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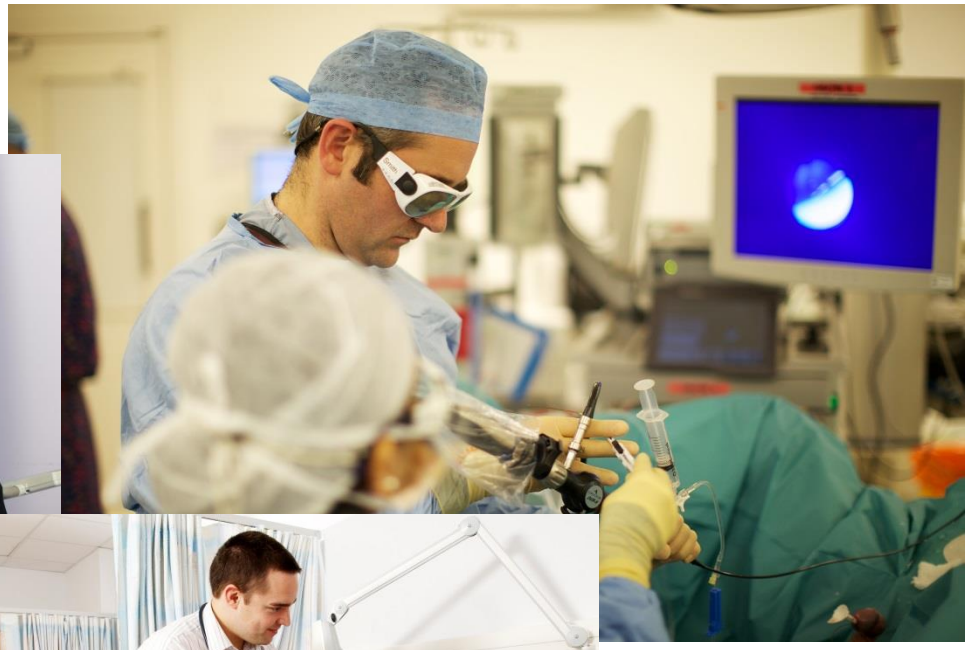
NHS
United Lincolnshire Hospitals
NHS Trust

Annual Report and Final Accounts 2016-17



Accessibility

This annual report and full accounts will be 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.

Contents

Chief executive and chair's foreword

Welcome to our annual report for 2016/17. We are both more settled in our positions within the Trust having started part way through last year in December and March respectively and we have continued to get to know our hospitals and staff. We have been deeply impressed by the commitment of staff to do the best for patients, as well as their dedication to the Trust.

The past year has been very challenging for almost all acute trusts in England particularly in terms of finances and performance. We were no exception. As you will read, the Trust recorded a large financial deficit, struggled to meet national targets such as the maximum four hour wait in accident and emergency and some of the cancer targets. We are working hard to address these challenges and within the year, we started to see green shoots of recovery.

In August 2016 we made the difficult decision to close the A&E department at Grantham and District Hospital overnight, on the grounds of patient safety. This was due to the reduction in the availability of doctors in Lincoln and Boston, together with an increase in the demand for emergency care services.

We also recently received a disappointing Care Quality Commission (CQC) report which saw the Trust placed into special measures. In April 2017 the report was produced following inspections at Lincoln County Hospital, Pilgrim Hospital, Boston and the A&E department at Grantham and District Hospital in October 2016. The CQC identified a range of issues which the Trust is required to tackle, but also many examples of good practice at ULHT.

The Trust has already improved on many of the areas of concern that were raised by the CQC, and we have started to see significant improvements since the inspection last October. Immediate action was taken and many issues raised by the CQC have since been resolved. Further actions are planned to ensure improvements are sustained.

As well as reported challenges, we also have much to be proud of. We've made good progress with developing our clinical strategy options. Following extensive staff and clinical engagement, Trust Board, Clinical Executive Committee (CEC) and Clinical Strategy Implementation Group (CSIG) reviewed the draft options in March putting us in a good position for developing a strategic outline case in 2016/17 to inform Lincolnshire's sustainability and transformation plans (STP).

Despite many vacancies, the quality of many of our services have been maintained or improved and we have taken forward innovative approaches. We were successful in being a pilot site for the new nursing associate role as well as taking the lead on the development of the first ever apprenticeship degree for the roles of physiotherapist and occupational therapist.

The endoscopy units at Boston and Grantham received the esteemed JAG status. Many of our staff have won or been nominated for national, regional and ULHT awards.

We also invested in the future of services with work starting on the £2.1m refurbishment of the neonatal unit at Lincoln and the revamped maternity and with the gynaecology modular unit at Pilgrim. The new Lincolnshire Clinical Research Facility at Pilgrim Hospital, was officially opened in August 2016. New services have also begun including the opening of a new ophthalmology unit at Grantham and a new eye cyst clinic at Pilgrim. A new ward accreditation scheme is being introduced.

Our enhanced teaching practice was recognised by the University of Lincoln at their joint awards evening with Health Education England where ULHT won several awards and many new teaching fellows were made. We are also working with the University of Lincoln to bring a new Medical School to the county which will help with our medical recruitment.

In February 2017 we held a rural health symposium in partnership with the Lincolnshire Economic Action Partnership (LEAP) to work towards our ambition of creating a national centre for rural health and care.

What are our plans for 2017/18? It will be a year of transformation for the Trust. To lead the transformation of our own services, we are developing our own five year plan called the 2021 strategy which will have a big focus on quality and safety. This will be our element of the STP.

As well as aiming to deliver our plans around quality, performance and finance we need to make improvements to the way we work for our patients and begin to transform our approach to the way we manage the movement of urgent care patients around and out of hospital. We will also look to carry out more elective work and improve how we employ, support, train and develop our workforce. Our plan, whilst realistic is also stretching because this time next year we need to be geared-up to deliver our services in a more sustainable way.

We hope this annual report will give a clear perspective on the challenges we face as well as highlighting a number of significant successes.

Our foreword to this annual report would not be complete without thanking our dedicated and talented staff. Around 7,700 people work at our hospitals, delivering services to the local community, which continue to be safe, and of high quality despite increasing pressures throughout the NHS. We are immensely proud to lead an organisation with so many hard-working colleagues who provide such important services. Thank you to all our staff for their continuing dedication to delivering high quality care. We hope that you find this report informative and that it demonstrates to you just how hard we are working to really focus on what matters to our patients.

Jan and Dean

Performance report

Overview

About us
United Lincolnshire Hospitals Trust (ULHT) is one of the biggest acute hospital trusts in England serving a population of around 736,700 people.

Our vision is to “work together to provide sustainable high quality patient-centred care for the people of Lincolnshire”.

We provide acute and specialist services to people in Lincolnshire and neighbouring counties. Lincolnshire is the second largest county in the UK. It is characterised by dispersed population in towns and in the city of Lincoln and largely rural communities.

We have an annual income of £437 million. Our main contracts are with Lincolnshire East, Lincolnshire West, South Lincolnshire, and South West Lincolnshire clinical commissioning groups (CCGs).

We provide services from three acute hospitals in Lincolnshire:
- Lincoln County Hospital
- Pilgrim Hospital, Boston
- Grantham and District Hospital.

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health Services NHS Trust or local GP clusters. These include:
- Louth County Hospital
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital, Spalding
- Skegness and District General Hospital.

We provide services from three acute hospitals in Lincolnshire with a bed stock, excluding obstetrics, of 953:

- Lincoln County Hospital (494 beds)
- Pilgrim Hospital, Boston (362 beds)
- Grantham and District Hospital (97 beds)

For 2016/17 our attendances were as follows:

- Outpatient appointments (consultant led) 489,000
- A&E attendances 160,000
- Elective admissions 76,000
- Non-elective admissions (excl. obstetrics) 61,000

In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients and over 140,000 inpatients, and deliver over 5,000 babies.

The Trust provides a broad range of other clinical services including community services, population-screening services, and a comprehensive range of planned and unscheduled secondary care services. We deliver services across:

Audiology	Dermatology	Haematology	Ophthalmology	Respiratory physiology
Breast services	Diabetic medicine	Hepatobiliary and pancreatic surgery	Oral and maxillofacial surgery	Rheumatology
Cardiology	Diagnostic services	Maternity and obstetrics	Orthodontics	Specialist rehabilitation medicine
Chemotherapy	Dietetics	Medical physics	Pain management	Vascular surgery
Children's community Services	Ear, nose and throat	Medical oncology	Palliative care	Therapies
Clinical immunology	Endocrinology	Neonatology	Pharmacy	Trauma and orthopaedics
Clinical oncology	Gastroenterology	Nephrology	Radiotherapy	Urology
Colorectal surgery	General medicine	Neurology	Rehab Medicine	
Community paediatrics	General surgery	Neurophysiology	Research and development	
Critical care	Gynaecology	Nuclear medicine	Respiratory medicine	

Whilst ULHT is the leading provider of elective care for three CCGs in Lincolnshire, Northern Lincolnshire and Goole NHS Foundation Trust and Peterborough and Stamford NHS Foundation Trust get a significant share of elective care in Lincolnshire East and South Lincolnshire respectively. It is of note that South Lincolnshire CCG commissions more than 50% of its elective care from hospitals outside Lincolnshire.

How we are organised

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.

Board membership comprises of 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 objectives.

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

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

The remuneration of executive and associate directors is determined by a remuneration and terms of service committee. During 2016/17, this committee consisted of the chair and the non-executive directors.

More about our Board, Board members and committees can be found in the governance section on page 47 onwards.

Staff profile

Our staff are fundamental to our ability to deliver high quality services that put our patients at the centre of all that we do and provide the best quality care with passion and pride. At the end of 2016/17, the Trust employed 7663 (full time equivalent) staff.

Table 1 below shows the percentage breakdown of staff groups at the Trust by whole time equivalent. It shows the large majority (79%) of our staff were female.

In terms of the Trust's senior managers, of the 12 executive directors employed in the year 2016/17, two were women and 10 were men. All our executive directors are very senior manager bands.

For full analysis of staff numbers, see table 21 on page 71.

Table 1: Staff by Gender as at 31/03/2017

Staff Group	Female	Male	Total
Add Prof Scientific and Technic	154	70	224
Additional Clinical Services	1190	146	1336
Administrative and Clerical	1314	259	1573
Allied Health Professionals	321	84	405
Estates and Ancillary	623	301	924
Healthcare Scientists	61	47	108
Medical and Dental	275	518	793
Nursing and Midwifery Registered	2148	138	2286
Students	9	5	14
Total	6095	1568	7663

Purpose, vision and objectives

We have one purpose, one vision, five values, three aims and in 2016/17 had seven annual objectives.

Our purpose is to deliver safe, excellent, compassionate and respectful healthcare for our patients.

We will reform our services. We want to deliver better services in Lincolnshire. We want services to be clinically and financially sustainable for the future. We cannot have one without the other.

Our vision is to be a first class healthcare provider serving its community with sustainable high quality clinical care, offering an exceptional experience for patients and creating a great place for our staff to work.

We aim to be safe and responsive, caring and effective, and well-led.

The long-term ambition for the Trust is to develop the potential to become a national, if not international, centre for rural health and care. In February 2017 we held a rural health symposium in partnership with the Lincolnshire Economic Action Partnership (LEAP) to work towards creating a national centre for rural health and care. We will develop our research, develop our staff and education. The aim is to improve patients' access to services locally, improve our quality of services whilst meeting challenging financial balances across the health and care system in Lincolnshire.

Our objectives and performance

We are building bold strategies and integrating our plans, focusing on priorities and developing new opportunities to reshape and improve the Trust. We are also working to improve public confidence in high quality patient centred care in Lincolnshire, with a continued focus on improving accessibility in our localities.

