintained with regular assurance given in the form of reports on governance compliance, internal control weaknesses, the Board Assurance Framework and Risk Management.

The Trust Board charges its assurance committees with providing upward reports highlighting areas of assurance in relation to risks to achievement of the strategic objectives. The Chair encourages challenge and rigour at Board meetings around the reports presented and assurances given.

The Trust's Risk Management Policy is based on the establishment of a core set of risks, which are aligned to strategic objectives as defined in the Board Assurance Framework (BAF) and routinely monitored through the assurance committees of the Trust Board. Lead management groups (such as the

Patient Safety Group; Information Governance Group; Health & Safety Committee) are responsible for reviewing and updating risks within their areas of responsibility. With this framework the Trust utilises data from reported incidents to better understand areas of significant risk, so that mitigating action can be taken and reporting to both the Board and its Committees has been developed in year. Divisional Triumvirates are responsible for maintaining oversight of the management of risks within their respective divisions, through the established Performance Review Meeting (PRM) process.

The primary objective of the Risk Management policy is to establish the foundations for consistent and effective risk management to become embedded in routine management activity throughout the Trust. It sets out clear definitions, responsibilities, and essential management requirements that enable risks to be managed in a consistent manner throughout the organisation to support the delivery of safer, more efficient, more effective and more resilient services. The policy aims to support the Trust in delivering against corporate governance requirements for maintaining an effective internal control environment, as reviewed by internal and external audit.

Every division within the Trust is expected to make active use of the risk register to support their management of risks. In addition, divisions provide a regular report on the content of their risk registers as part of the Trust's risk register confirm and challenge process.

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

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

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

Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

The trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust's approach in meeting the requirements of the above Modern Slavery and Human Trafficking Act 2015 has been to develop a statement in conjunction with the Trust's Head of Procurement. The provision of the statement is considered to be an element of the Trust's commitment and demonstration of the need to be aware of this requirement, and associated values relating to equality, diversity and community relations. The Trust also achieves this through ensuring that services are procured through approved suppliers or tendered through robust processes.

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

In 2022 following a CQC inspection in 2021 the Trust was able to announce that it was no longer in financial special measures and as a system has exited from SoF4.

The National Health Service Act 2006 requires that 'in auditing the accounts of any NHS trust an auditor must by examination of the accounts and otherwise satisfy himself that... (d) the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources'. External audit planning work involved an assessment against a number of criteria, including those issued by the National Audit Office, to identify any significant risks to the above conclusion. External Audit present to the Audit Committee any significant risks identified and the planned audit response for consideration by the Committee. In January 2024 the Trust's External Audit provider highlighted the following significant risks to the financial statements

- Management override of controls
- Risk of fraud in revenue recognition
- Risk of fraud in expenditure recognition – manipulating accruals and prepayments at the end of the year
- Valuation of land and buildings
- Capital additions
- Accounting for PFI

The Board receive reports from External Audit and Internal Audit through the Audit and Risk Committee and the Assurance Committees.

Recruitment and retention remains a concern for the Trust. The recruitment market for many medical staff, some Allied Health Professionals and Registered Nurses is challenging, as is recognised in the NHS Workforce Strategy. This is exacerbated by the difficulty of recruiting to Lincolnshire. The Trust is working with the wider system and has invested in additional staff to support recruitment activity to traditional roles and is using agencies to recruit from both the UK and overseas.

Alongside this, we are looking at our overall workforce model and establishment and the introduction of new roles, to reduce the need for roles

to which we find it hard to recruit. We are also focused on increasing retention levels.

Developing workforce safeguards

In accordance with the published requirements and given day-to-day operational challenges, the Trust has business-as usual dynamic staffing risk assessments including formal escalation processes to align staffing numbers to acuity, dependency and demand. The standards recognise that at times staff numbers may be insufficient to meet this demand or complexity. In this case, an organisation must have a process or standard operating procedure (SOP) to recognise the risks and co-ordinate a response on a shift-by-shift or daily basis. A staffing safeguards SOP should provide assurance from the front line to the board that safe staffing standards are being achieved and risks to quality and safety mitigated.

In accordance with CQC's well-led framework and National Quality Board's guidance any service changes, including skill-mix changes, have a full Quality Impact Assessment (QIA) review signed off by the Nursing and Medical Director. It is clearly understood that the redesign or introduction of new roles (including but not limited to nursing associates and advanced clinical practitioners) would be considered a service change and must have a full QIA.

An initial assessment of the maturity of workforce planning has been undertaken using the associated NHSI Operational Workforce Planning Toolkit an annual workforce plan is completed each year, and is informed by many of the points listed above (to varying degree).

Stakeholder engagement

The Trust has continued a programme of engagement events with patients, members of the public, staff and other key stakeholders where possible particularly to help inform and develop the clinical and financial strategies, to support arrangements for service change.

The Trust continues to work with the whole Lincolnshire health and care system – engaging with the whole community on proposals for improvements

to services. This includes the centralisation of some services to provide centres of excellence.

Information Governance

The Trust had 3 information governance data breaches which were reportable in line with the Information Commissioners Office guidance in 2023/24. The incidents related to a breakdown in process with regards to the monitoring of patient related data, deletion of data that should have been retained and a data quality issue resulting in a breach of confidentiality. 2 of these cases are still awaiting a response from the ICO and the other was closed with no action.

Data quality and governance

The Trust assures itself of the quality and accuracy of elective waiting time data through specific training for staff, the use of electronic solutions to improve accuracy, validation processes linked to systems and inclusion in the internal and external audit work programmes. The Trust has identified access to end user training, resource for refresher training and the inconsistent application of RTT codes to pathways despite training, as potential areas of risk to the data. The team have ensure monthly returns have been validated were possible to ensure that figures were accurate.

The risks associated with elective waiting times and specifically those attached to the Patient Administration System (PAS) have been reviewed and assurance sought at the Finance, Performance and Estates Committee throughout the year.

The roll out of a Data Quality Kite Mark continues. This is being applied to all metrics that are in the Trust Board Integrated Performance Report (IPR).

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the System of Internal Control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit

and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Maintenance and review of the effectiveness of the systems of Internal Control have been supported by The Board.

The Board have received assurance reports from the Audit and Risk Committee, Quality Governance Committee, Finance, Performance and Estates Committee and People and OD Committee as well as considering the Trust Integrated Performance Report and Board Assurance Framework. The Board have continued to direct their work to improve any identified weaknesses in the control framework and governance arrangements.

The Audit and Risk Committee

The Audit and Risk Committee have advised the Board on the overall effectiveness of the systems of control through their upward report to the Trust Board. The Committee have considered the Board Assurance Framework and the risk improvement plans and have monitored the delivery of internal and external audit plans.

Clinical Audit

During 2023/24 the Trust participated in 100% of possible national clinical audits and 100% of the national confidential enquiries in which it was eligible. The Trust benefitted from participating in gaining assurance that the services

delivered are safe and effective, and outcomes were good based on evidenced based practice and standards of care.

Internal Audit

The Head of Internal Audit provides an opinion for 2023/24 was that reasonable assurance could be given that there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently. However some weaknesses in the design and/or inconsistent application of controls , put the achievement of particular objectives at risk.

. The Opinion was based on:

- an assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- an assessment of the range of individual opinions arising from risk based internal audit assignments, contained within risk based audit plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and managements progress in respect of addressing control weaknesses;

Internal Audit reported the one urgent recommendation and issued two limited assurance reports with weaknesses in a number of areas that put some system objectives at risk.

- The most significant weaknesses were identified in the Mortality and Project Management reviews.

Conclusion

During the year the Trust identified the following significant control issues:

- The Trust exited Quality special measures following the CQC inspection in February 2022, and improved its well led rating to Good however the Trust still remains assessed overall as Requires Improvement.

- The Trust exited Financial Special Measures in February 2022. The Trust has continued to face significant financial challenges. A system led financial plan is in place for 2023/24 The wider Lincolnshire health system faces a significant financial challenge, both now and in the longer term. Local health and social care organisations continue to work together to identify ways in which we can collaborate to meet this challenge.
- The Trust also faces operational pressures with increasing demand. This is particularly difficult to deliver when many services have workforce or infrastructure challenges. As a result constitutional standards have not been met.
- The Trust has significant recruitment and retention challenges. The organisation relies heavily on agency staff to maintain services, this in turn increasing the challenge to further improve quality.

Overall, the Trust is clear on the issues and progress continues to be made in developing and implementing improvement plans, the Trust recognises that there remain improvements which it can make to its governance arrangements. The Board Assurance Framework remains under regular review for both format and content to ensure it is fit for purpose. The Committees and organisation structure have also been reviewed to support better board assurance and drive improvements.

Signed……..

Chief Executive Date:

Remuneration report

Remuneration Policy

Senior managers (executive directors) remuneration policy

We are committed to ensuring that the remuneration package for our executive directors or very senior managers (VSMs) enables us to recruit and retain individuals who provide the skills necessary to manage a very large, complex organisation, facing significant challenges. The Trust remuneration committee reviews the pay package on an annual basis, to ensure that what is received by individuals is commensurate with market conditions, the responsibilities and duties of the role and provides value for money to the Trust.

We review salaries also when new appointments are made and where the proposed salary is above £150,000, approval is sought from NHSI and HM Treasury, in line with the policy for VSM appointments.

The remuneration package comprises:

- Base salary
- Benefits
- Pension

Base Salary

In determining base salary, the committee takes account of the average for acute trusts of equivalent size.

Benefit

The primary benefit payable to VSM managers is annual leave, which is in line with Agenda for Change policy and increases with years of service.

The Chief Executive has confirmed that the key decision makers within the Trust for the purposes of the Remuneration and Staff Report are Board Executive and Non-Executive Members.

The tables below detail the Salaries and Allowances paid during the year to each Senior Executive along with a table showing Pension Benefits at 31 March 2024.

There were no payments made to former Directors in 2023/24.

Single total figures remuneration table (the figures incorporated within the note below are subject to audit)

Single total figures remuneration table (the figures incorporated within the note below are subject to audit)

					2023/24					2022/23				
Name	Position	Notes	Term in post		Salary (bands of £5,000) £000's	Expense payments - taxable (total to nearest £100) £00's	All pension-related benefits (bands of £2,500) £000's	Benefits in kind total to nearest £100 £00's	Total (bands of £5,000) £000's	Salary (bands of £5,000) £000's	Expense payments - taxable (total to nearest £100) £00's	All pension-related benefits (bands of £2,500) £000's	Benefits in kind total to nearest £100 £00's	Total (bands of £5,000) £000's
			Start	Finish										
Elaine Baylis	Trust Chair	8	Jan-18	Ongoing	50 - 55	-		-	50 - 55	60 - 65	2		-	60 - 65
Prof Philip Baker	Non-Executive Director		Aug-21	Ongoing	10 - 15	7		-	10 - 15	10 - 15	-		-	10 - 15
Rebecca Brown	Non-Executive Director		Aug-22	Ongoing	10 - 15	12		-	10 - 15	5 - 10	7		-	5 - 10
Dani Cecchini	Non-Executive Director		Jan-22	Ongoing	15 - 20	11		-	15 - 20	10 - 15	-		-	10 - 15
Dr Chris Gibson	Non-Executive Director		Aug-17	Ongoing	10 - 15	-		-	10 - 15	10 - 15	-		-	10 - 15
Neil Herbert	Non-Executive Director		Aug-22	Ongoing	10 - 15	-		-	10 - 15	5 - 10	-		-	5 - 10
Sarah Buik	Associate Non-Executive Director		Aug-22	Ongoing	10 - 15	6		-	10 - 15	5 - 10	3		-	5 - 10
Vicki Wells	Associate Non-Executive Director		Aug-22	Ongoing	10 - 15	-		-	10 - 15	5 - 10	-		-	5 - 10
Andrew Morgan	Chief Executive	1, 3, 5, 9	Jul-19	Ongoing	185 - 190	-	-	23	185 - 190	230 - 235	-	-	32	235 - 240
Jonathan Young	Director of Finance		Oct-23	Ongoing	60 - 65	-	-	12	60 - 65					
Barry Jenkins	Director of Finance & Digital	1, 9	May-23	Oct-23	80 - 85	-	-	-	80 - 85					
Paul Matthew	Director of Finance & Digital	2	Nov-18	Apr-23	15 - 20	-	-	5	15 - 20	140 - 145	-	-	68	150 - 155
Dr Karen Dunderdale	Director of Nursing & Deputy Chief Executive	1, 3, 4, 5, 9	Feb-20	Ongoing	150 - 155	8	-	8	150 - 155	175 - 180	4	-	14	180 - 185
Angie Davies	Deputy Director of Nursing	4	Nov-23	Ongoing	50 - 55	1	55 - 57.5	-	105 - 110					
Julie Frake Harris	Chief Operating Officer	4, 6	Dec-23	Ongoing	35 - 40	1	-	-	35 - 40					
Michelle Harris	Interim Chief Operating Officer	4	Dec-22	Mar-24	160 - 165	-	65 - 67.5	-	225 - 230	40 - 45	-	-	-	40 - 45
Simon Evans	Chief Operating Officer	1	Jan-20	Jan-23						120 - 125	-	-	26	125 - 130
Dr Colin Farquharson	Medical Director		Aug-21	Ongoing	220 - 225	-	87.5 - 90	-	310 - 315	195 - 200	-	107.5 - 110	-	305 - 310
Dr Paul Dunning	Acting Medical Director	9	Sep-22	Sep-23	95 - 100	-	-	-	95 - 100	100 - 105	2	-	-	100 - 105
Claire Low	Director of People and Organisational Development (OD)	4, 5	Oct-22	Ongoing	120 - 125	-	62.5 - 65	25	185 - 190	65 - 70	-	-	-	65 - 70
Dr Sameedha Rioh-Mahadkar	Acting Director of Improvement and Integration	7	Jan-22	Ongoing	140 - 145	-	42.5 - 45	-	185 - 190	120 - 125	-	47.5 - 50	-	170 - 175
Craig Ferris	Deputy Director of Safeguarding		Nov-23	Ongoing	50 - 55	1	15 - 17.5	-	65 - 70					
Kathryn Helley	Associate Director Clinical Governance		Nov-23	Ongoing	50 - 55	-	-	-	50 - 55					