Our key risks and issues

The Trust continues to face serious challenges. These cover the spectrum of performance, staffing, finance, quality, pace of transformation and population challenges.

The Trust is working hard to address these issues, which are causing difficulties across the whole NHS, and will continue to do so in 2017/18. The Trust has a corporate risk register outlining what it perceives its key challenges to be.

Performance challenges
Last year saw unprecedented demand for services and beds. There were delays in discharging medically-fit patients into the care of other organisations, which means that beds could not be used as efficiently as possible and we needed to postpone elective work to accommodate emergency patients. There were, and remains, significant shortages of doctors and nurses in many areas. This affected us not only operationally but also financially as our income fell.

Staffing challenges
We ended the year with 297 registered nurse and midwife vacancies and 131 doctor vacancies. We worked hard to recruit staff locally, nationally and internationally including nurses and doctors from the EU and the Philippines, and despite our turnover rate being low, we have an over reliance on locum and agency staff to get our staff numbers up.

The decision to close the A&E department at Grantham overnight was made as a result of the reduction in the availability of doctors in Lincoln and Boston, together with an increase in the demand for emergency care services. Despite our ongoing efforts to recruit to vacant posts, we do not have enough doctors to safely staff all three of our A&Es 24 hours a day, seven days week.

We are working hard to recruit more doctors and continue to pay premium rates to attract doctors to the county. ULHT are committed to fully reopening A&E as soon as we have enough doctors. But we won't compromise on safety to deliver convenient services.

To help with the staffing challenges we have a number of actions in place. We are working in partnership with other trusts developing a Lincolnshire attraction strategy to market Lincolnshire and individual organisations to clinical staff countrywide. We will progress developing Lincolnshire as a centre of rural health and care, building our research, development and education footprint through collaboration with regional universities to attract medical recruitment to a centre of excellence through a 'Team Lincolnshire' approach.

We are also promoting our nurse bank to promote flexible nursing work along with favourable NHS terms and conditions.
We are also looking at innovative ways to overcome reliance of registered nurses by employing assistant occupational therapists, physiotherapist and pharmacy technicians on wards.

Financial challenges

Like much of the rest of the NHS, ULHT faces unprecedented financial challenges and has done for several years now, but 2016/17 was particularly challenging. In some areas such as acute medicine and emergency care, rising demand for services meant the need to use more agency staff and that income-generating elective surgery sometimes had to be cancelled so that emergency patients could be treated instead.

Changes in our healthcare system would still be required even if the current deficit did not exist. Demand for our services will increase, particularly with an ageing population and increased prevalence of long term conditions and co-morbidities. This means we need to explore how health and social care organisations can work together in the future to be more efficient whilst improving quality of services through the sustainability and transformation plan for Lincolnshire (STP).

The Trust's internal financial plan will not, on its own, be sufficient to drive the scale and pace of change required to deliver our vision for clinically and financially sustainable services in the medium to long term. We will be seeking support from the sustainable and transformational fund (STF) to provide revenue and capital support to:

- Invest in strategic change.
- Invest to save – additional capital to produce short-term revenue payback.
- Continue to reduce the significant backlog maintenance in our estate and assets.

In 2017/18, the challenges will continue, as the Trust is required to make further efficiencies at a time when demand continues to rise.

Paediatric services

Due to challenges currently faced in recruiting paediatric clinicians and paediatric nurses, the current services are not performing to the required standards set by the Royal College of Paediatricians. These risks are being mitigated to ensure a safe service is delivered, but delivery of the mitigation is not sustainable either clinically or financially.

Urgent and emergency care services

Once again, due to challenges currently faced in recruiting A&E consultants, the current services are not sustainable financially, and in some areas are not clinically sustainable. The recommendations coming from Sir Bruce Keogh and Professor Keith Willetts indicate a new approach nationally for urgent and emergency care, which will see the hospital emergency departments caring for patients who need time critical care, and the urgent care centres seeing patients who need urgent but not necessarily time critical care.

In August, we made the difficult decision to temporarily change the opening hours at Grantham A&E due to a severe shortage of middle grade doctors at Lincoln and Boston A&Es. Since 17 August 2016, Grantham A&E has been open from 9am to 6.30pm 7 days a week. From March 27 we extended the opening hours of Grantham A&E to 8am to 6.30pm, seven days a week.

There is a national shortage of A&E doctors, and ULHT is very much affected by this. We are overly reliant on short and long term agency doctors to fill staff rotas. Reducing the opening hours of Grantham A&E has allowed us to provide better patient care in Lincoln – where the most serious cases from across the county go to. Grantham A&E doctors have provided up to an additional 85 hours of middle grade and consultant support per week at Lincoln. Though not ideal, this was the safest option for the provision of emergency care for the people of Lincolnshire including those who live in the Grantham and district area.

Population challenges

The population of Lincolnshire is estimated to be 736,700 (ONS, May 2015). Lincolnshire has one of the fastest growing populations in England and it is projected to rise to 838,200 by the year 2033. Greater life expectancy and increased long-term conditions will increase the demand for healthcare. If we stand still we will soon be unable to meet all the needs of increasing numbers of patients.

Latest statistics show that the proportion of residents in Lincolnshire over the age of 75 is predicted to increase by 101% between 2012 and 2037, which will result in increasing demand for hospital care from this age group.

These patients are often the most vulnerable in society and can have multiple long-term conditions. Elderly patients are also at high risk of hospital-associated harms and hospital is often not the best place for these people, especially on a long-term basis. The needs of the aging population are social, physical and mental, and not well met by the configuration of our current services. Integrating care with other health and social providers will help to ensure these citizens get the right care, in the right place and at the right time. This is being done in partnership with health and social care organisations through the STP.

In its ethnic profile, Lincolnshire is predominately white-British. However, 15.1% of the population of Boston were born outside the UK, which is higher than the UK average. The use of hospital services is lower for the migrant population compared to the Lincolnshire population as a whole, with the exception of maternity services.

Proficiency in English among those who don't speak it as their first language is poorer in Lincolnshire than in England (69.3% compared to 79.3%). Polish, Latvian and Lithuanian are the most common non-English languages spoken in the county.

Quality challenges
While the Trust has worked hard to deliver safe services and of high quality, sustaining this quality across all our sites at all times is a challenge.

National bodies and royal colleges set clinical standards so that safe and quality care can be delivered to patients. We are not achieving performance against all these standards for either women and children's care or emergency care on a consistent basis, because of how our care is organised and delivered. These risks are being mitigated to ensure a safe service is delivered, but this is not sustainable either clinically or financially.

In the medium to long term, we need to reconfigure our services as part of the STP to deliver sustainable, safe care for the people of Lincolnshire.

Pace of transformational change risk
One of our biggest risks to quality, sustainability and our finances is potential delays to reconfiguration of hospital services as part of the STP. To help mitigate this we will bring forward elements of the Trust's clinical strategy that are not dependent upon wholesale public consultation.

More information on our risks and how we manage them can be found in our accountability report from page 47 onwards.

STP New five year health and care plan for Lincolnshire
In December, the new five year sustainability and transformation plan (STP) for Lincolnshire was published.

For the first time we have a single plan that describes how health and care services across the whole county will change in order to deliver better quality care, improve health and wellbeing and bring our health and care system back into financial balance. All 44 areas of the country were asked in January to submit a plan.

The STP has been developed by all seven Lincolnshire health organisations, including ULHT, with discussion with officers from Lincolnshire County Council and other key organisations which provide local healthcare support.

Lincolnshire has worked together more closely than ever in the last three years to develop the Lincolnshire Health and Care Programme which sets out our blueprint for future health and care services in Lincolnshire and describes a new model of care.

The development of STP builds on, and includes, this work but looks further at how we can work together more effectively, as a single health and care system to better support our residents and ensure every pound spent delivers value for the people of Lincolnshire.

We need to work differently if we are to provide effective care to our growing ageing population, spread thinly over our rural county. Despite our best efforts, we sometimes fail to provide care that meets national standards. We struggle to recruit to key roles which pressure on our overstretched workforce and means we rely on expensive agency staff

We currently spend too much money on treating people in hospital rather than providing support in the community to prevent people needing hospital care.

Review of 2016/17

As well as reported challenges outlined in the previous section, we also have much to be proud of.

We had seven main objectives for 2016/17 and made great strides in meeting them. Below is a snapshot of some our achievements.

1. Continuously improve quality, provision of safe care, and deliver a positive patient experience

Revamping our estates
Last year, we worked hard on the refurbishment of our estates with our construction partners Kier.

The redevelopment of Stow Ward now called Scampton Ward at Lincoln into an innovative dementia friendly ward continued and is due to finish mid-2017. This new facility will help reduce levels of anxiety for patients.

A £650,000 investment in a state-of-the-art energy centre at Grantham opened in October 2016 which now sees the hospital with improved heating and hot water facilities. The hyper-efficient energy centre saw the replacement of temporary boilers with three new condensing boilers and the laying of new pipework around the hospital.

Investments in maternity services at Lincoln and Pilgrim
Work has continued on a new state of the art pre and post labour maternity ward. We've invested £5.2 million in Pilgrim hospital to create a new 22 bed maternity unit alongside a 16 bed gynaecology and post-natal ward to replace the outdated M1 and M2 wards there.

The new £3.7 million modular unit took great skill and effort from facilities staff and the new, modern unit will be an extension to the main hospital. It will provide a welcoming and comfortable environment for patients, visitors and staff. This is great news for our patients and our staff. It will open in mid to late 2017.

Work is now underway in a £2.1m investment in upgrading the neonatal unit at Lincoln County Hospital. The investment will see the existing unit ungraded into a state of the art facility housing between 18 and 20 cots. The unit will move down to the revamped first

floor of the maternity block whilst work takes place on the sixth floor. It is anticipated that the new unit will be up and running by mid to late 2017.

Lincolnshire first in the UK to use a new technique to treat skin cancer

Patients with non-melanoma skin cancer in Lincolnshire are benefitting from a new technique which is not only quicker and protects healthy tissue but is a first in the UK.

Non-melanoma skin cancer is one of the most common types of cancer in the world. There are more than 100,000 new cases every year in the UK and it affects slightly more men than women.

Brachytherapy is delivered in a series of treatments and for most people they will receive 5-8 sessions. Treatment can be completed in a relatively short space of time, usually over the course of 2-4 weeks.

Treatment is given on an outpatient basis at Lincoln County Hospital for patients from across Lincolnshire meaning the patient will not need to stay overnight in hospital. Each treatment delivery usually lasts only a couple of minutes per sessions which is more convenient for a patient and they can return to their daily life.

Patients are examined and have an ultrasound to determine the depth of the area needing treatment. The patient is positioned with the help of staff on a bed or chair and the treatment applicator is positioned on the area of skin requiring treatment. The applicators are designed to provide a close fit and to reduce radiation to nearby areas.

Following the course of treatment a follow-up appointment is scheduled for around 6 weeks later to check the treatment has gone well and to monitor progress. Follow-up visits are then scheduled every 3-6 months for the first year and once per year after this.

Falls collaborative pilot

Two wards at Pilgrim Hospital are taking part in a pilot with the aim of reducing inpatient falls and to reduce the rate of falls from harm.

To achieve this a small team of senior and experienced clinical staff consisting of a consultant, matron, nurse consultant and site duty manager are working collaboratively with allied health professionals including physiotherapists and occupational therapists as part of a national improvement team dedicated to reducing falls.

On wards 3B and 6B patients who are identified as possibly at risk of falling are issued with a fall safe leaflet explaining the use of the yellow wristband they are asked to wear. Those patients who are deemed as high risk of falling are given the leaflet, yellow wristband, yellow non-slip socks and a yellow magnet above their bed. Any falls incidents are fully investigated to ensure that all safety measures are in place which may include requesting additional support from staff to provide enhanced care.