Notes:

1. Salary payments for Andrew Morgan, Dr Karen Dunderdale, Barry Jenkins and Simon Evans include pension restructuring payments in lieu of employer contributions to the NHS pension scheme
2. Paul Matthew provided cover for the role of Director of People and Organisational Development until September 2022.
3. With the establishment of the United Lincolnshire Hospitals and Lincolnshire Community Health Services Group model from 1st April 2024, Andrew Morgan has taken on the role of Group Chief Executive, with Karen Dunderdale appointed Deputy Group Chief Executive. The remuneration shown within the table above is that which is attributable to ULHT employment only, and reflects the organisational sharing of costs. The total salary for Andrew Morgan across both Trusts is in the banding £250k - £255k. The total salary for Karen Dunderdale across both Trusts is in the banding £200k - £205k.
4. The positions of Director of Nursing (1/10/2023), Chief Operating Officer (11/10/23) and Director of People and Organisational Development (1/10/23) have became joint posts across the two Organisations. The remuneration shown within the table above is that which is attributable to ULHT employment only, and reflects the organisational sharing of costs. The total salary for Claire Low across both Trusts is in the banding £145k - £150k. The total salary for Julie Frake-Harris across both Trusts is in the banding £105k - £110k.
5. Lincolnshire Community Health Services NHS Trust has contributed to the costs of shared employment in 2023/24 as follows: Andrew Morgan: £77,328 Karen Dunderdale: £66,000 Claire Low: £35,831
6. Julie Frake Harris is substantively employed as Chief Operating Officer with Lincolnshire Community Health Services NHS Trust. From 11th October she combined her existing role in a shared arrangement to become the Group Chief Operating Officer. United Lincolnshire Hospitals has contributed £45,118 to the costs of employment.
7. Dr Rich-Mahadkar was initially seconded from Nottingham University Hospitals NHS Trust, joining the Trust on a permanent basis from November 2023.
8. Elaine Baylis' 2022/23 salary includes £10,500 pay arrears from 2021/22 which was awarded and paid in 2022/23.
9. The Pension related benefits for these Executive Directors is £nil, as they do not contribute to the NHS Pension Scheme.

Definitions:

Salary

The total amount of salary, fees and allowances paid to the individual for services provided (inclusive of salary sacrifice). This excludes reimbursement for expenses and employers superannuation and national insurance contributions.

Expense Payments

Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual.
Expense Payments relate to reimbursement for travel, subsistence and where appropriate re-location expenses. Figures presented are shown gross, before tax.

Pension related benefits

Pension related benefits disclosed arise from membership of the NHS Pensions defined benefit scheme. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. The calculation applies a prescribed formula as set out within the Finance Act (2004) and is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.
Where there has been only a small increase in pension and lump sum benefits current year compared to last year, this formula can sometimes generate a negative figure.
Where this is the case, Department of Health guidance states that a "zero" should be substituted for any negative figures.
Factors determining the variation in the values recorded between individuals include but is not limited to:

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

Benefits in Kind

These relate to the benefit in kind associated with lease cars obtained through the Trust Salary Sacrifice Lease Car Scheme or via the Trust Standard Lease Car scheme.

No performance related pay or bonus payments have been made in 2022/23 or 2023/24.

Pensions entitlement table (the figures incorporated within the note below are subject to audit)

The Trust operates the standard NHS Pension Scheme.

Pensions entitlement table (the figures incorporated within the note below are subject to audit)
The Trust operates the standard NHS Pension Scheme.

Name	Position	Notes	Real increase in pension at pension age (bands of £2,500) £000's	Real increase in pension lump sum at pension age (bands of £2,500) £000's	Total accrued pension at pension age at 31 March 2024 (bands of £5,000) £000's	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000) £000's	Cash Equivalent Transfer Value at 31 March 2023 £000's	Real increase in Cash Equivalent Transfer Value £000's	Cash Equivalent Transfer Value at 31 March 2024 £000's	Employer's contribution to stakeholder pension £000's
Andrew Morgan	Chief Executive	1, 3	-	-	-	-	-	-	-	
Jonathan Young	Director of Finance	2	-	-	35 - 40	90 - 95	89	269	707	
Barry Jenkins	Interim Director of Finance	1	-	-	-	-	-	-	-	
Paul Matthew	Director of Finance & Digital / Director of People & Organisational Development	2	0 - 2.5	-	55 - 60	-	457	25	804	
Dr Karen Dunderdale	Director of Nursing & Deputy Chief Executive	1, 3	-	-	-	-	-	-	-	
Angela Davies	Director of Nursing	3	5 - 7.5	35 - 37.5	70 - 75	90 - 95	920	157	1,410	
Julie Frake-Harris	Chief Operating Officer	2, 3	-	5 - 7.5	45 - 50	125 - 130	850	23	1,010	
Michelle Harris	Interim Chief Operating Officer	3	2.5 - 5	-	20 - 25	0 - 5	259	108	394	
Dr Colin Farquharson	Medical Director		2.5 - 5	42.5 - 45	60 - 65	165 - 170	996	336	1,433	
Dr Paul Dunning	Acting Medical Director	1	-	-	-	-	-	-	-	
Claire Low	Director of People & Organisational Development	3	2.5 - 5	-	5 - 10	10 - 15	88	62	159	
Dr Sameedha Rich-Mahadkar	Director of Improvement and Integration		2.5 - 5	-	25 - 30	-	206	96	322	
Craig Ferris	Director of Safeguarding		0 - 2.5	17.5 - 20	60 - 65	165 - 170	1,123	96	1,480	
Kathryn Helley	Director of Clinical Governance,	2	-	-	40 - 45	115 - 120	653	98	966	

Notes:

1. Andrew Morgan, Dr Karen Dunderdale, Dr Paul Dunning and Barry Jenkins chose not to be covered by the pension arrangements during the reporting year.

2. Jonathan Young, Paul Matthew, Julie Frake-Harris and Kathryn Helley are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

3. The Positions of Chief Executive, Deputy Chief Executive, Director of Nursing, Chief Operating Officer and the Director of People and Organisational Development have been shared for part of 2023/24 in preparation for the Group Model effective 1 April 2024. The pensions benefits detailed in the above table are the full benefit due in relation to their employment with ULHT irrespective of any organisational sharing of costs. Further details are provided within the notes to the 'Single total figures remuneration table'.

Lump Sum

No lump sum will be shown for senior managers who only have membership in the 2015 Scheme or 2008 Section (unless they chose to move their 1995 Section benefits to the 2008 Section under the Choice exercise).

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

No CETV will be shown for pensioners and senior managers over Normal Pension Age (NPA).
NPA is age 60 in the 1995 Section, age 65 in the 2008 Section or State Pension Age (SPA) or age 65, whichever is the later, in the 2015 Scheme.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Inflation

The inflation applied to the accrued pension, lump sum (where applicable) and CETV is the percentage by which the Consumer Prices Index (CPI) for the September before the start of the tax year is higher than it was for the previous September.
The Consumer Prices Index up to September 2022 was 10.1%, therefore, an increase of 10.1% has been applied to pensions and CETV at April 2023.

Fair pay disclosure (the figures incorporated within the note below are subject to audit)

In accordance with HM Treasury requirements, reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

Total remuneration comprises salary and allowances, non-consolidated performance-related pay and all taxable benefits. It does not include any severance payments, employer pension contributions and the cash equivalent transfer value of pensions.
(Performance pay and bonuses are not payable by the Trust and a separate disclosure of percentile and ratio data excluding these is not therefore required.)

Remuneration is calculated on the annualised full time equivalent staff in post at the Trust at the reporting date (31 March 2024)

The Chief Executive and Deputy Chief Executive / Director of Nursing have been operating across both United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) during 2023/24. In compiling this note, earnings relating to LCHS have been excluded. Remuneration of the highest paid director takes account of earnings relating to ULHT only.
The highest paid director in the United Lincolnshire Hospitals NHS Trust in the financial year 2023/24 was the Medical Director

The banded remuneration of the Medical Director in 2023/24 was £222,500 (2022/23, £232,500).

This represents a 4.3% decrease on the previous year.

The average percentage increase from 2022/23 in respect of employees of the Trust, taken as a whole was 4.6%.

The relationship between the remuneration of the highest paid Director to organisation's workforce is disclosed in the following tables.

The first table sets out the remuneration of the 25th, median and 75th percentiles within the workforce; while the second table shows these as a ratio to the salary of the highest paid Director.

To illustrate, the remuneration of the highest paid Director in 2023/24 was £222,500. This being 5 : 1 times that of the 25th percentile worker who received £ 48,392 remuneration over the same period.

	Remuneration all Trust staff		
Year	25th percentile total £	Median total £	75th percentile total £
2023/24	48,392	36,100	27,108
2022/23	47,486	34,726	26,121

	Pay Remuneration Ratio		
Year	25th percentile total £	Median total £	75th percentile total £
2023/24	5:1	6:1	8:1
2022/23	5:1	7:1	9:1

In 2023/24, 106 (2022/23, 46) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £434,590 to £10324 (2022/23 £445,886 to £9500).

Staff report (the figures incorporated within the note below are subject to audit)

The following tables contain details of staff costs and numbers employed in 2023/24 alongside comparators for 2022/23.

Permanently employed staff are defined as: members of staff with a permanent (UK) employment contract directly with the Trust.

Other staff are staff engaged on the objectives of the Trust that do not have a permanent (UK) employment contract with the Trust. It includes employees on short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities where the whole or majority of the employees' costs are met locally.

The tables exclude non-executive directors but include executive board members and staff recharged by other DHSC group bodies.

Staff Costs

Staff costs

	Permanent	Other	2023/24 Total	2022/23 Total
	£000	£000	£000	£000
Salaries and wages	391,630	6,490	**398,120**	372,285
Social security costs	41,599	-	**41,599**	35,797
Apprenticeship levy	2,061	-	**2,061**	1,750
Employer's contributions to NHS pension scheme	61,448	-	**61,448**	55,030
Pension cost - other	170	-	**170**	178
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	32,786	**32,786**	51,069
Total gross staff costs	**496,908**	**39,276**	**536,184**	**516,109**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**496,908**	**39,276**	**536,184**	**516,109**
Of which				
Costs capitalised as part of assets	1,727	170	**1,897**	193

Average number of employees (WTE basis)

	Permanent Number	Other Number	2023/24 Total Number	2022/23 Total Number
Medical and dental	1,050	250	**1,300**	1,233
Ambulance staff	9	-	**9**	10
Administration and estates	1,659	55	**1,714**	1,609
Healthcare assistants and other support staff	828	37	**865**	901
Nursing, midwifery and health visiting staff	3,580	545	**4,125**	3,872
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	925	36	**961**	916
Healthcare science staff	159	3	**162**	158
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**8,210**	**926**	**9,136**	**8,699**
Of which:				
Number of employees (WTE) engaged on capital projects	19	-	**19**	3

A breakdown of staff by gender (as at 31/3/23)

	Gender (Fte)	
Pay Band/Grade	**Female**	**Male**
Band 1	25.81	9.79
Band 2	1612.24	372.09
Band 3	566.33	137.98
Band 4	498.46	111.53
Band 5	1304.30	251.43
Band 6	786.83	204.65
Band 7	480.46	112.07
Band 8A	194.27	59.09

Band 8B	56.03	24.08
Band 8C	23.00	13.00
Band 8D	11.00	6.80
Band 9	9.00	10.00
Director	3.00	6.00
Consultant	89.05	254.90
Associate Specialist	2.65	18.18
Staff Grade		0.78
Specialty Doctor	53.10	152.83
GPCA/Hospital Practitioner	1.09	0.73
Specialty Registrar	83.31	102.53
Foundation Year 2	47.36	78.94
Foundation Year 1	38.36	59.00

The Trust reports annually on its gender pay gap. The latest report will be found here Gender pay gap reporting - United Lincolnshire Hospitals (ulh.nhs.uk)

Staff Turnover

Staff turnover rates are published by NHS organisation on a rolling basis each month and are available on the NHS Digital website.

NHS workforce statistics - NHS Digital

Sickness Absence

The Trust is committed to maintaining and promoting the health and wellbeing of its employees and to support all of them, both as individuals and as team members, in dealing with issues that affect their health and wellbeing.

The following table shows the average number of days lost to sickness absence in 2023/24

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE for 2023	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
7,909	97,074	12.3	2,886,966	157,476

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse
Period covered: January to December 2023

Data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Fairness and equity

As a large, public sector employer, the Trust is committed to promoting equality, diversity and inclusion and to tackling any inequalities that are identified in the workforce.

We have an agreed set of people policies, which provide a framework for the management and development of our staff. These cover the full employment lifecycle, from recruitment through to retirement and embrace how we support our staff to be successful and how we attend to their health and safety. Those policies are regularly reviewed with staff representatives to ensure they reflect employment law and best practice. All are assessed from an equality and

diversity perspective to ensure there can be no detriment to any group of staff through their application.

At United Lincolnshire Hospitals NHS Trust, our vision is to provide consistently outstanding and safe patient-centred care for the people of Lincolnshire, through highly skilled, committed and compassionate staff working together.

We believe that equality, diversity and inclusion are central to the success of our vision, just as equality, diversity & inclusion sit at the heart of the NHS constitution.

Our Equality Objectives are the building-blocks which turn that core principle of equality, diversity & inclusion into a reality for us all.

The Trust is fully committed to meeting its statutory and mandatory responsibilities, including implementation of the Equality Delivery System (EDS) 2022, the requirements of the Public Sector Equality Duty (PSED), the Workforce Race Equality Standard (WRES), Workforce Disability Standard (WDES) and the Accessible Information Standard (AIS).

The Trust has developed the Equality Objectives 2022-2025 with the above standards and responsibilities in mind. We have worked in partnership with our workforce and patient representatives to establish, check and confirm them.

Our plans and actions help us to ensure compliance with equality legislation, work to eliminate unlawful discrimination experienced by those who share a protected characteristic (as defined by the Equality Act 2010) and to foster understanding and good relationships between all people.

Equality Objectives

- Person-centred care is experienced by all, with a well-informed, responsive approach to equality of patient experience and to the reduction of health inequalities
- The information and communication we provide is accessible to all our patients
- Our Trust is equity-driven, inclusive and well-led with compassion
- Our Trust is a safe, inclusive place for all staff

- The Trust is a place where staff feel a sense of belonging, are offered opportunities to develop and are supported to thrive

We are fully committed to caring for all patients, service users, their families and carers, and staff in a manner which embraces, respects, promotes and celebrates equality and cultural diversity. We have a range of Staff Networks available to help support staff and in some cases, make valuable improvements to the ways in which we work.

Working in Partnership

The Trust is committed to building strong partnerships with all stakeholders. One key partner is our Trade Union staff representatives. The Trust has a Change Management Policy that states that:

“The Trust will enter into consultation with recognised staff professional organisations and trade unions before decisions are taken with a view, wherever practicable, to taking account of the views expressed.

The Trust will seek to introduce and effect change by agreement, but also to establish a climate within the organisation which actively encourages staff at all levels themselves to participate in and to support changes which affect them. “

The policy sets out a process a process and structure for consultation that ensures that there is consistency and that adequate time is set aside for the process.

The Trust meets with its staff representatives on at least a monthly basis, in two forums. The Executive Partnership Forum is an opportunity for staffside and Executives to meet to discuss strategic issues which will impact on our employees and provides an opportunity for staff representatives to help shape Trust strategy. The Joint Negotiating Forum (and its equivalent for Medical Staff) is the forum at which changes to terms and conditions are negotiated and consultation takes place on significant changes to policy (outside of terms and conditions) and working arrangements.

We provide facility time for Trade Union representatives to participate as staffside and to represent their members.

The Trade Union (Facility Time Publication Requirement) Regulations 2017 requires NHS employers to publish certain information on trade union officials and facility time on their website. Here is an extract of the information for the 2023/24 financial year):

Table 1	
Relevant Union Officials	
What was the total number of your employees who were relevant union officials during the relevant period?	
Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number (based upon average monthly FTE)*
44 (30 zero time and 14 paid time)	8210

Table 2	
Percentage of time spent on facility time	
How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?	
Percentage of time	Number of Employees
0%	30
1-50%	8
51-99%	2
100%	4

Table 3	
Percentage of pay bill spent on facility time	
Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.	
First Column	*Figures*
Provide the total cost of facility time	£270,759
Provide the total pay bill	£503.4mm (Includes: permanent, bank and capitalised staff costs)
Provide the percentage of the total pay bill spent on facility time, calculated as:	0.06%

Freedom to Speak Up (FTSU)

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust. ULHT is committed to ensuring that speaking up is part of the culture of the organisation. We want to support senior leaders to make the connection between speaking up and improving patient safety and staff experience, and will use this to inform the actions that are needed to continuously improve.

Speaking up cases raised with the Trust freedom to speak up guardian in 2023/24:

	Total Cases	Cases received anonymously	Cases with element of patient safety	Cases with element of bullying/ harassment	Cases where detriment reported
Q1	91	2	10	21	1
Q2	94	0	13	31	1
Q3	125	2	63	23	0
Q4	91	0	10	17	0

The Trust has a freedom to speak up policy in place and a full time freedom to speak up guardian, who has completed the national training programme.

The NHS staff survey for 2023 showed that our staff feel that they have a voice that counts, slightly increasing from 2022. The National Freedom to Speak Up Guardians Analysis Report of the Staff Survey reported the Trust in the top 10 most improved organisations in terms of staff survey responses and speaking up culture and the Freedom to Speak Up Sub Score.

The 2022 CQC well led report highlighted the progress that had been made with speaking up arrangements and the actions that were being taken to address the areas where there were still weaknesses. The Trust has an extending network of staff FTSU champions to promote and increase

awareness of speaking up. These champions all completed the nationally recognised training.

Consultancy Expenditure

Consultancy is defined as the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the 'business-as-usual' environment when in-house skills are not available and will be of no essential consequence and time-limited. Consultancy may include the identification of options with recommendations, or assistance with (but not delivery of) the implementation of solutions.

Under this definition Trust Consultancy expenditure in 2023/24 was £4,000 (2022/23: £Nil).

Off-payroll engagements

The Review of the tax arrangements of public sector appointees published by the Chief Secretary to the Treasury in 2012 set out the requirement for Government departments and their arm's length bodies to publish information on their highly paid and/or senior off-payroll engagements.

Subsequent changes to tax legislation, applicable to public sector bodies from April 2017, further reformed the 'off-payroll' tax rules. Under the reformed off-payroll working rules (commonly known as IR35), Departments must determine whether the rules apply when engaging a worker through a Personal Service Company (PSC).

A worker (or contractor) in this context is defined as:

> *"someone who is not employed by the client department, the supplier or any other organisation within the supply chain, that instead provides their services through their own limited company or another type of*

intermediary to the client. An intermediary will usually be the worker's own personal service company but could also be a partnership or an individual."

Treasury requires public sector bodies to report arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements, not being classed as employees) using the format set out in the tables below.

Off-payroll engagements

Highly paid off payroll worker engagements as at 31 March 2024, earning £245* per day or greater

No. of existing engagements as of 31 March 2024 *	**8**
Of which the number that have existed:	
for less than one year at time of reporting	**4**
for between one and two years at time of reporting	**4**
for between two and three years at time of reporting	
for between three and four years at time of reporting	
for four years or more at time of reporting	

* The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant

Off-payroll engagements

Off-payroll workers engaged at any point during the financial year

All off payroll engagements between 1 April 2023 and 31 March 2024, for more than £245* per day

No. of off-payroll workers engaged between 1st April 2023 and 31st March 2024	15
Of which	
Not Subject to off-payroll legislation**	47
Subject to off payroll legislation and determined as in the scope of IR35	11
Subject to off payroll legislation and determined as out of scope of IR35	4
No of engagements reassessed for compliance or assurance purposes during the year	2
Of which: Number of engagements that saw a change to IR35 status following review	0

* The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant

** Includes Agency Nursing staff engaged for more than 4 weeks during the financial year at an average cost exceeding £245.

Off-payroll board member/senior official engagements

For any off payroll engagements of board members, and/or senior officials with significant financial responsibility between 1 April 2023 and 31 March 2024

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility between 1 April 2023 and 31 March 2024

No of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off payroll and on payroll engagements.	22

Exit packages (the figures incorporated within the note below are subject to audit)

NHS Organisations are required to disclose details of any exit packages agreed in the year. The tables below are subject to audit and set out the number and cost of exit packages agreed by the Trust in 2023/24.

The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost and expenditure notes in the Trust accounts.

Reporting of compensation schemes – exit packages 2023/24

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	4	**4**
£10,000 - £25,000	-	2	**2**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	-	-	**-**

£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**6**	**7**
Total cost (£)	£46,000	£38,000	**£84,000**

Reporting of compensation schemes – exit packages 2022/23

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	-	7	**7**
£10,000 - £25,000	-	2	**2**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	1	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**10**	**10**
Total resource cost (£)	£0	£192,000	**£192,000**

Any reported redundancy and other departure costs are paid in accordance with the provisions of the NHS Agenda for Change and Medical and Dental Terms and Conditions.

Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the United Lincolnshire Hospitals NHS Trust and not by the NHS Pensions Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit packages: other (non-compulsory) departure payments

	2023/24		2022/23	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	1	109
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	6	38	8	58
Exit payments following Employment Tribunals or court orders	-	-	1	21
Non-contractual payments requiring HMT approval	-	-	1	4
Total	**6**	**38**	**11**	**192**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

As a single exit package can be made up of several components each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in *the Exit Package table (above)* which will be the number of individuals.

In 2023/24 the Trust made zero non-contractual payments in lieu of notice.

Parliamentary accountability and audit report

The Parliamentary accountability and audit report is required by those entities that report directly to Parliament. It is also required in the consolidated Department of Health and Social Care annual report.

Whilst individual DHSC bodies of which the Trust is one, are not required to produce a full Parliamentary accountability report, they must include where

applicable, disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges within its financial statements.

These can be within the Final Accounts Section of this Annual Report at notes 28,33 and 5.3.

Audit Completion Certificate issued to the Directors of United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2024

United Lincolnshire Hospitals NHS Trust

Annual accounts for the year ended 31 March 2024

CONTENTS

FOREWORD TO THE ACCOUNTS

Financial Review - year ended 31 March 2024

The financial results achieved by the Trust are shown in the table below. In common with all NHS trusts we are required to meet a number of financial targets set by the Department of Health and Social Care. Our performance against these targets is set out in the table below:

Financial Target	Actual Performance		
	2023/24 £000		2022/23 £000
To break even on income and expenditure, taking one year with another. (Target excludes technical adjustments for impairment following revaluation and the impact of changes in accounting policy relating to Donated / Government Granted Assets)	(28,064)	(Deficit)	(19,301)
	6,580	Impairments	5,079
	708	Impact of Grants & Donations	597
	(20,776)	Reported Performance	(13,625)
	0	Exclude DEL impairments	-
	1,132	IFRIC 12 adjustments	588
	(19,644)	Performance against breakeven duty	(13,037)
	(399,217)	Cumulative position against breakeven duty (deficit)	(379,573)
To achieve a capital cost absorption rate of 3.5%	3.5%	Achieved	3.5%
To operate within an External Financing Limit set by the Department of Health and Social Care	£0m	Underspent	£0m
To operate within a Capital Resource Limit set by the Department of Health and Social Care	£0m	Underspent	£0m
To pay 95% of creditor invoices within 30 days (by number of invoices)	83%	Trade (Non-NHS)	70%
	88%	NHS	67%

Jonathan Young
Director of Finance
24 June 2024

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

• value for money is achieved from the resources available to the Trust

• the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them

• effective and sound financial management systems are in place and

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

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

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

Signed 

Name	Andrew Morgan
Position	Chief Executive Officer
Date	24 June 2024

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

• make judgements and estimates which are reasonable and prudent;

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

• prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

By order of the Board

Signed 

Name Andrew Morgan
Position Chief Executive Officer

Signed 

Name Jonathan Young
Position Director of Finance

Date 24 June 2024

Independent auditor's report to the Directors of United Lincolnshire Hospitals NHS Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of United Lincolnshire Hospitals NHS Trust ('the Trust') for the year ended 31 March 2024, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2023/24 as contained in the Department of Health and Social Care Group Accounting Manual 2023/24, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information

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

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

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements

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. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2023/24 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accounting Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements

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

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and we considered the extent to which non-compliance might have a material effect on the financial statements.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were

- inquiring with management and the Audit Committee, as to whether the Trust is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance; management bias through judgements and assumptions in significant accounting estimates; incorrect recognition of expenditure principally in relation to the completeness of manual accruals and provisions and the cut-off of non-pay expenditure; and significant one off or unusual transactions.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual,suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing and
- discussing amongst the engagement team the risks of fraud; and
- addressing the risk of fraud in expenditure recognition through testing of year-end payables and accruals and the testing of non-pay expenditure either side of the financial year end.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in February 2023.