A falls prevention workbook has been designed to drive the training for falls prevention on both wards/ this will improve the education and knowledge of staff on these wards of patients at risk and the multifactorial reasons they fall. Medication reviews are also taking place to increase the awareness of culprit medications relevant to the cause of falling to include occupational therapists and physiotherapists. The aim of this is to reduce falls through medication cause. A sticker will be placed in the notes of patients for medication review.

Risk areas on the wards are also being looked at with the layout of both wards. When a fall occurs staff are logging where this has happened to highlight any risk areas on both wards.

Work is also ongoing to increase the compliance of lying and standing blood pressure which is to be taken of patients as a clear indicator in the potential for patients having a fall. This training is being given to staff from both wards in a twenty minute rolling session with a plan to be rolled out across the Trust.

The pilot finishes in June 2017.

Hospital introduces one-stop prostate service

Men with suspected prostate cancer are now being seen for diagnostic tests on the same day as their first hospital appointment at a new one-stop shop at Lincoln County Hospital.

This speeds up their diagnosis by up to two weeks- reducing worry and stress and giving them earlier access to treatment if necessary.

Patients with a raised prostate specific antigen (PSA) level are referred into hospital for further investigation by their GP, as this can be a sign of problems with the prostate. All of these patients should be seen in hospital within two weeks, and at their appointment, an examination will be done and if the doctor believes there could be a problem they will be offered a biopsy of their prostate.

Until now, all patients would be sent away following their examination and given a biopsy appointment at a later date, up to two weeks later, depending upon the availability of the urology consultant.

Now, urology clinical nurse specialist Zina Bojin has been trained to carry out the biopsy, meaning that they can be done on the same day as the consultant appointment for those patients who want to.

Innovating to reduce pressure ulcers

New heel pressure ulcer mirrors have been purchased for every ward. These mirrors can be used by nursing and support staff to observe the heels of patients, helping the staff to quickly identify any skin changes on the heel that could lead to pressure damage. This means action can be taken early to prevent painful and debilitating pressure ulcers.

Lincolnshire's hospitals have a very good track record at managing them, and innovating to reduce the numbers of patients affected. In recent years the incidence of pressure ulcers in ULHT hospitals has reduced by nearly 40% to 0.9%, compared with the national reported incidence rate of 4-6%.

Pressure ulcers are hugely important in terms of the quality of care that we provide to our patients, as they can have profound effects on a patient's quality of life if not prevented, assessed and managed properly.

National recognition for endoscopy units
The endoscopy units at Pilgrim and Grantham hospitals were recognised nationally for the high standards of care they provide.

The endoscopy units were given Joint Advisory Group accreditation. Known as JAG, this is a national award set up to ensure high standards of care in clinical quality, quality of patient experience, training and workforce.

Lincoln and Louth endoscopy units were JAG accredited the year before. The units care for patients undergoing endoscopy procedures, which are procedures that are used to assess areas inside the body by inserting a flexible tube that can provide images of the area in question and be used to take samples.

Achieving this standard for the units is a sign that our patients are being provided with a quality service on their doorstep, with evidence of high standards of patient care and safety.

One-stop shop for lung CT scans in Lincolnshire's hospitals
Patients with possible lung cancers are benefitting from a one-stop diagnostic service at Lincoln County Hospital which means that patients are being seen for their initial lung computed tomography (CT) scan more quickly.

A CT scan uses x-rays and a computer to create detailed images of internal organs, blood vessels and bones inside the body, and are used to diagnose various conditions.

Patients can now see the consultant in a clinic and then go straight down to radiology and have their CT scan done in one appointment before they go home.

This speedier service has reduced patient waits by at least one week, thus providing quicker diagnosis to the patient and improved patient experience. It also means treatment can begin more quickly if needed.

New eye unit provides more access to treatment for Lincolnshire patients

A new eye department at Grantham and District Hospital is providing better access to treatment for Lincolnshire patients.

The newly refurbished department is a major improvement and includes both full clinics and theatres. The department provides 16 – 18 clinics per week and three and a half theatre lists per week. This is a 100% increase in clinics and a 15% increase in theatre slots for those patients who require local ophthalmology for conditions such as cataracts and glaucoma. There will also be paediatric ophthalmology services.

Before the unit was opened about 1,000 patients were travelling elsewhere in Lincolnshire for their appointments.

New eyelid cyst clinic transforming care for Lincolnshire patients

A new see and treat clinic means assessment and surgery is carried out in the same appointment and patients are able to go home within the hour.

Patients are seen within a few weeks of the initial referral from their GP or optometrist in the clinic within the Royle Eye Department at Pilgrim Hospital, Boston. Patients are assessed and if surgical treatment is required, it is carried out at the same appointment.

Conditions treated include chalazions and meibomian cysts which are painless bumps inside the upper or lower eyelid caused by blockage of oil glands in the eyelid and eye lid papillomas which look like a skin tag and can be solitary or multiple, smooth or rough and is similar in colour to adjacent skin and skin tags.

The aim of the service is for Lincolnshire GPs and local optometrists to be able to refer directly into this clinic, rather than secondary care where the patient may not be able to be treated.

2. Create the conditions for our staff to achieve their best

Lincolnshire hospital's project receives international acclaim
An innovative tool developed in Lincolnshire's hospitals to help reduce the number of pressure ulcers in patients has attracted international interest.

PUNT (Pressure Ulcer Notification Tool), a unique online system that allows staff to record, monitor, report and review reliable pressure ulcer data for hospital patients, is being adopted by US company Bruin Biometrics.

Based in California, Bruin Biometrics (BBI) is a developer of innovative sensor-based diagnostic equipment. The company has developed a hand-held, portable device that detects early signs of pressure damage, including pressure ulcers and deep tissue injuries, before visual skin damage or pressure ulcer formation can be seen on or within a patient's skin. They will use the PUNT tool in line with these devices to report and review reliable pressure ulcer data.

The tool has been developed with support from the Trust's information communication technology team, who work closely with clinicians to develop tools to dramatically improve the lives of our patients.

First developed in 2004, PUNT has allowed ULHT to objectively report a decrease in the occurrences of all categories of pressure ulcers, especially since its further redevelopment in 2011.

Lincoln Hospital ward recognised with carers award
Clayton ward at Lincoln County Hospital is the first ward at ULHT to be presented with a Lincolnshire Carers Quality Award.

The award, presented by Every-One, is given to health and social care departments who have been proven to recognise the importance of carers in supporting their patients.

Clayton ward has been recognised following letters and cards from carers who found the team were supportive whilst their relative was on the ward and because they offer information about open visiting times for carers, free car parking and support for staff who are carers.

Radiographer wins national award
Jane Hall, who works as an information and support radiographer, was announced as the Radiographer of the Year by the Society of Radiographers.

Therapy radiographers like Jane are responsible for working with patients to plan and deliver radiotherapy treatment for people with cancer. This treatment uses high-energy rays to destroy cancer cells.

Jane was selected for the award in recognition of the work she has done to introduce new services to help patients and their families cope with radiotherapy and the side effects of treatment, including using her time off to organise open days for staff and members of the public to explain radiotherapy.

She has also been working alongside head and neck nurse specialists to improve the management of symptoms for patients, as well as working towards creating an oncology website that patients use to access information.

Consultant physicist honoured with Gold Medal award
Philip Cosgriff, Head of Nuclear Medicine was the first recipient of the national Healthcare Gold Medal, awarded by the Institute of Physics and Engineering in Medicine (IPEM).

This award is presented to members of the institute who have a substantial and sustained track record of contributing to the advancement of healthcare practice related to physics and engineering in medicine and biology.

Carers badge scoops Rosa Parks Award
ULHT developed a carers policy to ensure we consider carers as experts in care, but it was identified that there was a problem with identifying who was a carer. To help us do so the Trust launched its carers badge, which enables carers to be at the hospital 24/7 if they wish, to be present at ward rounds and whenever they need to be. This work was awarded the Rosa Parks Award by the Academy of Fabulous NHS Stuff.

In the recent CQC report the carers badge was highlighted as “outstanding practice”.

Record number of ULHT staff award nominations received
In total, 44 individuals and teams who work across Lincolnshire's hospitals have been shortlisted for this year's staff awards in 11 categories. They were chosen from an impressive 690 nominations this year, including 100 from patients.

3. Recruit the right staff to the right places

Recruiting nurses from far and wide
We started to see results from our UK targeted recruitment drive. However, as with many Trusts in the UK, we were finding that we still needed more nurses and also needed to look abroad.

We went out to recruit in the Philippines where we made offers to more than 100 registered nurses in the Philippines. So far, eight band five nurses are working with the Trust and we have five band three nurses who are awaiting Objective Structured Clinical Examination (OSCE) results. The OSCE is designed to test clinical skill performance and competence in skills such as communication, clinical examination, medical procedures / prescription, exercise prescription, joint mobilisation / manipulation techniques, radiographic positioning, radiographic image evaluation and interpretation of results.

100 newly qualified nurses welcomed
In September, we welcomed 100 newly qualified nurses to our wards. This fantastic success was part of the Trust's recruitment campaign and followed close partnership working with the University of Lincoln.

It is a great accolade that they chose ULHT particularly as this is often based on the experience they received during their work placements, so for them to come back shows we are a great place to work.

Trust welcome first mental health nurse into team
The first mental health nurse to work directly for the Trust was welcomed into an elderly care team.

Rochelle King attended a recruitment open day at Pilgrim Hospital, Boston where she spoke to staff with a desire to improve patient care by combining her mental health experience with general medicine and was offered an interview.

She is enjoying her role and will attend mental health courses to keep her knowledge up to date and share her skills with the rest of her team on the ward.

Dementia practitioners transforming the care of patients in Lincolnshire's hospitals
Patients with dementia in Lincolnshire's hospitals are getting specialist one to one assessment and care thanks to the appointment of two new specialist nurses.

The dementia practitioners started work at Lincoln County Hospital and Pilgrim Hospital in Boston.

Between them, Jodie Barwick and Jenny Meng have extensive experience in assessing and managing patients with dementia.

The new job involves them assessing every patient admitted to hospital with suspected dementia, to ensure that any patients with dementia get the tailored care that they require through the hospitals' mental health liaison teams. This can be up to 15 patients per day across both hospitals.

Importantly, they also visit patients on the wards who have been identified with dementia and assess what support they require. They are regularly called upon by staff to provide enhanced care or one to one care if dementia patients require additional support. They also involve families and carers to be able to provide support for the patient.

4. Move towards a clinically led organisation

Clinical research takes centre stage with new research facility
The new Lincolnshire Clinical Research Facility at Pilgrim Hospital, was officially opened in August 2016.

Clinical research in Lincolnshire's hospitals has gone from strength to strength in recent years, with the number of clinical trials and studies carried out in ULHT soaring from around 10 to nearly 200.

At Pilgrim, the research team is working on a number of trials including oncology, haematology, stroke, cardiology, paediatric, dermatology, diabetes, midwifery, ophthalmology, respiratory, anaesthesia, gastroenterology, renal and orthopaedics.

The new facility has been designed to maximise the potential of research at Pilgrim and includes a patient consulting room, research laboratory, filing storage room, research offices, meeting room and kitchen.

5. Deliver our 2016/17 financial plan

Financial overview

We ended the year with a deficit of £56.9 million, meeting our in-year adjusted financial target but not the plan set out at the start of the year of £47.9 million. There are various reasons for our deficit, one of the most important being high spending on agency nurses and doctors to cover a shortage of permanent staff and the additional beds open. These were needed for the high number of patients who are medically fit for discharge but couldn't be discharged due to a lack of care out of hospital.

We also believe that the national funding regime, called the tariff, does not adequately reflect the costs of serving a relatively dispersed rural population from three acute hospitals. We are working hard with commissioners and other partners to try to address these factors.