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

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in May 2024, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2024.

In September 2021 we identified a significant weakness in relation to Financial Sustainability for the 2020/21 year. In our view this significant weakness remains for the year ended 31 March 2024:

Significant weakness in arrangements	Recommendation
Capital Backlog and Fire Safety Notices The Trust's financial sustainability is dependent on the resolution of long-standing issues and in implementing the outcomes of the public consultation on the future configuration of Lincolnshire health services initiated in March 2019. These ongoing issues have not been addressed by the Trust and this continues to prevent it from improving arrangements to secure financial sustainability in 2023/24. Overall, therefore, we have concluded that there is an ongoing significant weakness in arrangements to secure financial sustainability.	The Trust must agree a Financial Recovery Plan with NHS England, and monitor its progress in achieving that plan, including addressing the underlying issues the Trust faces in relation to workforce and site configuration planning

Responsibilities of the Accountable Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements

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

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in May 2024.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act;
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

Other than the matters described in the section below, we have nothing to report in respect of these matters.

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 provides that each NHS Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account. This duty is known as 'the breakeven duty'. The phrase 'taking one year with another' has been interpreted by the Department of Health and Social Care and HM Treasury as meaning that the duty is met if income equals or exceeds expenditure over a three-year rolling period, or exceptionally a five-year rolling period.
Considering the 'Statutory breakeven duty: a guide for NHS trusts' issued in April 2018, on 21 June 2024 , we made a referral to the Secretary of State for Health under Section 30 (1) (b) of the Act because the Trust has set a deficit budget of £7m for the year ending 31 March 2025, that plans to lead to its expenditure exceeding its income for the three-year period ending 31 March 2025 by £40m, and does not address the Trust's total cumulative deficit of £399m as at 31 March 2024.

Use of the audit report

This report is made solely to the Board of Directors of United Lincolnshire Hospitals NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust 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 Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

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

Mark Surridge, *Key Audit Partner*
For and on behalf of Mazars LLP

2 Chamberlain Square, Birmingham, B3 3AX

Statement of Comprehensive Income

	Note	2023/24 £000	2022/23 £000
Operating income from patient care activities	3	740,456	708,886
Other operating income	4	48,133	48,792
Operating expenses	7, 9	(809,543)	(771,049)
Operating surplus/(deficit) from continuing operations		**(20,954)**	**(13,371)**
Finance income	11	2,554	1,293
Finance expenses	12	(198)	(90)
PDC dividends payable		(8,277)	(7,177)
Net finance costs		**(5,921)**	**(5,974)**
Other gains / (losses)	13	(1,189)	44
Surplus / (deficit) for the year		**(28,064)**	**(19,301)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(1,719)	2,355
Revaluations	17	8,731	11,646
Other reserve movements		-	(1)
Total comprehensive income / (expense) for the period		**(21,052)**	**(5,301)**

Statement of Financial Position

	Note	31 March 2024 £000	31 March 2023 £000
Non-current assets			
Intangible assets	14	10,924	11,383
Property, plant and equipment	15	333,031	298,859
Right of use assets	18	13,956	11,807
Receivables	20	2,022	2,157
Total non-current assets		**359,933**	**324,206**
Current assets			
Inventories	19	6,581	6,133
Receivables	20	19,781	52,874
Non-current assets for sale and assets in disposal groups	22.1	-	-
Cash and cash equivalents	23	50,858	41,269
Total current assets		**77,220**	**100,276**
Current liabilities			
Trade and other payables	24	(95,425)	(89,905)
Borrowings	26	(3,167)	(3,129)
Provisions	27	(12,154)	(17,670)
Other liabilities	25	(1,195)	(1,260)
Total current liabilities		**(111,941)**	**(111,964)**
Total assets less current liabilities		**325,212**	**312,518**
Non-current liabilities			
Borrowings	26	(13,557)	(12,189)
Provisions	27	(5,271)	(5,108)
Other liabilities	25	(10,566)	(11,069)
Total non-current liabilities		**(29,394)**	**(28,366)**
Total assets employed		**295,818**	**284,152**
Financed by			
Public dividend capital		756,760	724,042
Revaluation reserve		48,454	42,584
Other reserves		190	190
Income and expenditure reserve		(509,586)	(482,664)
Total taxpayers' equity		**295,818**	**284,152**

The notes on pages 19 to 76 form part of these accounts.

Signed:

Name Andrew Morgan
Position Chief Executive Officer
Date 24 June 2024

Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**724,042**	**42,584**	**190**	**(482,664)**	**284,152**
Surplus/(deficit) for the year	-	-	-	(28,064)	**(28,064)**
Other transfers between reserves	-	(1,139)	-	1,139	**-**
Impairments	-	(1,719)	-	-	**(1,719)**
Revaluations	-	8,731	-	-	**8,731**
Transfer to retained earnings on disposal of assets	-	(3)	-	3	**-**
Public dividend capital received	32,718	-	-	-	**32,718**
Other reserve movements	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2024	**756,760**	**48,454**	**190**	**(509,586)**	**295,818**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**704,180**	**29,294**	**190**	**(464,266)**	**269,398**
Implementation of IFRS 16 on 1 April 2022	-	-	-	192	**192**
Surplus/(deficit) for the year	-	-	-	(19,301)	**(19,301)**
Other transfers between reserves	-	(711)	-	711	**-**
Impairments	-	2,355	-	-	**2,355**
Revaluations	-	11,646	-	-	**11,646**
Public dividend capital received	19,863	-	-	-	**19,863**
Other reserve movements	(1)	-	-	-	**(1)**
Taxpayers' and others' equity at 31 March 2023	**724,042**	**42,584**	**190**	**(482,664)**	**284,152**

Information on reserves

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

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

Other reserves
Liabilities transferred to NHS Resolution (previously the NHS Litigation Authority) on 1st April 2000 have been recorded as 'other reserves'.

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

Statement of Cash Flows

	Note	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(20,954)	(13,371)
Non-cash income and expense:			
Depreciation and amortisation	7.1	25,768	22,001
Net impairments	8	6,580	5,079
Income recognised in respect of capital donations	4	(114)	(82)
Amortisation of PFI deferred credit		(503)	(503)
(Increase) / decrease in receivables and other assets		33,556	(38,148)
(Increase) / decrease in inventories		(448)	(127)
Increase / (decrease) in payables and other liabilities		293	1,723
Increase / (decrease) in provisions		(5,390)	10,861
Other movements in operating cash flows		(4)	-
Net cash flows from / (used in) operating activities		**38,784**	**(12,567)**
Cash flows from investing activities			
Interest received		2,551	1,175
Purchase of intangible assets		(7,132)	(4,142)
Purchase of PPE and investment property		(44,652)	(42,693)
Sales of PPE and investment property		59	156
Initial direct costs or up front payments in respect of new right of use assets		(53)	-
Net cash flows from / (used in) investing activities		**(49,227)**	**(45,504)**
Cash flows from financing activities			
Public dividend capital received		32,718	19,863
Movement on other loans		(805)	(402)
Capital element of finance lease rental payments		(2,393)	(2,416)
Other interest		(9)	-
Interest paid on finance lease liabilities		(142)	(121)
PDC dividend (paid) / refunded		(9,328)	(5,873)
Cash flows from (used in) other financing activities		(9)	(8)
Net cash flows from / (used in) financing activities		**20,032**	**11,043**
Increase / (decrease) in cash and cash equivalents		**9,589**	**(47,028)**
Cash and cash equivalents at 1 April - brought forward		**41,269**	**88,297**
Cash and cash equivalents at 31 March	23.1	**50,858**	**41,269**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

Following Treasury's agreement to apply IFRS10 to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the Corporate Trustee of the linked NHS Charity – United Lincolnshire Hospitals NHS Trust Charity, it effectively has the power to exercise control so as to obtain economic benefits. However, the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' note.

The Trust does not hold further interests in other entities.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The Trust and main commissioner agreed not to enforce any over / (under) performance against the variable element of contract in 2023/24.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

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

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment 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.

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

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

De-recognition

Non-current assets intended for disposal are reclassified as 'held for sale' if their carrying amount will be recovered principally through a sale transaction rather than through continuing use and once all of the following IFRS5 criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e:

- management are committed to a plan to sell the asset,
- an active programme has begun to find a buyer and complete the sale,
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale',
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

This includes assets donated to the Trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust.

Initial recognition
In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement
Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The nature of the PFI held by United Lincolnshire Hospitals NHS Trust means that no unitary payment is included within operating expenses. Instead the operator derives income from charges made to users rather than from payments by the Trust.
Further description of the scheme is set out in note 30.

Initial application of IFRS 16 liability measurement principles to PFI liabilities
IFRS16 principles are not applicable under the Trust's PFI as there is no unitary payment and therefore no imputed lease liability.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	10	90
Dwellings	60	90
Plant & machinery	3	20
Transport equipment	5	15
Information technology	2	10
Furniture & fittings	5	15

Note 1.9 Intangible assets

Recognition

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

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

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

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Information technology	2	15
Websites	3	10
Software licences	2	15

Note 1.10 Inventories

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

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets and liabilities are classified as subsequently measured at amortised cost due to their nature.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

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

Expected credit losses are made up of three constituent elements:
- Compensation Recovery Unit, where a provision of 23.07% is made based upon historic recovery rates as set out within the DHSC GAM.
- Full 100% provision for those debts referred to the Trust's appointed debt collection agent.
- All other non-NHS sales invoices based upon expected recovery rates for each category and ageing of debt, except for other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds' assets where repayment is ensured by primary legislation.

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

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

Derecognition

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

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

Note 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% has been applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Finance leases

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

Operating leases

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

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2024:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
Very long-term	Exceeding 40 years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2024:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.70%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the tTrust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 27.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in Note 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at .

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

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

Note 1.17 Value added tax

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

Note 1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.19 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 1.20 Third party assets

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

Note 1.21 Losses and special payments

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

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

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 14 Regulatory Deferral Accounts , applies to first time adopters of IFRS after 1 January 2016. It is therefore, not applicable to DHSC group bodies.

IFRS 17 Insurance Contracts is not yet adopted by the FReM which is expected to be from April 2025.
The scope of the standard is not different to IFRS 4, but it is expected that the implementation of the new standard will require a review of existing arrangements which may result in reclassification of contracts as insurance contracts.

Note 1.24 Critical judgements in applying accounting policies

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

Valuation of Buildings

The Department of Health and Social Care (DHSC) guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as 'the cost of a modern replacement asset that has the same productive capacity as the property being valued'. Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds but a theoretical calculation for accounting purposes of what the Trust could need to spend in order to replace the current assets.
In determining the MEA the Trust supported by its appointed valuer (Cushman and Wakefield) has made judgements around alternative sites and required footprint for an MEA build. In determining the MEA, the Trust has to make assumptions that are practically achievable and would meet the service needs of users, but the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust and would not impact on service delivery or the level and volume of service provided. The Trust has no plans to implement any of the theoretical assumptions that underpin the MEA valuation.

For the purposes of the MEA valuation, the Trust has defined that the services provided at the:
• Lincoln County Hospital site could theoretically be provided from a location on the outskirts of Lincoln with easy access to the A46 ring road.
• Grantham District General Hospital site could theoretically be provided from a location on the outskirts of Grantham with access to the A1 / A52.
• Boston Pilgrim Hospital would not be re-sited.
Further details concerning the valuation of Property, Plant and Equipment are provided in note 1.8 and note 15.

Right of Use Assets: Lease Term

Note 1.13 describes how the Trust determines the lease term of a right of use asset with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.
The Trust leases a number of buildings from NHS Property Services (NHSPS). Whilst the Trust has occupied the majority of these for a substantial number of years, contractual documentation is limited to a one year rolling service level agreement in each case.
In assessing the lease term to apply on initial application of IFRS 16, the Trust reviewed future planned service delivery and in consultation with NHSPS agreed a ten year outlook for the purposes of calculating borrowings and Right of Use Asset valuation.

Note 1.25 Sources of estimation uncertainty

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

Property Plant and Equipment Valuations (carrying value 31 March 2024: £333.0m):

An annual revaluation of Trust Property is conducted by Cushman & Wakefield. The value of land, buildings and dwellings post revaluation was £234.4m and is detailed at Note 15.

As part of this revaluation process the Trust reviews the remaining useful life of its buildings in accordance with advice received from the valuer. This estimation of remaining useful life is in accordance with the Royal Institute of Chartered Surveyors (RICS) appraisal and valuation manual. Details of the method of the recognition of asset lives are disclosed in Note 1.8.

Depreciation and asset lives:

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion), internal review and profession assessment (equipment and IT assets predominantly) and physical asset verification exercises.

Progress Housing (carrying value 31 March 2024 £44.7m):

The Trust entered into a contract with a third party in 2006, Progress Living, in which they provide accommodation to Trust employees. As part of the contract a minimum occupancy level was guaranteed. Costs of under-occupancy are met by the Trust.

Future occupancy levels have been estimated for the relevant properties based upon average occupancy levels over the preceding 12 months ending November 2023.

The valuation of Progress Housing Dwellings recognised as a PFI asset on the Trust Statement of Financial Position is based upon it being a non-specialised asset in existing use. The valuation undertaken by Cushman and Wakefield takes into account factors including annual rental charges for each unit, management charges and assessment of future occupancy levels. The selection of average occupancy levels over the preceding 12 months as a basis for future occupancy is therefore a key source of estimation uncertainty.

Note 2 Operating Segments

The Trust Board (the Chief Operating Decision Maker as defined by IFRS 8 Operating Segments) has determined that the Trust operates one material business segment which is the provision of healthcare services. The operating results of this segment are regularly reviewed by the Board.
The financial results for this segment are the same as in the primary statements.

The provision of healthcare (including medical treatment, research and education) is within one main geographical segment, the United Kingdom, and materially from Departments of HM Government in England.

Revenue from activities (medical treatment of patients) is analysed by customer type in Note 3 to the financial statements. Other operating revenue is analysed in Note 4 and materially consists of revenues from education, training and research, non-patient care services to other bodies, income generation and other revenue.

The percentage of total revenue receivable from within the whole of HM Government is disclosed below.

	2023/24		2022/23	
	£000s	**%**	£000s	%
Revenue from HM Government sources	**754,968**	**95.7**	**726,462**	**95.9**
Revenue from non HM Government sources	**33,621**	**4.3**	**31,216**	**4.1**
Total	**788,589**	**100.0**	**757,678**	**100.0**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2023/24 £000	2022/23 £000
Acute services		
Income from commissioners under API contracts - variable element [1]	127,550	
Income from commissioners under API contracts - fixed element [1]	526,170	620,085
High cost drugs income from commissioners	58,420	50,044
Other NHS clinical income	4,392	5,441
All services		
Private patient income	188	196
National pay award central funding [3]	328	14,600
Additional pension contribution central funding [2]	18,624	16,734
Other clinical income [4]	4,784	1,786
Total income from activities	**740,456**	**708,886**

[1] Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

The analysis of API contracts between the fixed and variable elements is based upon data held within the Trust's contract monitoring system (SLAM). This system provides the link between contractual activity and finance with data uploaded monthly to a national database which in turn is used to inform performance against individual ICB contracts.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

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

[3] Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024.
2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

[4] Other Clinical Income includes: income earned through the Injury Cost Recovery Scheme £1.1m (2022/23: £1.0m) and the treatment of Overseas and Private Patients £1.3m (2022/23: £0.5m)

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2023/24 £000	2022/23 £000
NHS England	122,577	127,930
Clinical commissioning groups		131,358
Integrated care boards	614,516	446,130
Department of Health and Social Care	104	230
Other NHS providers	366	1,256
Local authorities	117	115
Non-NHS: private patients	188	196
Non-NHS: overseas patients (chargeable to patient)	1,084	303
Injury cost recovery scheme	1,063	989
Non NHS: other	441	379
Total income from activities	**740,456**	**708,886**
Of which:		
Related to continuing operations	740,456	708,886

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

	2023/24	2022/23
	£000	£000
Income recognised this year	1,084	303
Cash payments received in-year	262	149
Amounts added to provision for impairment of receivables	1,164	516
Amounts written off in-year	225	165

Note 4 Other operating income

	2023/24			2022/23		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,688	-	**1,688**	1,505	-	**1,505**
Education and training	23,229	1,727	**24,956**	22,713	1,896	**24,609**
Non-patient care services to other bodies	5,265		**5,265**	5,463		**5,463**
Reimbursement and top up funding				113		**113**
Income in respect of employee benefits accounted on a gross basis	6,806		**6,806**	7,059		**7,059**
Receipt of capital grants and donations and peppercorn leases		114	**114**		82	**82**
Charitable and other contributions to expenditure [1]		235	**235**		1,863	**1,863**
Revenue from operating leases		1,214	**1,214**		1,150	**1,150**
Amortisation of PFI deferred income / credits		503	**503**		503	**503**
Other income [2]	7,352	-	**7,352**	6,445	-	**6,445**
Total other operating income	**44,340**	**3,793**	**48,133**	**43,298**	**5,494**	**48,792**
Of which:						
Related to continuing operations			48,133			48,792

[1] This includes the value of Personal Protective Equipment donated by DHSC to NHS Trusts as part of the pandemic response £0.2m (2022/23: £1.2m).

[2] Other Income includes: car parking £1.2m (2022/23: £1.1m), catering £2.5m (2022/23: £1.5m), retail sales £1m (2022/23: £0.2m), Medical Examiner Fees £0.7m (2022/23: £0.6m), Insurance income £0.9m (2022/23: £1.8m), staff lease cars £0.1m (2022/23: £0.1m) and miscellaneous other income £0.9m (2022/23: £1.1m)

Note 5 Additional information on contract revenue and performance obligations'

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

	2023/24	2022/23
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	757	757
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

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

Note 5.3 Fees and charges

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

	2023/24	2022/23
	£000	£000
Income	4,723	2,500
Full cost	(3,916)	(2,090)
Surplus / (deficit)	**807**	**410**

This note addresses and aggregates schemes that, individually, have a cost exceeding £1m.
This comprises catering and car parking income and from 2023/24 retail sales from the public and staff.

Catering	2023/24	2022/23
	£000s	£000s
Income	**2,513**	**1,442**
Full cost	**(2,778)**	**(1,667)**
Surplus / (deficit)	**(265)**	(225)

Car Parking	2023/24	2022/23
	£000s	£000s
Income	**1,187**	**1,058**
Full cost	**(284)**	**(422)**
Surplus / (deficit)	**903**	636

Retail Sales	2023/24	2022/23
	£000s	£000s
Income	**1,023**	**196**
Full cost	**(854)**	**(339)**
Surplus / (deficit)	**169**	(143)

Note 6 Operating leases - United Lincolnshire Hospitals NHS Trust as lessor

This note discloses income generated in operating lease agreements where United Lincolnshire Hospitals NHS Trust is the lessor.

The Trust has leased a number of buildings to non-NHS organisations which provide ancillary services to patients.

Note 6.1 Operating lease income

	2023/24	2022/23
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,132	948
Variable lease receipts / contingent rents	82	202
Total in-year operating lease income	**1,214**	**1,150**

Note 6.2 Future lease receipts

	31 March 2024	31 March 2023
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	275	252
- later than one year and not later than two years	248	252
- later than two years and not later than three years	236	227
- later than three years and not later than four years	203	216
- later than four years and not later than five years	36	185
- later than five years	115	141
Total	**1,113**	**1,273**

Note 7 Operating expenses

Note 7.1 Operating expenses

	2023/24	2022/23
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	141	1,284
Purchase of healthcare from non-NHS and non-DHSC bodies	7,144	5,479
Purchase of social care	3	-
Staff and executive directors costs	526,911	509,230
Remuneration of non-executive directors	154	157
Supplies and services - clinical (excluding drugs costs)	74,098	68,540
Supplies and services - general	11,547	13,795
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	71,205	67,417
Inventories written down	209	222
Consultancy costs	4	-
Establishment	8,314	6,926
Premises	29,591	26,091
Transport (including patient travel)	1,954	2,339
Depreciation on property, plant and equipment	21,085	18,613
Amortisation on intangible assets	4,683	3,388
Net impairments [2]	6,580	5,079
Movement in credit loss allowance: contract receivables / contract assets	732	233
Change in provisions discount rate(s)	(139)	(729)
Fees payable to the external auditor		
audit services- statutory audit [1]	176	173
Internal audit costs	221	270
Clinical negligence	22,967	22,347
Legal fees	716	696
Insurance	23	11
Research and development [3]	1,974	1,916
Education and training [3]	10,101	10,668
Expenditure on short term leases	61	248
Redundancy	48	120
Car parking & security	25	60
Hospitality	2	1
Losses, ex gratia & special payments [4]	1,128	(754)
Other services, eg external payroll	3,168	3,490
Other	4,717	3,739
Total	**809,543**	**771,049**
Of which:		
Related to continuing operations	809,543	771,049
Related to discontinued operations	-	-

[1] The Statutory audit fee comprises three elements:

	2023/24	2022/23
	£000	£000
Statutory Audit fee for the year	146	142
Statutory Audit fee 2021/22 - additional fee		2
Non recoverable VAT	29	29
Total	**175**	**173**

[2] Note 8 provides further detail relating to the Net Impairments expense

[3] The figures presented above for Research and Development along with Education and training comprise £7.3m pay costs (2022/23: £6.6m) and £4.7m non-pay costs inclusive of notional expenditure funded from the apprenticeship fund (2022/23: £4.1m).

[4] The total losses presented in 2022/23 include the reversal of certain provisions that have resulted in a net credit.

Note 7.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2023/24 or 2022/23.

Note 8 Impairment of assets

	2023/24	2022/23
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price [1]	6,580	3,608
Other [2]	-	1,471
Total net impairments charged to operating surplus / deficit	**6,580**	**5,079**
Impairments charged to the revaluation reserve [3]	1,719	(2,355)
Total net impairments	**8,299**	**2,724**

1) Material Impairment losses / (reversals) charged to the SOCI resulting from changes in market price following valuation are summarised below:"

	2023/24	2022/23
	£000	£000
Reversals of impairments charged to SOCI in previous years:		
Maternity Unit Lincoln County Hospital	-	(2,586)
Phase 2: Lincoln County Hospital	-	(4,817)
Outpatients Lincoln County Hospital	-	(752)
A&E/X-ray Pilgrim Hospital	(11)	(670)
Endoscopy Lincoln County Hospital	(5)	(655)
Other - buildings*	(444)	(4,217)
Impairments charged to SOCI in current year:		
Tower Block Pilgrim Hospital	57	1,275
Generator House Lincoln County Hospital	1,218	1,466
Maternity Unit Pilgrim	2,135	6,291
Modular Theatres Grantham Hospital	-	1,003
New Resus building	132	5,611
Maternity Unit Lincoln County Hospital	572	
Data Centre 3 (new build)	910	
Other - buildings [a]	2,016	1,659
	6,580	**3,608**

[a] Consists of multiple buildings individually with 'low' value impairment less than £0.5m

2) Other Material Impairment losses / (reversals) charged to SOCI are summarised below:

	2023/24	2022/23
	£000	£000
Reversal of impairments charged to SOCI in previous years		
Progress Care Housing Association [b]	-	(90)
Lincoln County Hospital Land	-	1,561
	-	**1,471**

[b] The Trust entered into a contract with a third party in 2006, Progress Living, in which accommodation is provided to Trust employees at Lincoln, Boston and Grantham sites. As part of the contract, a minimum occupancy level was guaranteed. Costs of under occupancy are met by the Trust.

The projected future occupancy levels and therefore projected income streams associated with this contract are reviewed annually. The Annual property valuation takes account of this assessment and may result in an impairment or reversal.

Impairments charged / (reversed) against this contract were:	2023/24	2022/23
	£000	£000
Grantham District Hospital	-	(90)
	-	**(90)**

3) Property, Plant and Equipment impairments and reversals charged to the revaluation reserve

	2023/24	2022/23
	£000	£000
Other	-	(17)
Changes in market price	(1,719)	(2,338)
Total impairments for PPE charged to reserves	**(1,719)**	**(2,355)**

Note 9 Employee benefits

	2023/24 Total £000	2022/23 Total £000
Salaries and wages	398,120	372,285
Social security costs	41,599	35,797
Apprenticeship levy	2,061	1,750
Employer's contributions to NHS pensions [1]	61,448	55,030
Pension cost - other [2]	170	178
Temporary staff (agency)	32,786	51,069
Total gross staff costs	**536,184**	**516,109**
Recoveries in respect of seconded staff	-	-
Total staff costs	**536,184**	**516,109**
Of which		
Costs capitalised as part of assets	1,897	193

[1] Employer's contributions to NHS pensions
Following consultation and revaluation of public sector pension schemes, the Department of Health and Social Care (DHSC) increased the employer contribution rate from 14.3% to 20.6% (20.68% including the 0.08% administration levy) from 1 April 2019.
Since 2020/21 the scheme administrator, NHS Business Services Authority, has continued to collect an employer contribution of 14.38 per cent from employers. Central payments have been paid to the scheme by NHS England to cover the remaining increase.
NHS Trusts are required to account for employer contributions of 20.68% in full and on a gross basis in year end accounts.
The total employer NHS Pension contribution of £61.4m (2022/23: £55.0m) shown in the table above includes £18.6m (2022/23: £16.7m) paid by NHS England on behalf of the Trust.

[2] Pension cost - other relate to payments into the National Employment Savings Trust (NEST) defined contribution scheme.