We have many actions and plans in place to save money and boost our income, and we are working with the wider NHS to make sure we do this. Finance is a key part of our 2017/18 integrated annual plan and our medium term plan.

A significant way we can reduce our deficit over the next few years is to directly employ more doctors and nurses, be more creative with how we use other clinical staff such as pharmacists and therapists, and change how we provide services.

Although our deficit was higher than originally planned, we did have some successes. They are highlighted in the following paragraphs.

6. Improve performance

In February the Trust achieved the 6 week diagnostic standard for the fourth month in a row. The performance level was 0.26%. The number of 6-week breaches reduced from 102 patients in November down to 18 patients in February and March.

The Trust entered 2016/17 achieving the national RTT incompletes standard, and maintained this position for the first three months of the year.

This is great for our patients who are now seen in the expected timeframe and also for the Trust as a whole.

This really was a team effort with people across the Trust involved.

Improving patient flow through Red to Green
Red to Green helps to reduce overall bed occupancy and improve patient flow within our hospitals.

A red day is when a patient waits for more than 14 hours for an intervention, such as a diagnostic test, therapy or senior clinical review. If these delays are avoided, it's a green day. Put most simply, a red day is when, for whatever reason, nothing happens to progress a patient's discharge from hospital.

The Red to Green model has been designed by NHS England's Emergency Care Intensive Support Team (ECIST) and is being used by several NHS trusts across the country with excellent results. It is an effective way to demonstrate that we are being as proactive as we can for the benefit of our patients.

Red to Green also lends itself very closely with SAFER, the national best practice bundle that implements five clear steps which are proven to reduce blockages in the system and reduce mortality.

In February, we launched Red to Green across all wards at Lincoln County Hospital. During the launch week the Red to Green team worked closely with colleagues from Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust, and adult social care to help identify and unblock the things that prevent staff from discharging patients as soon as it is safe to do so. This might be that a planned diagnostics (x-ray or CT scan) is not carried out as requested, leading to a delay in the patient being treated and discharged.

The process followed each day during the launch week was:

- 8.30am – 10am: board round takes place on all wards, lasting between 20 – 30 minutes.
- 10.30am-12pm: All wards present the delays identified by the board round to the Red to Green team and plan agreed for addressing these. Social care, community, therapy, diagnostic, managers and executive directors all present at this meeting.

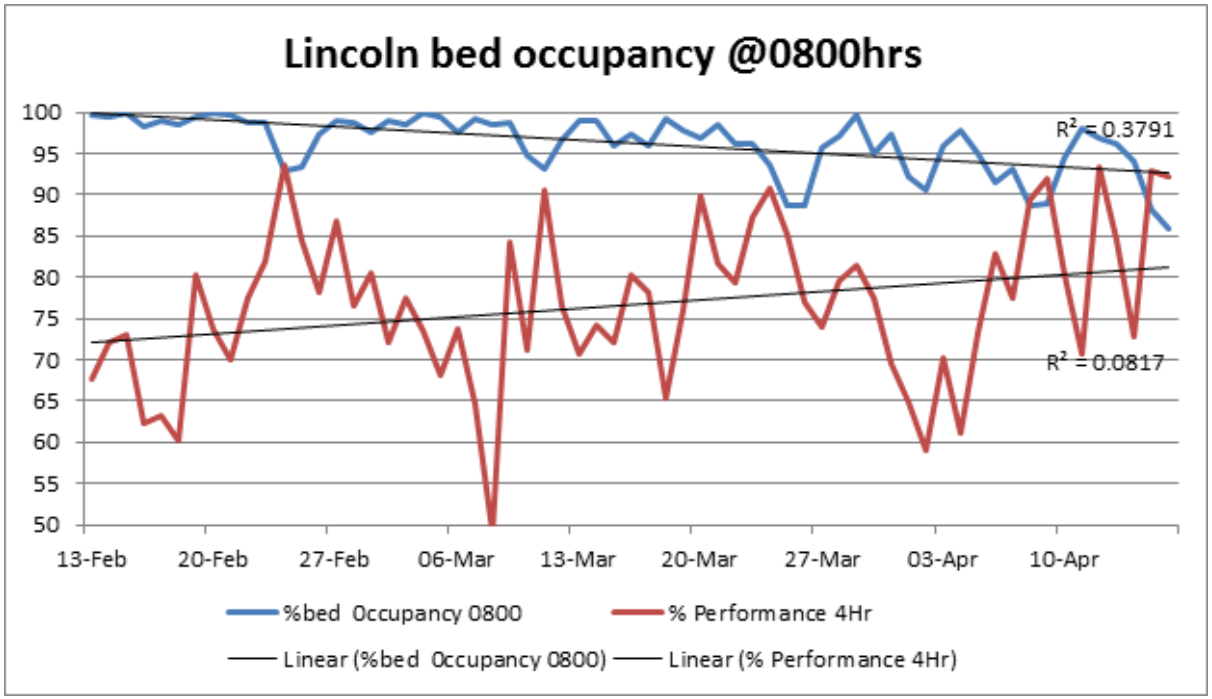
- 2pm: Update meeting to check all actions have been undertaken. Have the delays been unblocked, if not is there time to address these today.
- 4.30pm: Wash up meeting – what went well, what are the challenges, how can we improve, what do we want to share.

Highlights from the launch week at Lincoln included:

- On Friday 24 February, only 11 patients waited longer than four hours in A&E. Performance was at 93.61%
- On Friday and across the weekend we did not use the surgical admissions lounge for escalation beds. This meant that we did not cancel any patients waiting for an elective bed due to bed pressures for the first time since before Christmas
- On Saturday 25 February Lincoln had a positive number of beds of 76
- The number of medical patients not being cared for on a medical ward was down to 24
- Following the weekend we had 13 empty beds, with a further six ring fenced, which meant we didn't cancel any elective operations on Monday 27 February

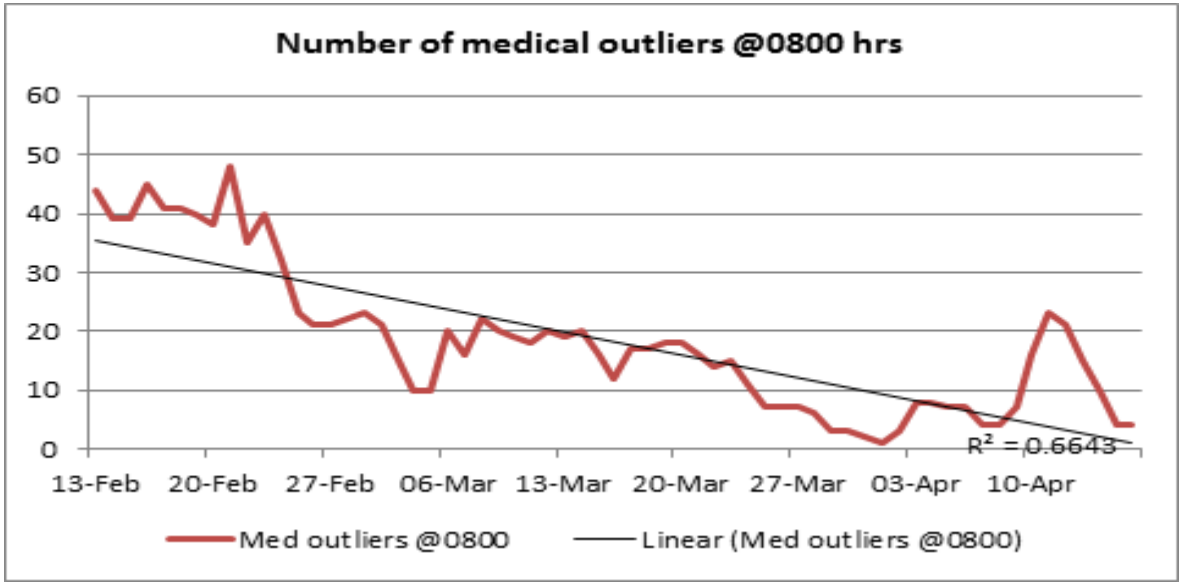
Since its introduction in February Red to Green has continued in a slightly revised format at Lincoln however it is encouraging to see that so far we are maintaining good patient flow through the hospital.

Graph 1: Graph below shows a reduction in bed occupancy and slight increase in the performance trend:



We have seen a reduction in bed occupancy and slight increase in the performance trend. There has also been a significant reduction in the number of medical outliers. These are patients who are placed on wards not best suited to their needs due to a lack of capacity (for example a medical patient on a surgical ward).

Graph 2: Graph below shows a reduction in the number of medical outliers:



We have seen a significant decrease in the number of elective cancellations due to bed capacity. This is mainly due to the fact we have not needed to open extra beds for some time.

Following the success at Lincoln, Red to Green has launched in April at Pilgrim Hospital. This has been embedded within the existing Pride and Joy approach which has been running at the hospital since last year. Pride and Joy is an electronic system to help manage patient flow and works well with the Red to Green approach. Grantham will also be rolling out Red to Green from the beginning of May.

7. Set out our plans for the future

2021 strategy
As well as a main focus on out of hospital care, the Lincolnshire STP also includes redesign of acute services.

ULHT has been developing our clinical strategy over the past two years, and many staff and the public have had the chance to shape what our services will look like. Our strategy helped shape Lincolnshire Health and Care (LHAC). The STP and 2021 strategy are the natural evolution of both our clinical strategy and LHAC.

To lead the transformation of our own services, we are developing our own five year plan called the 2021 strategy. This will be our bit of the STP.

Keeping all services as they are is not an option, since many services don't meet clinical guidelines and national standards, and we struggle to recruit.

We want to deliver services so patients are always cared for by highly skilled, compassionate staff. We all want to prevent emergency admissions to hospital. But those who need specialised, emergency treatment will get safe, high quality care at the best hospital, perhaps not always the nearest hospital. Those patients who do need our services will have shorter stays and be discharged home more quickly, to where they want to be.

These changes will lead to better health outcomes, quicker access to tests and treatments, fewer cancellations, fewer deaths and better services for the people of Lincolnshire.

We want our staff to be supported and have access to training and development, and technology to deliver great care, first time.

Our services will:

- Be centres of excellence
- Be secure in Lincolnshire where possible
- Get things right first time, valuing patient's time

Our patients will:

- Want to choose us for their care and be our advocates
- Shape how our services run

Our staff will:

- Be proud to work at ULHT
- Always strive for excellence and continuous learning and improvement
- Challenge convention and improve care

After engaging our staff, the public and patients, and our stakeholders, we will publish our 2021 strategy in the summer of 2017.

Seeking the views of the public and staff on our plans

ULHT is fully committed to engaging the public and our patients in shaping our decisions. We actively engage with our local communities and patient groups to ensure they have genuine input into the development of our hospitals and services.

We engaged around the future of ULHT services for most of 2016/17, and this continues into 2017/18.

In October 2016, Trust Board agreed a new strengthened approach to meaningful engagement. The paper is on our website here. The approach sets out 18 principles that cover our engagement such as engage people early on in our decision making processes; involve hard to reach groups; we will work with our partners to avoid duplication and overload for the public; and we will meet our equalities duties.

Our Board agreed that our engagement will be carried out for three purposes which in turn will be different stages (shown in diagram one). For example, the first purpose of engagement may be collecting evidence on change which includes looking at patient experience data such as FFT surveys and complaints, which will then prompt a service review, and once service changes have been implemented, impacts will be monitored via seeking views of patients.

We have an annual communications and engagement plan. As set out in ULHT's annual communications and engagement plan, two of six objectives are to:

- Embed communications and engagement as a key part of any service development, quality improvement, transformation and change programme.
- To ensure our engagement is inclusive, robust and provide meaningful data, so that Lincolnshire's diverse communities have opportunities to become involved with the Trust.