In line with the HM Treasury requirements a further breakdown of employee benefits across staffing categories is provided within the Annual Report.

Note 9.1 Retirements due to ill-health

During 2023/24 there were 6 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £253k (£111k in 2022/23).

Note 10 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision.
The Trust is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrols the employee into NEST. Under either scheme the employee is able to opt in / out at any point.
NEST is a defined contribution scheme.

As at 31 March 2024 there were 11,667 employees (31 March 2023: 10,785) employed by the Trust, of these 9,890 (31 March 2023: 7,983) are members of the NHS Pension Scheme; 344 (31 March 2023: 404) are enrolled within NEST and 1,433 (31 March 2023: 2,398) are not currently contributing through a workplace pension scheme.

Employer Pension contributions for 2023/24 were £61.4m; these are anticipated to rise in line with the annual Pay Award in 2024/25. Based on a 2.1% award contributions are expected to be circa £62.7m.

Note 11 Finance income

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

	2023/24	2022/23
	£000	£000
Interest on bank accounts	2,554	1,293
Total finance income	**2,554**	**1,293**

Note 12 Finance Expenses

Note 12.1 Finance expenditure

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

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on lease obligations	142	121
Interest on late payment of commercial debt	9	-
Total interest expense	**151**	**121**
Unwinding of discount on provisions	37	(39)
Other finance costs	10	8
Total finance costs	**198**	**90**

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

	2023/24	2022/23
	£000	£000
Total liability accruing in year under this legislation as a result of late payments [1]	883	1,213
Amounts included within interest payable arising from claims made under this legislation	9	-
Compensation paid to cover debt recovery costs under this legislation	-	-

[1] This is estimated based upon invoice date rather than date of receipt of invoice.

Note 13 Other gains / (losses)

	2023/24	2022/23
	£000	£000
Gains on disposal of assets	104	146
Losses on disposal of assets	(1,293)	(102)
Total gains / (losses) on disposal of assets	**(1,189)**	**44**

Note 14 Intangible assets

Note 14.1 Intangible assets - 2023/24

	Software licences	Internally generated information technology	Websites	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**22,096**	**20**	**15**	**3,653**	**25,784**
Additions	3,254	-	-	597	**3,851**
Reclassifications	4,026	-	-	(3,653)	**373**
Disposals / derecognition	(3,568)	-	-	-	**(3,568)**
Valuation / gross cost at 31 March 2024	**25,808**	**20**	**15**	**597**	**26,440**
Amortisation at 1 April 2023 - brought forward	**14,366**	**20**	**15**	**-**	**14,401**
Provided during the year	4,683	-	-	-	**4,683**
Reclassifications	-	-	-	-	**-**
Disposals / derecognition	(3,568)	-	-	-	**(3,568)**
Amortisation at 31 March 2024	**15,481**	**20**	**15**	**-**	**15,516**
Net book value at 31 March 2024	**10,327**	**-**	**-**	**597**	**10,924**
Net book value at 1 April 2023	**7,730**	**-**	**-**	**3,653**	**11,383**

All intangible assets are held at historical cost, less accumulated amortisation, and are generally amortised on a straight line basis over 5 years.

IT - in-house & 3rd party software showing as fully depreciated relates to one internally developed asset which is still in use.

Other fully amortised assets still in use and reported within Software Licenses had an original purchase cost of £1.7m.

Note 14.2 Intangible assets - 2022/23

	Software licences	Internally generated information technology	Websites	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	**16,263**	**20**	**15**	**2,946**	**19,244**
Additions	2,496	-	-	3,653	**6,149**
Reclassifications	3,902	-	-	(2,946)	**956**
Disposals / derecognition	(565)	-	-	-	**(565)**
Valuation / gross cost at 31 March 2023	**22,096**	**20**	**15**	**3,653**	**25,784**
Amortisation at 1 April 2022 - as previously stated	**11,534**	**20**	**15**	**-**	**11,569**
Provided during the year	3,388	-	-	-	**3,388**
Reclassifications	-	-	-	-	**-**
Disposals / derecognition	(556)	-	-	-	**(556)**
Amortisation at 31 March 2023	**14,366**	**20**	**15**	**-**	**14,401**
Net book value at 31 March 2023	**7,730**	**-**	**-**	**3,653**	**11,383**
Net book value at 1 April 2022	**4,729**	**-**	**-**	**2,946**	**7,675**

Note 15 Property, plant and equipment

Note 15.1 Property, plant and equipment - 2023/24

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2023 - brought forward	**11,800**	**181,022**	**37,113**	**18,742**	**79,675**	**593**	**16,478**	**1,127**	**346,550**
Additions	-	5,770	-	42,992	4,151	-	722	302	**53,937**
Impairments / reversal of Impairments	-	(13,049)	-	(1,267)	-	-	-	-	**(14,316)**
Revaluations	-	41	7,596	-	-	-	-	-	**7,637**
Reclassifications	-	5,346	-	(13,007)	4,558	57	2,673	-	**(373)**
Transfers to / from assets held for sale	-	-	-	-	(1,019)	(17)	-	-	**(1,036)**
Disposals / derecognition	-	(1,229)	-	-	(2,283)	(29)	(3,392)	(27)	**(6,960)**
Valuation/gross cost at 31 March 2024	**11,800**	**177,901**	**44,709**	**47,460**	**85,082**	**604**	**16,481**	**1,402**	**385,439**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**-**	**-**	**-**	**40,504**	**516**	**6,078**	**593**	**47,691**
Provided during the year	-	6,538	599	-	7,698	25	3,546	127	**18,533**
Impairments	-	(4,964)	-	-	-	-	-	-	**(4,964)**
Reversals of impairments	-	(1,053)	-	-	-	-	-	-	**(1,053)**
Revaluations	-	(495)	(599)	-	-	-	-	-	**(1,094)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	(942)	(17)	-	-	**(959)**
Disposals / derecognition	-	(26)	-	-	(2,272)	(29)	(3,392)	(27)	**(5,746)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**-**	**44,988**	**495**	**6,232**	**693**	**52,408**
Net book value at 31 March 2024	**11,800**	**177,901**	**44,709**	**47,460**	**40,094**	**109**	**10,249**	**709**	**333,031**
Net book value at 1 April 2023	**11,800**	**181,022**	**37,113**	**18,742**	**39,171**	**77**	**10,400**	**534**	**298,859**

Note 15.2 Property, plant and equipment - 2022/23

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	**10,855**	**155,367**	**31,347**	**24,770**	**76,225**	**551**	**14,984**	**1,153**	**315,252**
Additions	2,301	14,820	-	16,660	5,062	25	462	-	**39,330**
Impairments	(1,751)	(19,569)	-	-	-	-	-	-	**(21,320)**
Reversals of impairments	320	13,278	105	-	-	-	-	-	**13,703**
Revaluations	75	4,522	5,661	-	-	-	-	-	**10,258**
Reclassifications	-	12,604	-	(22,688)	5,298	17	3,813	-	**(956)**
Transfers to / from assets held for sale	-	-	-	-	(3,340)	-	-	-	**(3,340)**
Disposals / derecognition	-	-	-	-	(3,570)	-	(2,781)	(26)	**(6,377)**
Valuation/gross cost at 31 March 2023	**11,800**	**181,022**	**37,113**	**18,742**	**79,675**	**593**	**16,478**	**1,127**	**346,550**
Accumulated depreciation at 1 April 2022 - as previously stated	**-**	**-**	**-**	**-**	**40,651**	**498**	**5,868**	**482**	**47,499**
Provided during the year	-	5,781	493	-	6,688	18	2,991	137	**16,108**
Impairments	-	(1,619)	-	-	-	-	-	-	**(1,619)**
Reversals of impairments	-	(3,272)	(2)	-	-	-	-	-	**(3,274)**
Revaluations	-	(890)	(491)	-	-	-	-	-	**(1,381)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	(3,315)	-	-	-	**(3,315)**
Disposals / derecognition	-	-	-	-	(3,520)	-	(2,781)	(26)	**(6,327)**
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**40,504**	**516**	**6,078**	**593**	**47,691**
Net book value at 31 March 2023	**11,800**	**181,022**	**37,113**	**18,742**	**39,171**	**77**	**10,400**	**534**	**298,859**
Net book value at 1 April 2022	**10,855**	**155,367**	**31,347**	**24,770**	**35,574**	**53**	**9,116**	**671**	**267,753**

Note 15.3 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	11,800	177,342	-	47,460	37,737	109	10,249	709	**285,406**
On-SoFP PFI contracts and other service concession arrangements	-	-	44,709	-	-	-	-	-	**44,709**
Owned - donated/granted	-	559	-	-	2,357	-	-	-	**2,916**
Total net book value at 31 March 2024	**11,800**	**177,901**	**44,709**	**47,460**	**40,094**	**109**	**10,249**	**709**	**333,031**

Note 15.4 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	11,800	180,449	-	18,742	33,826	77	10,400	534	**255,828**
On-SoFP PFI contracts and other service concession arrangements	-	-	37,113	-	-	-	-	-	**37,113**
Owned - donated/granted	-	573	-	-	5,345	-	-	-	**5,918**
Total net book value at 31 March 2023	**11,800**	**181,022**	**37,113**	**18,742**	**39,171**	**77**	**10,400**	**534**	**298,859**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	1,136	9,706	-	-	-	-	-	-	**10,842**
Not subject to an operating lease	10,664	168,195	44,709	47,460	40,094	109	10,249	709	**322,189**
Total net book value at 31 March 2024	**11,800**	**177,901**	**44,709**	**47,460**	**40,094**	**109**	**10,249**	**709**	**333,031**

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	1,135	9,780	-	-	-	-	-	-	**10,915**
Not subject to an operating lease	10,665	171,242	37,113	18,742	39,171	77	10,400	534	**287,944**
Total net book value at 31 March 2023	**11,800**	**181,022**	**37,113**	**18,742**	**39,171**	**77**	**10,400**	**534**	**298,859**

Note 16 Donations of property, plant and equipment

The Trust has received donated assets in the financial year as follows:

Donor: United Lincolnshire Hospitals NHS Trust Charitable Fund - 2023/24

Asset Description - Donation of physical asset	Plant & machinery £000	Fair value of asset £000
M5SC-D Cardiac Ultrasound Probe	13	13
4VC-D Matrix Cardiac Probe	13	13
PSCS Paxman-Scalp Cooling Systems (3)	40	40
Catsmart Auto Transfusion Device (2)	28	28
Cubescan Biocon-700-S Bladder Scanner	7	7
Pagewriter TC20 ECG Recorder	7	7
Nippy 4+ Ventilator	6	6
Total value of physical assets donated	**114**	**114**

Donor: United Lincolnshire Hospitals NHS Trust Charitable Fund 2022/23

Asset Description - Donation of physical asset	Plant & machinery £000	Fair value of asset £000
R5 dStream MRI Breast Coil inc Mattress	9	9
Cubescan Bladder Scanner BioCon 700	6	6
Two Pagewriter Tc20 Ecg Recorders	12	12
Three Avalon Fm30 Fetal Monitors	34	34
Living Sky System	6	6
Ambient Experience Kitten Scanner	15	15
Total value of physical assets donated	**82**	**82**

Note 17 Revaluations of property, plant and equipment

The Trust commissioned a desktop revaluation of land, buildings and dwellings with a valuation date of 31 March 2024. This revaluation was conducted by Mr D Wilson BSc MRICS, of Cushman & Wakefield Debenham Tie Leung Limited.

This desktop revaluation has been undertaken on the following basis:

1) Assets in existing use: For specialised properties (i.e. those for which no active market exists), depreciated replacement cost has been used and is considered to be a satisfactory approximation of current value in existing use.
Within this methodology, the Modern Equivalent Asset (MEA) concept is applied: the “replacement cost” being based on the cost of a modern replacement asset that has the same productive capacity as the property being valued. An alternative site basis has been adopted.

The alternative site basis takes into account that the modern equivalent replacement with the same service potential as the existing hospitals may require a smaller footprint and may be sited at alternative locations to serve the populations of Lincoln, Boston Grantham and surrounding towns.

2) Land and Buildings which are no longer in operational use and are therefore 'surplus' have been valued at Fair Value.

The carrying value of assets not in active use but not classified as held for sale is £1.0m (31 March 2023: £1.0m)

3) Property valued on an open market existing use basis at 31 March 2024 is shown in the table below.

	2023/24	2022/23
	£000s	£000s
Land	-	-
Dwellings*	44,709	37,113
Buildings	-	-
	44,709	37,113

* Relates to Progress Care Housing Association Ltd accommodation units (non-specialised - dwellings) - see also notes 1.8, 1.25 & 30

Accounting policies note 1.8 provides further information regarding the method of valuation.

The useful economic asset lives for intangibles and plant and equipment are initially assessed when an asset is first recognised. Thereafter an annual review is undertaken to identify and adjust for any assets impaired or where the useful economic life requires adjustment.
The asset lives for individual buildings and dwellings are in accordance with the latest valuation report prepared by the external valuer.

The gross value of fully depreciated assets still in use is £5.47m (31 March 2023: £6.2m).

The value of buildings owned by the Trust that are leased out under operating leases is shown below.

	2023/24	2022/23
	£000s	£000s
Net book value 1 April	10,915	5,214
New leases	16	5,943
Additions	372	228
Depreciation	(317)	(352)
Increase in valuation 31 March	6	291
Impairments/Reversals	(150)	126
Terminated Leases	-	(535)
Net book value 31 March	**10,842**	**10,915**

Note 18 Leases - United Lincolnshire Hospitals NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust is the lessee for a number of properties: Buildings at John Coupland Hospital Gainsborough, Louth County Hospital, Skegness and District Hospital and Johnson Community Hospital Spalding along with Medical Centres at Gainsborough and Mablethorpe are leased through NHS Property Services with a collective annual lease cost of £0.8m (2022/23: £0.7m)
Other Properties where the Trust is lessee include: Beach House and Car Parks at Lincoln County Hospital. These have a collective annual lease cost of £0.2m (2022/23: £0.2m).

The Trust's arrangements relating to the lease of plant and equipment are supplied under normal commercial terms by non-NHS suppliers.
These incorporate lease cars, MRI scanners and other smaller items of medical equipment and photocopiers.

Note 18.1 Right of use assets - 2023/24

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**7,423**	**6,315**	**487**	**14,225**	**6,917**
Additions	2,377	-	159	**2,536**	-
Remeasurements of the lease liability	2,242	-	-	**2,242**	2,242
Disposals / derecognition	(37)	(278)	(41)	**(356)**	-
Valuation/gross cost at 31 March 2024	**12,005**	**6,037**	**605**	**18,647**	**9,159**
Accumulated depreciation at 1 April 2023 - brought forward	**830**	**1,402**	**186**	**2,418**	**698**
Provided during the year	975	1,379	198	**2,552**	763
Disposals / derecognition	(23)	(232)	(24)	**(279)**	-
Accumulated depreciation at 31 March 2024	**1,782**	**2,549**	**360**	**4,691**	**1,461**
Net book value at 31 March 2024	**10,223**	**3,488**	**245**	**13,956**	**7,698**
Net book value at 1 April 2023	**6,593**	**4,913**	**301**	**11,807**	**6,219**
Net book value of right of use assets leased from other NHS providers					187
Net book value of right of use assets leased from other DHSC group bodies					7,511

Note 18.2 Right of use assets - 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2022 - brought forward	**-**	**-**	**-**	**-**	**-**
IFRS 16 implementation - adjustments for existing operating leases / subleases	7,090	4,987	392	**12,469**	6,910
Additions	449	1,364	113	**1,926**	11
Remeasurements of the lease liability	(4)	(36)	-	**(40)**	(4)
Movements in provisions for restoration / removal costs	30	-	-	**30**	-
Revaluations	(22)	-	-	**(22)**	-
Disposals / derecognition	(120)	-	(18)	**(138)**	-
Valuation/gross cost at 31 March 2023	**7,423**	**6,315**	**487**	**14,225**	**6,917**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	**-**	-
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	-	-	-	**-**	-
Provided during the year	913	1,402	190	**2,505**	698
Revaluations	(29)	-	-	**(29)**	-
Disposals / derecognition	(54)	-	(4)	**(58)**	-
Accumulated depreciation at 31 March 2023	**830**	**1,402**	**186**	**2,418**	**698**
Net book value at 31 March 2023	**6,593**	**4,913**	**301**	**11,807**	**6,219**
Net book value at 1 April 2022	**-**	**-**	**-**	**-**	**-**
Net book value of right of use assets leased from other NHS providers					215
Net book value of right of use assets leased from other DHSC group bodies					6,004

Note 18.3 Revaluations of right of use assets

HM Treasury application guidance identifies that the cost model can function as an appropriate proxy to the current value in use or fair value provided:
- there are provisions within the agreement to regularly update lease payments for market rent
- there is minimal risk that the asset value will fluctuate significantly due to market prices and conditions.

Accordingly, having reviewed each Right of Use Agreement, the Trust has applied the cost model.

Note 18.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 26.1.

	2023/24	2022/23
	£000	£000
Carrying value at 31 March	**11,695**	**-**
IFRS 16 implementation - adjustments for existing operating leases		12,277
Lease additions	2,483	1,926
Lease liability remeasurements	2,242	(40)
Interest charge arising in year	142	121
Early terminations	(121)	(52)
Lease payments (cash outflows)	(2,535)	(2,537)
Carrying value at 31 March	**13,906**	**11,695**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.
These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.5 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2023	31 March 2023
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,563	798	2,426	730
- later than one year and not later than five years;	6,040	3,189	6,079	2,915
- later than five years.	6,795	4,210	3,578	2,873
Total gross future lease payments	**15,398**	**8,197**	**12,083**	**6,518**
Finance charges allocated to future periods	(1,492)	(424)	(388)	(267)
Net lease liabilities at 31 March 2024	**13,906**	**7,773**	**11,695**	**6,251**
Of which:				
Leased from other NHS providers		189		216
Leased from other DHSC group bodies		7,584		6,035

Note 19 Inventories

	31 March 2024	31 March 2023
	£000	£000
Drugs	3,114	2,815
Consumables	3,467	3,318
Total inventories	**6,581**	**6,133**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £76,663k (2022/23: £75,888k). Write-down of inventories recognised as expenses for the year were £209k (2022/23: £222k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £166k of items purchased by DHSC (2022/23: £1,222k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 20 Receivables

Note 20.1 Receivables

	31 March 2024 £000	31 March 2023 £000
Current		
Contract receivables	8,286	43,095
Allowance for impaired contract receivables / assets	(1,383)	(846)
Deposits and advances	-	1
Prepayments (non-PFI)	10,060	8,260
Interest receivable	143	138
PDC dividend receivable	323	-
VAT receivable	1,852	1,974
Other receivables[1]	500	252
Total current receivables	**19,781**	**52,874**
Non-current		
Contract receivables	1,963	2,015
Allowance for impaired contract receivables / assets	(453)	(501)
Other receivables [1]	512	643
Total non-current receivables	**2,022**	**2,157**
Of which receivable from NHS and DHSC group bodies:		
Current	4,786	39,245
Non-current	512	643

[1] Other receivables includes:

Clinicians pension tax scheme receivable £0.5m (2022/23: £0.7m)
Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the tax year 2019/20 face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme. Individual trusts have reflected this future liability within the provisions note 27.
NHS England are to meet the cost of this liability, this being reflected within the 2023/24 current (£0.02m) / non current (£0.51m) receivables (2022/23: current £0.02m / non current £0.64m).

Note 20.2 Allowances for credit losses

	2023/24 Contract receivables and contract assets £000	2022/23 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	**1,347**	**1,346**
New allowances arising	2,438	1,599
Reversals of allowances	(1,706)	(1,366)
Utilisation of allowances (write offs)	(243)	(232)
Allowances as at 31 Mar 2024	**1,836**	**1,347**

Note 20.3 Exposure to credit risk

Under IFRS 7 disclosure should be made to demonstrate exposure to credit risk.

The tables below show the level of outstanding invoiced receivables at 31 March split between those which have been impaired / not impaired.

Ageing of impaired financial assets

	31 March 2024 £000	31 March 2023 £000
0 - 30 days	-	-
30-60 Days	-	13
60-90 days	-	33
90- 120 days	217	42
Over 120 days	703	480
Total	**920**	**568**

Ageing of non-impaired financial assets past their due date

	31 March 2024 £000	31 March 2023 £000
0 - 30 days	2,561	2,526
30-60 Days	43	140
60-90 days	85	148
90- 120 days	22	53
Over 120 days	43	269
Total	**2,754**	**3,136**

In addition to providing against specific invoiced debt £0.9m (2022/23: £0.6m), the Trust also makes general provision for impairment based upon expected recovery rates.
This general provision covers both invoiced debt £0.2m (2022/23: £0.1m) and income from the Compensation recovery unit £0.7m (2022/23: £0.8m).

Note 21 Finance leases (United Lincolnshire Hospitals NHS Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the United Lincolnshire Hospitals NHS Trust is the lessor.

The Trust owns 3 properties where it has granted long leases to other NHS bodies; each has an annual peppercorn rent of £1.

	Term Years	Commencing
Ambulance Station at Boston Pilgrim Hospital	125	1992
Manthorpe Centre at Grantham Hospital	80	1997
Adult Mental Illness Unit at Boston Pilgrim Hospital	125	1993

The above properties revert to the Trust at the end of the lease term.

Note 21.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

	2023/24	2022/23
	£000	£000
Finance lease receivables at 31 March	-	-

Note 22 Non-current assets held for sale

Note 22.1 Non-current assets held for sale and assets in disposal groups

	2023/24	2022/23
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**
Assets classified as available for sale in the year	77	25
Assets sold in year	(77)	(25)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 23 Cash

Note 23.1 Cash and cash equivalents movements

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

	2023/24	2022/23
	£000	£000
At 1 April	**41,269**	**88,297**
Net change in year	9,589	(47,028)
At 31 March	**50,858**	**41,269**
Broken down into:		
Cash at commercial banks and in hand	11	11
Cash with the Government Banking Service	50,847	41,258
Total cash and cash equivalents as in SoFP	**50,858**	**41,269**
Total cash and cash equivalents as in SoCF	**50,858**	**41,269**

Note 24 Trade and other payables

Note 24.1 Trade and other payables

	31 March 2024 £000	31 March 2023 £000
Current		
Trade payables	16,097	7,035
Capital payables	27,095	21,205
Accruals	32,915	44,923
Social security costs	6,061	5,045
Other taxes payable	6,928	5,246
PDC dividend payable	-	728
Pension contributions payable	6,116	5,421
Other payables	213	302
Total current trade and other payables	**95,425**	**89,905**
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	10,363	3,117
Non-current	-	-

Note 25 Other liabilities

	31 March 2024 £000	31 March 2023 £000
Current		
Deferred income: contract liabilities	692	757
Deferred PFI credits / income [1]	479	479
Other deferred income	24	24
Total other current liabilities	**1,195**	**1,260**
Non-current		
Deferred PFI credits / income [1]	10,056	10,535
Other deferred income	510	534
Total other non-current liabilities	**10,566**	**11,069**

[1] The Trust entered into an agreement with Progress Care Housing Association Ltd in 2006, whereby the Trust transferred ownership of a number of staff accommodation flats to Progress, who agreed to refurbish the flats and build additional units. The Trust does not make any payments to Progress Care Housing, as they receive income from employees who pay for accommodation.
Due to the nature of the transaction, the Trust has recorded the assets on its balance sheet in accordance with IFRIC 12, with the corresponding liability being shown as an 'other liability'. This 'other liability' is amortised to the income and expenditure account to offset the depreciation.

Note 26 Borrowings and Financing Activities

Note 26.1 Borrowings

	31 March 2024 £000	31 March 2023 £000
Current		
Other loans	805	805
Lease liabilities	2,362	2,324
Total current borrowings	**3,167**	**3,129**
Non-current		
Other loans	2,013	2,818
Lease liabilities	11,544	9,371
Total non-current borrowings	**13,557**	**12,189**

Note 26.2 Reconciliation of liabilities arising from financing activities - 2023/24

	Other loans	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2023	**3,623**	**11,695**	**15,318**
Cash movements:			
Financing cash flows - payments and receipts of principal	(805)	(2,393)	**(3,198)**
Financing cash flows - payments of interest	-	(142)	**(142)**
Non-cash movements:			
Additions	-	2,483	**2,483**
Lease liability remeasurements	-	2,242	**2,242**
Application of effective interest rate	-	142	**142**
Early terminations	-	(121)	**(121)**
Carrying value at 31 March 2024	**2,818**	**13,906**	**16,724**

Note 26.3 Reconciliation of liabilities arising from financing activities - 2022/23

	Other loans	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2022	**4,025**	**-**	**4,025**
Cash movements:			
Financing cash flows - payments and receipts of principal	(402)	(2,416)	**(2,818)**
Financing cash flows - payments of interest	-	(121)	**(121)**
Non-cash movements:			
Impact of implementing IFRS 16 on 1 April 2022		12,277	**12,277**
Additions	-	1,926	**1,926**
Lease liability remeasurements	-	(40)	**(40)**
Application of effective interest rate	-	121	**121**
Early terminations	-	(52)	**(52)**
Carrying value at 31 March 2023	**3,623**	**11,695**	**15,318**

Note 27 Provisions for liabilities and charges

Note 27.1 Provisions for liabilities and charges analysis

	[1] Pensions: early departure costs	[1] Pensions: injury benefits	[2] Legal claims	[3] Other	Total
	£000	£000	£000	£000	£000
At 1 April 2023	**727**	**1,474**	**3,239**	**17,338**	**22,778**
Change in the discount rate	(22)	(117)	-	(114)	**(253)**
Arising during the year	97	167	1,374	400	**2,038**
Utilised during the year	(99)	(99)	(349)	(10)	**(557)**
Reversed unused	(46)	(11)	(656)	(5,939)	**(6,652)**
Unwinding of discount	12	25	-	34	**71**
At 31 March 2024	**669**	**1,439**	**3,608**	**11,709**	**17,425**
Expected timing of cash flows:					
- not later than one year;	100	96	3,608	8,350	**12,154**
- later than one year and not later than five years;	369	363	-	48	**780**
- later than five years.	200	980	-	3,311	**4,491**
Total	**669**	**1,439**	**3,608**	**11,709**	**17,425**

The amount and timings of these provisions are based on facts that were known at the time of completion of the Trust's accounts. Subsequent changes may alter the estimated value of the provision and / or the timing of the cash flow.