The plan can be found on our website here.

Membership
One of the regular ways we engage and inform the people of Lincolnshire, is via our members. ULHT has been a membership-based organisation since early 2012 and we currently have over 1,300 members. Of those, 90 have been through an in-house training programme to become patient representatives. Between them, our patient reps sit on 32 different boards and committees of the Trust.

Our patient reps also take part in numerous activities including sitting on 17 job interview panels in 2016 and taking part in visits inspections including PLACE inspections, pathway reviews and ad-hoc inspections.

All members are involved in surveys and consultations and are regularly sent information about what's going on within the Trust. Examples include a monthly members newsletter, consultation on the 2016/17 Annual Plan, our clinical strategy includes long-term options for urgent and emergency care, planned care, and women and children's services, and the draft STP for Lincolnshire. They are encouraged to feedback and respond, and regularly do. Our members views helped to shape our final annual plan for 2017/17 and shape medium list of options for the STP.

We have quarterly members meetings called locality forums, held at our four sites. These are a formal mechanism for the membership to feed into the decision-making of the organisation. Agenda covers strategic planning and service development, plus an action log and questions to the panel.

Locality forum meetings in Lincoln, Boston, Grantham and Louth took place in April, July and October 2016, with an additional central meeting held in March 2017.

Community engagement
In addition to working with our membership on developing and testing plans, we also seek to engage with the wider community of Lincolnshire.

During 2016, we have identified and contacted more than 90 groups to engage with across the county. These groups cover a wide range of locations, communities and also cover the nine protected characteristics. We have met with more than 45 different community groups across Lincolnshire to engage with them on a range of issues. A snapshot of the groups we've spoken to includes:

- Lincoln dementia café
- Carers First Sleaford (carers of people with mental health problems)
- Grantham social club for the blind
- Boston Little SNAPPS group (neonates group)
- Skegness Salvation Army coffee club
- International parents group

We sought people's views and input on a wide range of issues to inform our strategies and plans, and review our services. This includes developing the STP/2021 plan; understanding the impact the temporary overnight closure Grantham A&E was having on residents and understanding any potential impacts the closure of Laundon House in Sleaford. Feedback from the engagement around Grantham A&E has been reported back to the Trust Board as part of the A&E decision review papers.

In addition, we have carried out specific pieces of work engaging with the deaf community (five meetings during October and November 2016) and work on interpretation and translation.

A monthly report on what we've heard in engagement activities is shared with the Trust strategy lead, STP group, and clinical strategy lead, and service leads such as Head of Women and Children's services. We feed back to the public via our members' newsletter and Lincolnshire Wire our ULHT magazine.

A report on what we've heard in engagement activities relating to patient experiences is taken to Patient Experience Committee on a bi-monthly basis.

Methods

We use multiple methods of engagement, reflecting the differing issues we need to engage on, the level of involvement required and the group we need to target in each case. This includes:

- Surveys and gathering opinions from Trust membership
- Locality forums/ membership meetings
- Focus groups
- Public meetings
- Engagement at community meetings

- Engagement via social media
- Sending out information to groups
- Wider public surveys

We have visited more than 45 groups and sent information to a further six groups (they told us they just wanted information). Overall, we have engaged with more than 1,500 people in meetings and via surveys. These views will be taken into account before finalising our plans.

A performance analysis

Overview

In spite of our challenges, there have been many developments and improvements across the Trust this year.

We have kept our focus on infection control, pressure ulcers and falls. This has seen improved infection control practices – although we acknowledge there is still more that we can do.

The Trust's performance in its key national target areas of referral-to-treatment (RTT), cancer waiting times and A&E waiting times has been mixed this year.

The Trust entered 2016/17 achieving the national RTT incompletes standard, and maintained this position for the first three months of the year. However, a number of events and changes occurred in quarters one and two which contributed to a deterioration in the Trust performance against this standard.

Cancer performance has been mixed during 2016/17, and the Trust has not met the 62 day standard consistently throughout the year. Performance against the 2 week wait targets has been better.

The Trust didn't meet the A&E performance within year or at year end for 2016/17.

The Trust's performance in 2017/18 will be improved through the delivery of the integrated annual operational plan.

Table 2: Overview of key constitutional standards in 2015/16

Standard	Achieved	Narrative
A&E 4 hour wait	✗	The Trust continues to experience increased patient demand which contributed to challenges around emergency care and in particular our A&E performance target of 95%. We are currently 82.18% for quarter 1, which is above the required 82.01% for quarter 1 2017/18. We have problems with flow, limited resources – beds and staff - are a recognised issue for many trusts, and delayed transfers of care are creating a shortage of available beds, contributing to difficulties with meeting the A&E target.
Planned care and referral to treatment (RTT)	✗	We met the RTT standard of 92% for the first three months of the year consecutive months. However, we didn't meet the annual target.
Cancer pathways	✗	The Trust achieved improved cancer performance in some areas. We have had some success meeting the two week wait standard in 10 out of 11 tumour sites. In all areas of 62 day standard, demand and patient choice continues to cause challenges to diagnose all patients within appropriate timescales.
Cancelled ops	✗	Our cancelled operations performance was 2.36%, above the national target of 0.80%. Due to increase in number of emergency admissions and a lesser extend due to the junior doctors' strikes.
Infection control	✓	We had one case of MRSA and met our C Diff target of 12 against 59.
Diagnostics	✓	We continued to do well against our diagnostics standards.

A performance summary

The Trust continued its improvement journey in 2016/17, making progress in planned care delivery against core constitutional standards. The Trust has delivered the RTT 92% incomplete standard and maintained this position for the first three months of the year. However, a number of events and changes occurred in quarters one and two which contributed to a deterioration in the Trust performance against this standard.

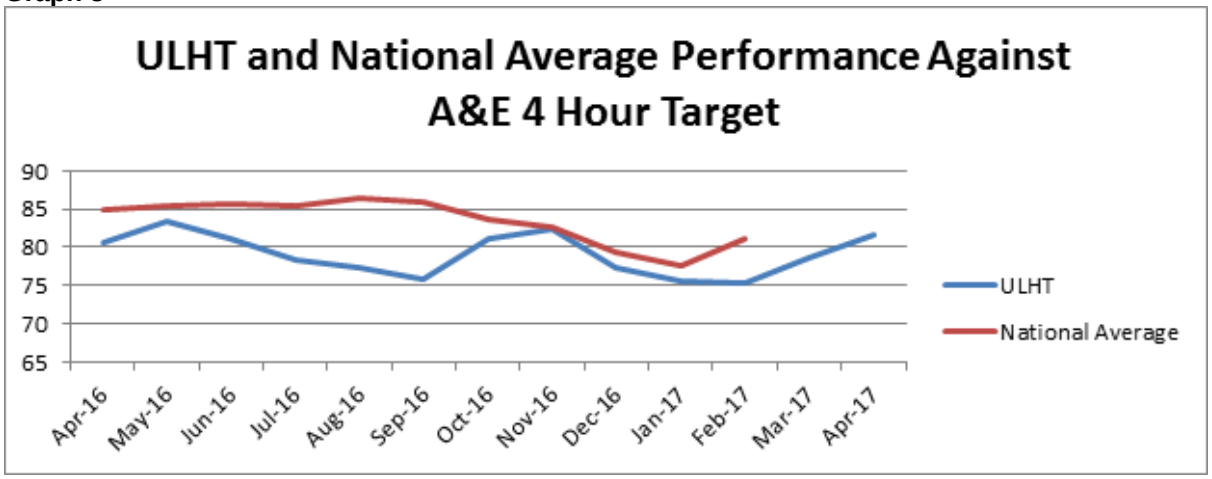
The Trust has also seen improvements in its cancer performance. Challenges do remain as we move into 2017/18, with a strong improvement focus on A&E and 62 day cancer standards. These areas are underpinned by system-wide action plans in collaboration with our health and social care partners. With activity levels increasing, improved efficiency and increased productivity are key. Making the best use of limited resources will be used to help to deliver performance against the required standards going into 2017/18.

Performance against national targets – a responsive organisation

A&E performance

The Trust remains challenged on delivery of urgent care. Our performance against the 4 hour target – a key indicator which states 95% of patients should be seen, treated, admitted or discharged within 4 hours of arrival – has fluctuated but remained well below the 95% target. This winter has seen immense pressure across the whole NHS trusts with the national average for the 4 hour target also falling:

Graph 3



In August 2016 staffing within the A&E departments became critical and the Trust Board were left with the difficult decision to temporarily close the A&E department at Grantham and District Hospital overnight. This allowed us to free up staff to support the other departments but did result in a fall in performance.

Whilst the temporary reduction in hours at Grantham has helped we are still facing a high reliance on locum staffing within our A&E departments and shifts remain hard to fill, especially over bank holiday periods when locum staff do not come forward.

Recent changes in tax regulations have reduced take home pay of locum staff which has also led to a further reduction in fill rates. These staffing challenges are not restricted to ULHT alone. We have seen gaps in staffing in our community services which reduce demand on our A&Es and also a national picture of shortages.

We therefore need to think differently about how our departments are staffed and in recent weeks we have benefitted from the support of other clinicians such as orthopaedic surgeons helping in the departments as well as support from our highly skilled advanced nurse practitioners.

These challenges are also set against a backdrop of key challenges for the departments. Our staffing and facilities, particularly at Lincoln and Boston were designed at a point in time when demand was much less. We are now seeing more patients attended the A&E departments but staffing levels have not increased sufficiently to keep up. We also struggle with the available space in the departments to see all of the patients coming through.

When the hospitals are full patients who need admitting often wait too long in the A&E department for a bed to come available. This further block up the A&E department resulting in delays for all patients.

As well as working on different staffing models to address the lack of A&E doctors we will also be uplifting our staffing numbers and working on redesigning the departments. This will be in line with a national mandate to have GPs at the front door of all A&Es to “stream” away patients who do not need to be in A&E but can be seen in primary care.

We have also undertaken a lot of work on reducing bed blocking in the wider hospital with initiatives such as Red to Green (a mind-set to reduce in patient delays) and implementing the SAFER patient flow bundle improving the number of available beds for patients waiting for them in the A&E department.

At Lincoln we moved our Ambulatory Emergency Care department from the A&E department to a bespoke new area closer to the admissions wards. This unit will see patients referred from A&E and from GPs who would otherwise have been admitted and provides treatment that can prevent people from having to stay in hospital. The space this left vacant in the A&E department is being put to use as an ambulance handover bay to speed up the release of ambulance crews. We are also undertaking building works to increase the number of cubicles in the department so that we can see more patients.

There will be a focus over the coming months on improving our urgent care performance – an area recognised nationally as vital to the care a hospital provides.

Referral to treatment (RTT)
The Trust entered 2016/17 achieving the national RTT incompletes standard, and maintained this position for the first three months of the year. However, a number of events and changes occurred in quarters one and two which contributed to a deterioration in the Trust performance against this standard.