[1] The provision for Early Departure Costs (Pensions) and Pension Injury benefits have been assessed by discounting current pension costs and applying average life expectancies. The amount and timing of cash flows are thus uncertain.

[2] The provision for legal claims are made up of two component elements:
(a) Third party liability and property expense claims as notified by NHS Resolution £0.3m (2022/23: £0.3m)
(b) Projected liabilities in relation to claims made against the Trust for employment, commercial and other litigation issues £3.3m (2022/23: £3.0m).
The Trust's legal advisors have provided details to support an assessment of the potential liability for those claims where they are representing the Trust. This takes account of the potential range of outcomes, the related probability and the expected settlement date.

[3] Other provisions comprise:
- Costs associated with the Clinicians pension tax scheme - £0.5m (2022/23: £0.6m).
Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the tax year 2019/20 face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme.
Individual trusts have been instructed to reflect this future estimated liability within the provisions note and include a corresponding amount as owing from NHS England within the receivables note.

- Estimated costs associated with potential employee pay claims £8.3m (2022/23: £14.2).
- Costs associated with withdrawal / exit at a future date from a long term medical records storage contract £2.8m (2022/23: £2.4).

Note 27.2 Clinical negligence liabilities

At 31 March 2024, £281,830k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of United Lincolnshire Hospitals NHS Trust (31 March 2023: £341,671k).

Note 28 Contingent assets and liabilities

	31 March 2024 £000	31 March 2023 £000
Value of contingent liabilities		
NHS Resolution legal claims	(61)	(22)
Gross value of contingent liabilities	**(61)**	**(22)**
Net value of contingent liabilities	**(61)**	**(22)**
Net value of contingent assets	**-**	**-**

Note 29 Contractual capital commitments

	31 March 2024 £000	31 March 2023 £000
Property, plant and equipment [1]	38,991	30,131
Intangible assets	70	100
Total	**39,061**	**30,231**

[1.] **Property, plant and equipment capital commitments include:**	31 March 2024 £000	31 March 2023 £000
Pilgrim Hospital Boston: Emergency Dept	20,241	28,500
Pilgrim Hospital Boston: Emergency Dept - Electricity sub-station	1,445	-
Skegness: CDC	6,054	-
Lincoln: CDC	8,258	-
Other	2,993	1,631
	38,991	**30,131**

Note 30 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has a single PFI contract which has been capitalised under IFRIC 12 as a service concession arrangement.

This relates to an agreement with Progress Care Housing Association Ltd made in 2006 under which the Trust transferred ownership of staff accommodation flats to Progress Housing on a 99 year lease.

The contract contains a break clause, which, under the original model is expected to be after 40 years on 31 March 2046. This is the point at which under the original model, Progress Care would realise its target internal rate of return. At this point the Trust may serve notice and terminate the contract.

Under the arrangement, Progress Care must provide accommodation but have no obligation to acquire or build any new properties. In addition Progress Care must maintain and later return the properties to the Trust in good condition as defined within the agreement.

At the end of the 99 year lease term, ownership of the properties will revert back to the Trust.

In addition the contract includes a 20 year occupancy guarantee at 85.3%.

In the event that the 85.3% occupancy rate is not achieved, the Trust is invoiced by Progress Care for the shortfall and costs recorded as 'Premises' costs within operating expenses.
An assessment of historic occupancy levels and trends is undertaken annually and is utilised by the Trust Valuer in undertaking the annual property valuation.

The Trust has recorded the assets on its balance sheet in accordance with IAS 17, with the corresponding liability being shown as an ‘other liability’ (note 25). This is amortised to the Statement of Comprehensive Income over 40 years with an end date of 31st March 2046.

Note 31 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities

Initial application of IFRS 16 liability measurement principles to PFI liabilities
IFRS16 principles are not applicable under the Trust's PFI as there is no unitary payment and therefore no imputed lease liability.

Note 32 Financial instruments

Note 32.1 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 the Lincolnshire Integrated Care Board (LICB) and NHS England and the way these 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 Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Currency risk

The United Lincolnshire Hospitals NHS 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

Reforms to the NHS cash regime in 2020/21 resulted in the repayment of all DHSC revenue and capital loans through the issue of Public Dividend Capital (PDC).

The rate of return on PDC is set at 3.5% of net relevant assets.
The Trust has a single Salix finance loan which carries no interest charge.
The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the United Lincolnshire Hospitals NHS 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 2024 are in receivables from customers, as disclosed in the trade and other receivables note.

Throughout the Covid-19 pandemic in 2020/21 and 2021/22, the Payment by Results mechanism was replaced with block contract payments from commissioners.
Block payment arrangements have now been replaced with 'Aligned payment and incentive contracts' which contain a block and much smaller variable element.
This maintains and further supports the Trust Credit risk as low.

Liquidity risk

United Lincolnshire Hospitals NHS Trust's operating costs are incurred under contracts with Integrated Care Boards, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 32.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2024	Held at amortised cost
	£000
Trade and other receivables excluding non financial assets	9,568
Cash and cash equivalents	50,858
Total at 31 March 2024	**60,426**

Carrying values of financial assets as at 31 March 2023	Held at amortised cost
	£000
Trade and other receivables excluding non financial assets	44,796
Cash and cash equivalents	41,269
Total at 31 March 2023	**86,065**

Note 32.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost
	£000
Obligations under leases	13,906
Other borrowings	2,818
Trade and other payables excluding non financial liabilities	79,751
Provisions under contract	11,679
Total at 31 March 2024	**108,154**

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost
	£000
Obligations under leases	11,695
Other borrowings	3,623
Trade and other payables excluding non financial liabilities	78,886
Provisions under contract	17,308
Total at 31 March 2023	**111,512**

Note 32.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2024 £000	31 March 2023 £000
In one year or less	91,469	98,354
In more than one year but not more than five years	8,101	8,939
In more than five years	10,076	6,596
Total	**109,646**	**113,889**

Note 32.5 Fair values of financial assets and liabilities

Book value (carrying value) is considered to be a reasonable approximation of fair value in relation to the financial assets and liabilities held by the Trust.

Note 33 Losses and special payments

	2023/24		2022/23	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	23	9	20	10
Fruitless payments and constructive losses	1	21	1	2
Bad debts and claims abandoned	289	249	87	230
Stores losses and damage to property	2	207	2	239
Total losses	**315**	**486**	**110**	**481**
Special payments				
Compensation under court order or legally binding arbitration award	21	262	13	39
Ex-gratia payments	61	46	84	32
Special severance payments	-	-	1	4
Total special payments	**82**	**308**	**98**	**75**
Total losses and special payments	**397**	**794**	**208**	**556**

Note 34 Related parties

IAS 24, 'Related Party Disclosures' requires material transactions between the Trust and directors / key management and / or close families / entities controlled by any of these to be disclosed.
The details below represent those material transactions in 2023/24 between the Trust and Organisations with whom Trust Senior Executives / Management hold positions of influence.

ULHT Key Management details	Position / related party relationship		Related Party
Elaine Baylis -Trust Chair	Trust Chair		Lincolnshire Community Health Services NHS Trust
Andrew Morgan - Chief Executive	Chief Executive		
Karen Dunderdale - Deputy Chief Executive and Director of Nursing	Executive Chief Nurse		
Claire Low - Director of People and Organisational Development	Director of People		
Julie Frake-Harris - Chief Operating Officer	Chief Operating Officer		
Rebecca Brown - Non Executive Director	Non Executive Director		

The Department of Health and Social Care is the Trust's 'Parent body' and is regarded as a related party.
During the year the United Lincolnshire Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent.
The main entities with whom the Trust had dealings with during 2023/24 are listed below.

NHS Cambridgeshire and Peterborough ICB
Nottingham University Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust
Lincolnshire Community Health Services NHS Trust
NHS Nottingham and Nottinghamshire ICB
NHS Leicester, Leicestershire and Rutland ICB
Lincolnshire Partnership NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
NHS Cambridgeshire and Peterborough ICB
NHS Lincolnshire ICB
NHS Derby and Derbyshire ICB
NHS Lancashire and South Cumbria ICB
NHS Humber and North Yorkshire ICB
NHS West Yorkshire ICB
NHS England
NHS Resolution
NHS Property Services
Care Quality Commission
NHS Blood and Transport

In addition, the Trust has had a number of material transactions with other UK government departments and other UK central and local government bodies. The most significant of which are listed below.

NHS Pension Scheme
HM Revenue & Customs
South Kesteven District Council
Boston Borough Council
Lincoln City Council

The DHSC Group Accounting Manual identifies DHSC Ministers and senior officials, and entities controlled or influenced by them as being related parties of DHSC group bodies.
The Trust has conducted business in 2023/24 with the following organisations with whom Ministers or senior officials have declared interests to the Department of Health and Social Care.

Vyaire Holding Company
NHS Confederation
NHS England

The Trust is the Corporate Trustee for the United Lincolnshire Hospitals Charity (Charity No:1058065). The Charity is therefore deemed to be a related party.

The purpose or objects of the fund are set out within the Charity Deed and state:
The Trustees shall hold the Trust fund upon Trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service.

The Charity has supported numerous initiatives during 2023/24 including the purchase / donation of various capital assets to the Trust as detailed at note 16.

Other Direct transactions with the Charity are summarised below:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
United Lincolnshire Hospitals Charity	-	242	5	1

Note 35 Events after the reporting date

There have been no significant events after the reporting date which require disclosure.

Note 36 Better Payment Practice code

	2023/24 Number	2023/24 £000	2022/23 Number	2022/23 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	111,386	272,033	108,430	386,996
Total non-NHS trade invoices paid within target	92,285	236,483	76,364	313,915
Percentage of non-NHS trade invoices paid within target	82.9%	86.9%	70.4%	81.1%
NHS Payables				
Total NHS trade invoices paid in the year	2,384	50,001	2,888	53,470
Total NHS trade invoices paid within target	2,100	47,010	1,939	34,262
Percentage of NHS trade invoices paid within target	88.1%	94.0%	67.1%	64.1%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 37 External financing limit

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

	2023/24 £000	2022/23 £000
Cash flow financing	19,931	64,073
External financing requirement	**19,931**	**64,073**
External financing limit (EFL)	19,931	64,073
Under / (over) spend against EFL	**-**	**-**

Note 38 Capital Resource Limit

	2023/24 £000	2022/23 £000
Gross capital expenditure	62,566	47,365
Less: Disposals	(1,368)	(164)
Less: Donated and granted capital additions	(114)	(82)
Charge against Capital Resource Limit	**61,084**	**47,119**
Capital Resource Limit	61,084	47,119
Under / (over) spend against CRL	**-**	**-**

Note 39 Adjusted financial performance and Breakeven duty financial performance

	2023/24 £000	2022/23 £000
Surplus / (deficit) for the period	(28,064)	(19,301)
Remove net impairments not scoring to the Departmental expenditure limit	6,580	5,079
Remove I&E impact of capital grants and donations	652	548
Remove net impact of inventories received from DHSC group bodies for COVID response	56	49
Adjusted financial performance surplus / (deficit) (control total basis)	**(20,776)**	**(13,625)**
IFRIC 12 breakeven adjustment	1,132	588
Breakeven duty financial performance surplus / (deficit)	**(19,644)**	**(13,037)**

Note 40 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,282	(13,880)	320	124	(25,813)	(15,161)	(56,917)
Breakeven duty cumulative position	4,071	5,353	(8,527)	(8,207)	(8,083)	(33,896)	(49,057)	(105,974)
Operating income		391,141	392,202	407,975	422,802	425,524	433,250	423,428
Cumulative breakeven position as a percentage of operating income		1.4%	(2.2%)	(2.0%)	(1.9%)	(8.0%)	(11.3%)	(25.0%)

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(56,891)	(79,664)	(87,945)	(41,876)	3,149	2,665	(13,037)	(19,644)
Breakeven duty cumulative position	(162,865)	(242,529)	(330,474)	(372,350)	(369,201)	(366,536)	(379,573)	(399,217)
Operating income	437,324	433,161	447,492	539,248	643,878	680,194	757,678	788,589
Cumulative breakeven position as a percentage of operating income	(37.2%)	(56.0%)	(73.9%)	(69.0%)	(57.3%)	(53.9%)	(50.1%)	(50.6%)

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust'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.

Performance in respect of financial years prior to 2009/10 have not been restated to IFRS and remain on a UK GAAP basis.