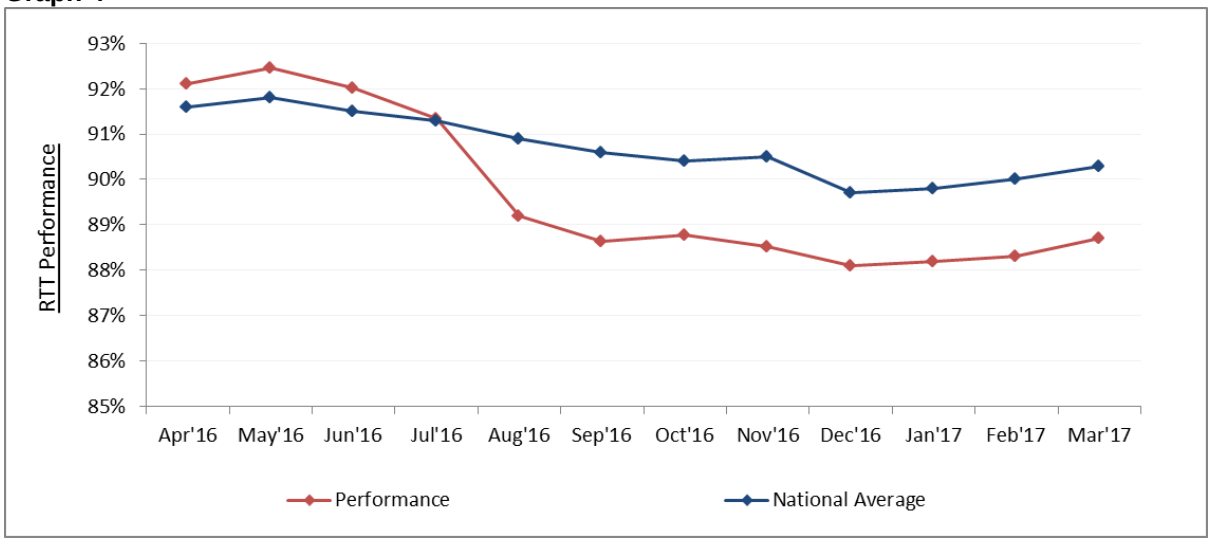
There were three significant factors which had an impact on performance across a range of specialities:

- Junior doctor industrial action – During the two periods of industrial action in April alone there were 1335 outpatient appointments cancelled as a direct consequence of the Trust needing to maintain patient safety during this action. In addition there was a significant reduction in surgical activity during these periods. The impact from the industrial action in April 2016 was the most significant, however additionally the were separate days of industrial action during quarters 3 and 4 of 2015/16 which had already begun to have an impact on the incomplete backlog.
- Grantham Fire – As a result of the fire which occurred at Grantham in April there were c.300 outpatient cancellations and 25 elective cancellations.
- Partial booking waiting list – The number of patients overdue over 6 weeks past their target date reduced by c.1800 patients between the end of June and the end of September. This reduction in the size of the partial booking waiting list reduced the capacity available to treat patients on incomplete pathways during that time.

In addition to these Trust-wide issues there were issues at speciality level which led to greater decline in certain specialities. For instance, consultant vacancies which occurred during April 2016, which were not able to be filled, contributed to significant deterioration in gastro and cardiology performance.

The chart below shows the Trust's incompletes performance during 2016/17 compared with that of the country as a whole.

Graph 4

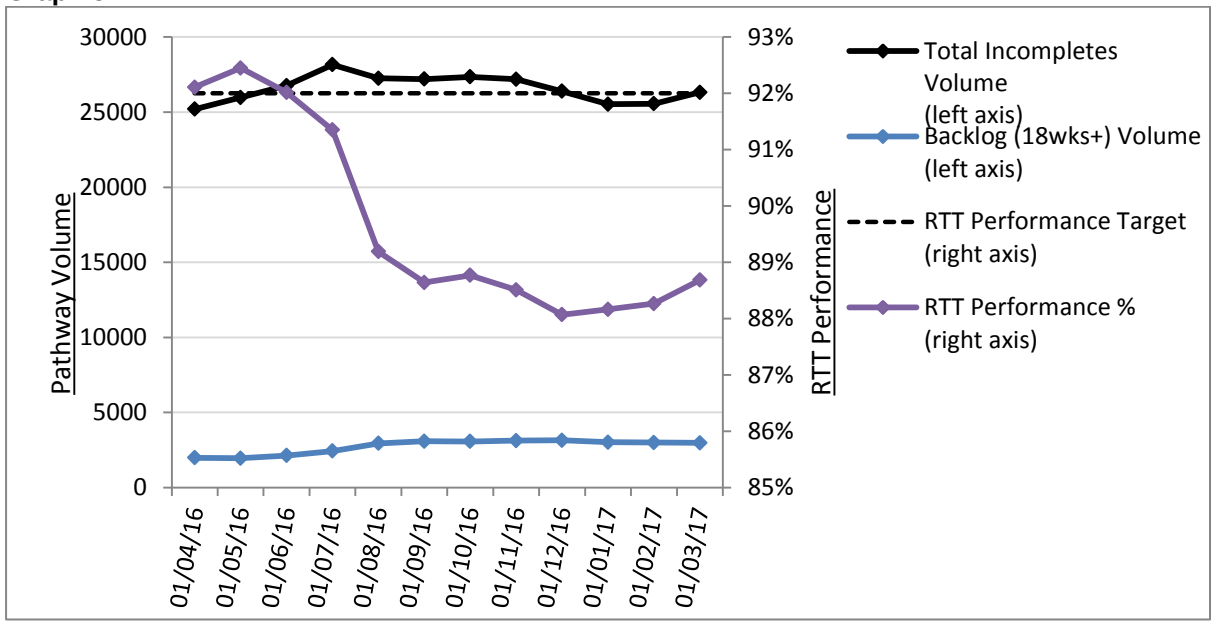


During 2016/17 there were a number of speciality areas where activity was significantly above the contracted activity plan for the year. Neurology was 27% above the contracted activity plan, dermatology was 16%, endocrine was 22%, gastro was 15%, rheumatology was 16% and pain was 11%. All of these areas have RTT incompletes performance below 92%.

The increase in urgent care pressures during winter have a knock on impact onto RTT performance. In December and January, as part of the winter plan and to assist with the achievement of 85% bed occupancy by Christmas Eve and maintenance of urgent care flow, the Trust planned to complete a total of 130 less elective cases than standard (plus the impact of bank holidays).

In addition to this planned reduction, the Trust cancelled over 650 operations during between December and March as a result of capacity issues such as lack of HDU and general beds. The Trust's backlog of incomplete patients over 18 weeks has declined in recent months, in February falling below 3,000 for the first time since August 2016.

Graph 5



The graph above shows the Trust's RTT performance for combined admitted and non-admitted pathways monthly for 2016/17.

The table overleaf shows the Trust's RTT incompletes performance in March at a speciality level, highlighting the 24 specialities which failed to achieve the 92% incompletes target during this month. Each of these areas have speciality level recovery action plans which are in place in order to drive actions which will return speciality level performance back to above 92%.

Specialty Name	Within 18 Weeks	Not Within 18	Total	Within 18 Weeks %
General Surgery	1564	250	1814	86.22%
Urology	1320	104	1424	92.70%
Breast Surgery	155	8	163	95.09%
Colorectal Surgery	451	47	498	90.56%
Vascular Surgery	295	71	366	80.60%
Trauma & Orthopaedics	2058	353	2411	85.36%
ENT	2639	452	3091	85.38%
Ophthalmology	2782	99	2881	96.56%
Orthodontics	267	17	284	94.01%
Maxillo-Facial Surgery	1136	128	1264	89.87%
Cardiothoracic Surgery	3	1	4	75.00%
Paediatric Surgery	25	7	32	78.13%
Pain Management	712	84	796	89.45%
Paediatric Urology	26	5	31	83.87%
Paediatric Trauma & Orthopaedics	101	25	126	80.16%
PAEDIATRIC ENDOCRINOLOGY	1	0	1	100.00%
PAEDIATRIC DERMATOLOGY	119	89	208	57.21%
PAEDIATRIC NEPHROLOGY	3	1	4	75.00%
COMMUNITY PAEDIATRICS	594	13	607	97.86%
General Medicine	43	3	46	93.48%
Gastroenterology	1200	150	1350	88.89%
Endocrinology	343	56	399	85.96%
Haematology (Clinical)	361	11	372	97.04%
Diabetic Medicine	89	22	111	80.18%
Rehabilitation	49	3	52	94.23%
Cardiology	1176	297	1473	79.84%
PAEDIATRIC CARDIOLOGY	9	0	9	100.00%
Transient Ischaemic Attack	52	1	53	98.11%
Dermatology	1465	182	1647	88.95%
Chest	507	154	661	76.70%
Respiratory Physiology	159	4	163	97.55%
Nephrology	140	20	160	87.50%
Medical Oncology	20	1	21	95.24%
Medical Physics	1	0	1	100.00%
Neurology	385	179	564	68.26%
Rheumatology	496	92	588	84.35%
Paediatrics	396	7	403	98.26%
Geriatric Medicine	173	8	181	95.58%
Gynaecology	1155	51	1206	95.77%
Clinical Oncology	88	3	91	96.70%
Interventional Radiology	4	1	5	80.00%
Diagnostic Imaging	1	0	1	100.00%
Total	**22563**	**2999**	**25562**	88.27%

Table 3

Progress against these plans is monitored within the clinical directorates, and then reviewed for assurance at the fortnightly RTT Improvement and delivery group meeting. These actions include provision of additional clinics and theatre sessions, increasing theatre productivity, outsourcing of referrals to the independent sector, pathway optimisation reviews, working with the CCGs to reduce referrals where appropriate and equalising waits across the sites.

Risks to RTT recovery include:

- Continued high levels of cancelled operations
- Restricted day case capacity at Pilgrim following the fire
- Clinical workforce gaps
- Restrictions in management capacity for planned care improvements due to urgent care pressures and management gaps
- Impact of IR35 on fill-rates within temporary medical cover
- Impact of cyber-attack.

Open referrals

Referrals received by the Trust which are waiting for a new appointment go onto an open referrals waiting list. The time between referral and first assessment is a key indicator when monitoring RTT performance.

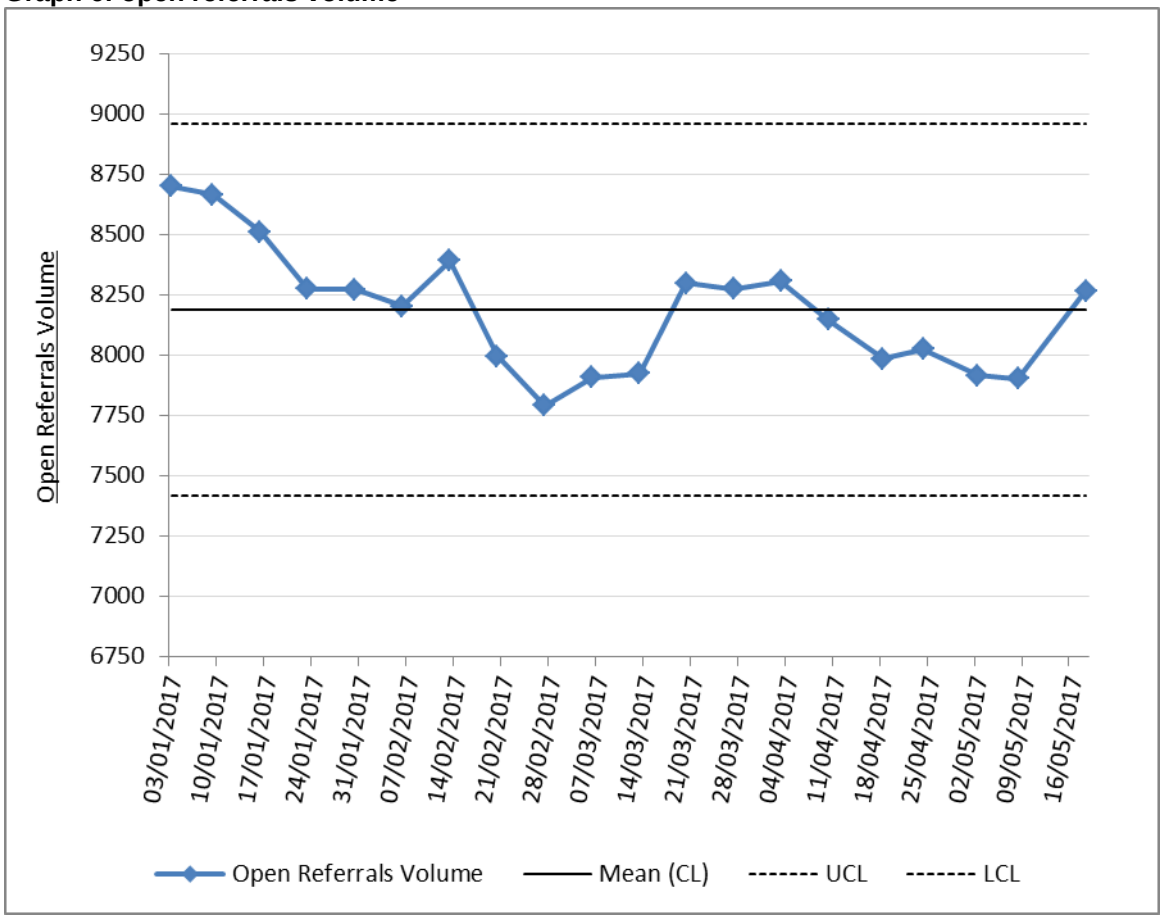
The table below gives the total open referrals waiting list for the Trust, sub-divided by speciality, as at May 18 2017. The figures have not been validated, and do not include patients who have cancelled or did not attend their first appointment and have not yet been re-appointed, however these figures overall give a good indication of which specialities have long waiting times for first appointments. Waiting times for first appointments will vary within a speciality by site, but the clinical directorate teams are working together to attempt to reduce variation between sites where possible.

Count of DIM_REFERRAL_ID	Wait Time as at 18/04/2017										
Referred To Specialty	0<4wks	4<8wks	8<12wks	12<16wks	16<20wks	20<24wks	24<28wks	28<32wks	32<36wks	36<40wks	Grand Total
100: General Surgery	83	72	41	7	7						210
101: Urology	59	89	52	23	17						240
103: Breast Surgery	104	5	5	8	1	6	1		1		131
104: Colorectal Surgery	4	2						1			7
105: Hepatobilary-Panc Surg	1										1
107: Vascular Surgery	31	20	20	6							77
110: Orthopaedic	138	127	109	86	35	11	3	2	1	1	513
120: Ear Nose & Throat	260	203	176	103	128	34	11	7			922
130: Ophthalmology	247	70	26	22	4						369
130: Orthoptist	12		1								13
140: Community Dental	1			1							2
143: Orthodontics	61	43									104
144: Maxillo Facial Surgery	179	67	14								260
171: Paediatric Surgery	2	6	3	2	3	5					21
180: Accident & Emergency						1					1
190: Anaesthetics	6	3	2								11
190: Pre-Anaes (Nurse)		1				1					2
191: Pain Management	40	69	60	30	15						214
211: Paediatric Urology	2	6	4		2						14
214: Paediatric Trauma & Orthopaedics	3	9	10	9	4	6	5	5			51
254: Paediatric Audiological Medicine				1							1
257: Paediatric Dermatology	11	22	21	24	17	18	19	19	6	3	160
290: Community Paediatrics	117	165	143	92	96	1					614
300: General Medicine		1		1							2
301: Gastroenterology	93	118	92	79	70	7	4				463
302: Endocrinology	65	50	53	21	16	9	5	6	5		230
303: Haematology (Clinical)	23	16	4	12	4	1					60
307: Diabetic Medicine	12	11	2	1			1				27
314: Rehabilitation	3	3		1	1	1					9
320: Cardiology	116	147	101	68	88	99	67	4	2		692
321: Paediatric Cardiology	1			4							5
329: Trans Ischaemic Attack	1										1
330: Dermatology	196	257	287	174	100	38	42				1094
340: Chest	38	40	44	27	38	56	49	32	31	12	367
341: Respiratory Physiology		1									1
361: Nephrology	25	19	8	3							55
400: Neurology	35	31	23	10	4	18	18	7	3		149
401: Clinical Neuro-Physiology	214	4									218
410: Rheumatology	55	121	78	81	45	2					382
420: BCG	1	4	1	12			5	6			29
420: Paediatrics	79	18	4	1							102
430: Care of the Elderly	11	9	3				1	1			25
501: Obstetrics(Ante-Natal)							1		1		2
502: Gynaecology	66	54	8	1	1	1					131
800: Clinical Oncology	1				1						2
950: Nursing Episode							1				1
Grand Total	**2396**	**1883**	**1395**	**910**	**697**	**315**	**233**	**90**	**50**	**16**	**7985**

Table 4: Open referrals waiting list which shows that as of April 18 2017 there were 7,985 patients on the open referrals waiting list.

As a comparison, on January 4 2016 this figure was 5,875 patients, by May 3 2016 it had increased to 7,215 patients, and by December 27 2016 it had increased further to 9,064 patients.

Graph 6: open referrals volume



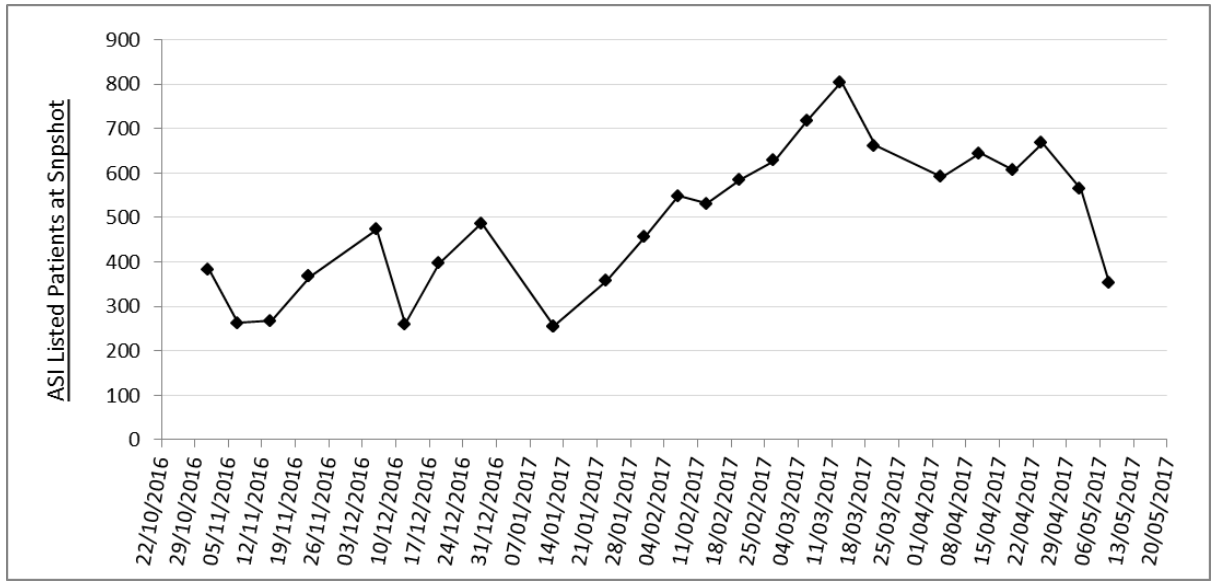
The graph above shows that the number of open referrals had been slowly reducing since the end of March, until the figures from May 19. The significant increase in this most recent data point is a direct result of the international cyber-attack, with a loss of outpatient capacity through cancellations and a pause in the booking of further new appointments due to lack of access to IT systems.

A key component of the speciality RTT action plans is to reduce the backlog of new patients waiting for appointments, with the effect being a reduction of the open referrals waiting list.

Appointment Slot Issue (*ASI*) work *list*

When GPs refer patients into the Trust via the electronic referrals system, but are unable to book a specific appointment slot due to limitations in capacity, the patient is added to the Trust's ASI list. The patient waits on this ASI list until either their details are drawn down from the system and they are added to the open referrals list or they are booked into a new appointment.

Graph 7: The graph below shows the number of patients on the Trust's ASI list at weekly intervals over the last six months.



The last two weeks show an improving picture as the number of ASIs have reduced, due to increased choice and access capacity being dedicated to drawing these referrals down. There has been a delay in the production of the most recent data set for ASI figures, due to the effect of the cyber-attack, and it is anticipated that ASIs will have increased following the cyber-attack.

Table 5: The table below shows the distribution of patients within the ASI list by speciality and duration.

1. Weekly ASI Report (as at 08/05/2017)

Data Source: C&A Weekly Report: 'ASI 080517.xls'

SITE (All

Count of UBRN Nat	Two Week Wait	100 - General Surgery	103 - Breast Surgery	110 - Trauma & Orthopaedics	120 - ENT	130 - Ophthalmology	144 - Maxillo-Facial Surgery	171 - Paediatric Surgery	191 - Pain Management	215 - Paediatric Ear Nose and Throat	301 - Gastroenterology	302 - Endocrinology	303 - Haematology (Clinical)	320 - Cardiology	330 - Dermatology	340 - Respiratory Medicine	361 - Nephrology	410 - Rheumatology	420 - Paediatrics	421 - Paediatric Neurology	430 - Geriatric Medicine	502 - Gynaecology	307 - Diabetic Medicine	400 - Neurology	Grand Total
Weeks Waiti																									
00-01w	7	1	2		10	6	1	1	5	2	13	9	8	7	54	7	6	19	2	1	2	4	2	3	172
01-02w					10		1			1	16	7	1	10	28	3		10			1	8	1	1	98
02-03w				1					1	1	11	6		2	26				1			7	2	1	59
03-04w											1		1		4		1	2				1			10
04-05w										1	1	1		1	5		1					1			11
05-06w									1						1							1			3
Grand Total	7	1	2	1	20	6	2	1	7	5	42	23	10	20	118	10	8	31	3	1	3	22	5	5	353

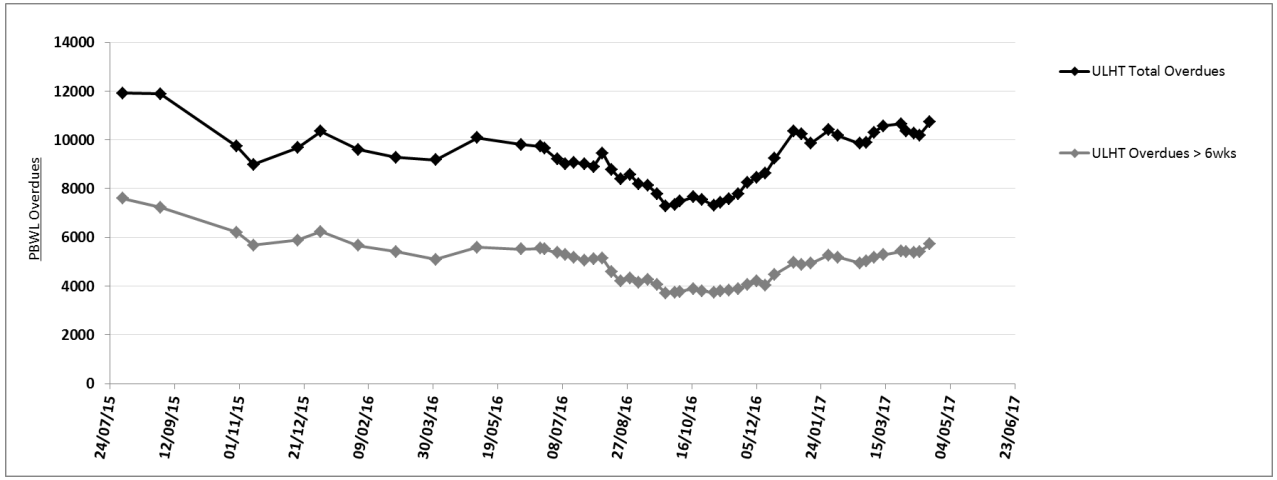
The longest waiters on the ASI list has reduced significantly, with 5-6 weeks being the longest waiting ASI as of May 8. However this needs to reduce further to achieve the national standard of 48 hours.

Identification of appropriate capacity within the speciality action plans will be key to improving the ASI position. Additionally, the choice and access team are developing a plan to deliver the electronic referrals CQUIN in 2017/18, which will enhance the processes currently in place to manage this position, and is intended to reduce the number of ASI's as a result.

Partial booking waiting list

The Trust has a backlog of patients which are overdue for a follow-up appointment by six weeks or more. This backlog reduced between the summer of 2015 and October 2016, down to 3,721 patients. However, during the latter part of quarter 3 and during quarter 4 this backlog has increased again, reaching 5,725 patients over six week overdue as on April 18 2017.

During the three weeks following April 18 the number of patients which are overdue for a follow-up appointment by six weeks or more reduced from 5,725 to 5,337. However, the impact of the lost capacity and reduced booking activity during the cyber-attack has led to an increase in this position back up to 5,673 as at May 18.



The split by speciality of the patients overdue by over six weeks or more, with four specialities (ENT, neurology, rheumatology, endocrine) accounting for over 50% of the patients and nine specialities (in addition to the previous four add – respiratory, ophthalmology, cardiology, trauma and orthopaedics, community paediatrics) accounting for 86% of the overdue patients.

All of these areas have action plans to recover their speciality PBWL position including:

- Additional outpatient clinic sessions
- Virtual clinics
- Utilising locum consultants to increase capacity
- Reviewing vacant slot processes
- Reviewing pathways to ensure standardisation of discharge point across the service
- Suspension of service to routine referrals (Neurology)

Patients missing from the partial booking waiting list (PBWL)

A full Trust-wide standardised approach to all PBWL processes has been adopted since the end of June 2015. This process included:

- Full standard operating procedures (SOP)
- The ability for clinicians to identify “time critical” patients at their outpatient appointment

- A booking bible – step by step guide to technical application of booking for booking teams
- A full training plan for all those necessary from doctors to administrative staff
- Flow charts for relevant staff (also formed part of training plan)

However, despite this approach the Trust is aware that a small proportion of patients who require a follow-up appointment are not added to the PBWL. There is a report available from Medway which identifies patients that may potentially be missing from the PBWL in error, however this report isn't sufficiently specific to enable the output to be utilised directly in order to address this matter. Instead the data produced needs to be manually validated in order to confirm whether the patient is incorrectly missing from the PBWL.

Due to the timeline of progress relating to this matter, patients have been divided into different cohorts depending upon when their last appointment took place, and the approach to reviewing the potential patients missing from the PBWL for these different cohorts differs as outlined below.

- Cohort 2 – September 2016 – February 2017. 31,433 patients
  The choice and access team will be writing to patients and asking them to phone the Trust in order to confirm whether they are expecting a further follow up following on from their last appointment. Therefore £45,300 was committed. There is an expectation that this would be completed within a 5 month timescale.

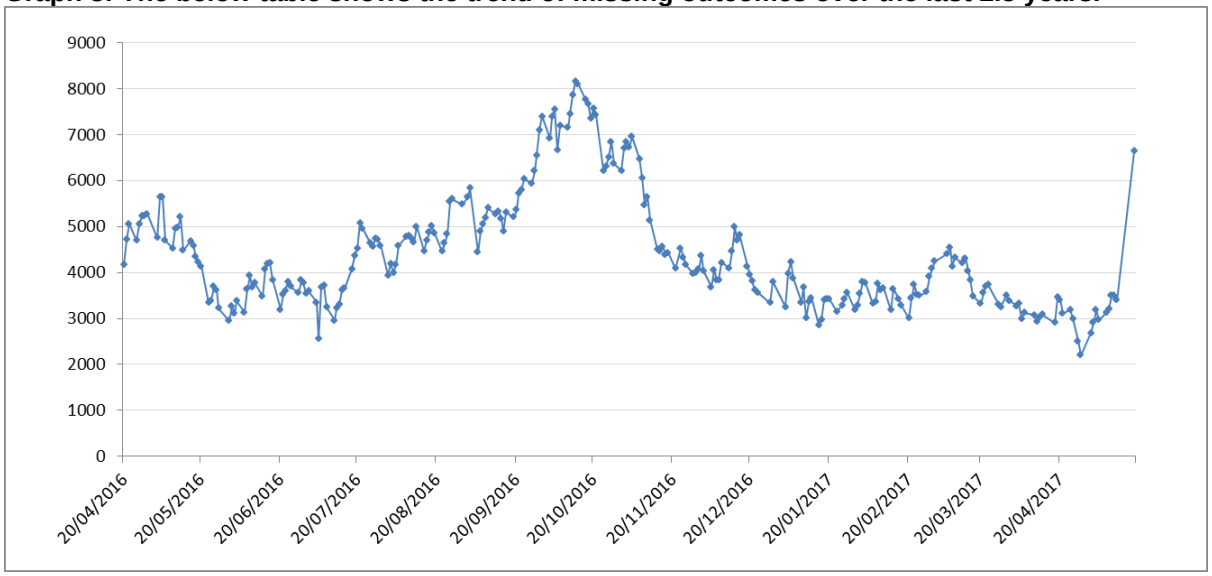
Prevention from March 2017 onwards
Additional non-recurrent resources have been made available to the choice and access team in order to provide sufficient capacity to review and correct patients identified within weekly reports, and to enable leads to provide related training to prevent the continued occurrence of these issues. It is expected that this non-recurrent funding will only be required for up to eight months.

This has commenced, but not at the level required to fully address the issue. Additional non-recurrent resources have been made available to the choice and access team in order to provide sufficient capacity to review and correct patients identified within weekly reports, and to enable leads to provide related training to prevent the continued occurrence of these issues. Approval has now been given to access these funds, and therefore it is expected that additional staff will join the Trust in from the week commencing May 22.

Missing Outcomes

The majority of outcomes are entered onto Medway within one day of an outpatient appointment taking place. When clinic outcomes are not entered onto Medway on the day of the outpatient appointment the outcome is highlighted as a 'missing outcome', indicating a delay in the outcome being added to the system. A report is produced each day which identifies all historic missing outcomes at that point in time.

Graph 8: The below table shows the trend of missing outcomes over the last 2.5 years.



During the summer of 2016 a project was completed to move all choice and access areas onto an electronic outcomes system. Following a bedding period this change resulted in a significant improvement in missing outcomes within this area.

The last phase of the electronic outcomes project is to roll-out e-outcomes within all non-choice and access areas, which will be completed by May 2017. It is anticipated that this will result in further reductions in the daily missing outcomes position.

Missing outcomes will be managed as a work stream within the outpatient improvement programme plan.

Although total missing outcomes have remained fairly stable in recent months, the volume of missing outcomes over three months old has reduced significantly, from 244 outcomes on April 4 to 71 on May 18. However, the most significant change is the spike in total missing outcomes in the most recent week, which is again a direct impact of the cyber-attack resulting in a period where outcomes could not be entered onto Medway and choice and access staff demands in terms of rebooking clinics.

Recovery Plans
The executive team have written to all clinical directorates requesting confirmation of the speciality level plans that they have developed in order to address the issues within planned care identified within this paper. Letter attached below.


Planned Care letter to Clinical directorate:

A key action which is currently being explored is a request to the Lincolnshire CCGs to agree to a temporary pause in routine referrals for between three-six months into three services – dermatology, cardiology, ENT. It is considered that such a pause in routine referrals would give these services the opportunity to reduce their backlog of new and follow-up patients whilst working on more sustainable service models. A request has been made to the CCGs to extend the pause in routine referrals into the neurology service until the end of August.

Cancer performance
During 2016/17 the majority of tumour sites improved the reliability of the provision of first outpatient appointments within two weeks of referral, with the exception of the breast tumour site. At Trust level the two week wait standard was achieved for the four consecutive months between September and December 2016. The Trust then failed the standard during the following three months, however if the breast tumour site were to be excluded from these figures then the Trust would have achieved the two week wait standard in February and March 2017, as 10 out of the 11 other tumour sites achieved the standard in both February and March.

During 2016/17 the breast service went through two periods where performance deteriorated significantly. During July and August 2016, and then separately February and March 2017 (and into April 2017), the service was unable to maintain a new patient polling range below 14 days and therefore performance deteriorated and took a prolonged period to recover.

The service is extremely vulnerable due to the size and vacancies within the workforce – both surgical and radiological – and currently receives a greater number of referrals per week than it has core capacity to assess. Therefore the service provides additional clinics at weekends in order to manage the demand, however when demand increases significantly or workforce restrictions occur then the services struggles to maintain performance levels.

During quarter 1 of 2016/17 the Trust only achieved one out of the four 31 day standards. However, reliability of 31-day performance improved during the year, with three of the four standards met in quarters 2 and 4, and all 31-day standards met during quarter 3. 31-day first treatment, 31-day subsequent drug and 31-day subsequent surgery all achieved the standards when measured on a quarterly basis during quarters 2, 3 and 4.

Although 31-day subsequent radiotherapy only achieved the standard for half of the months during 2016/17, performance is much more reliable than during the previous 2 years, and with the LINAC replacement programme now complete it is anticipated that this improvement will continue.

The Trust achieved the 62-day screening standard during five out of the 12 months in 2016/17, ending the year with a cumulative performance of 86.8% against the 90% standard. There was a similar performance level against the upgrade standard, achieving for 6 out of 12 months, with a cumulative performance of 82.5% against the 85% standard.

The most challenging standard has been the 62-day classic. The Trust has not achieved this standard during 2016/17, with monthly performance ranging from 67.1% to 75.6%, with an average for the year of 71.6% (compared with 74.9% in 15/16), against a standard of 85%, which places ULHT in the bottom quartile of NHS Trusts relating to this measure.
The below table gives a summary of cancer performance by month and standard for 2016/17:

Month	14 Day	2ww Symptomatic Breast	31 Day 1st Treatments	31 Day Subsequent treatment Drug	31 Day Subsequent treatment Surgery	31 Day Subsequent treatment Radiotherapy	62 Day	62 Day Screening	62 Day Consultant Upgrade
Apr-16	87.8%	94.6%	95.8%	84.6%	80.4%	84.0%	74.7%	80.6%	85.0%
May-16	92.6%	96.6%	95.0%	97.7%	90.9%	94.0%	70.0%	86.2%	87.8%
Jun-16	92.1%	93.0%	98.7%	100.0%	95.0%	92.8%	68.9%	96.2%	73.9%
Jul-16	82.7%	24.8%	97.6%	98.0%	95.8%	89.9%	75.6%	90.9%	73.5%
Aug-16	81.1%	26.3%	96.6%	98.8%	97.8%	84.6%	74.0%	78.9%	90.0%
Sep-16	94.6%	88.8%	98.0%	98.4%	91.2%	94.3%	71.9%	92.9%	90.5%
Oct-16	95.3%	94.3%	96.2%	98.8%	91.2%	97.9%	69.3%	79.2%	87.5%
Nov-16	94.1%	82.4%	97.4%	98.9%	100.0%	98.9%	67.8%	89.7%	75.9%
Dec-16	93.4%	88.1%	98.4%	96.4%	97.1%	97.3%	71.9%	96.9%	82.6%
Jan-17	90.1%	74.3%	94.1%	99.0%	100.0%	89.4%	74.4%	67.9%	85.7%
Feb-17	89.5%	56.8%	94.3%	100.0%	95.8%	95.1%	67.1%	94.1%	75.0%
Mar-17	82.1%	18.9%	96.3%	100.0%	91.3%	93.4%	72.6%	87.5%	80.4%

Sustainability

ULHT has sustainability, energy efficiency and carbon reduction at the heart of its management policy. In practice this leads us to focus on the following:

- By reducing energy consumption and our carbon footprint, we also save money, enhance and protect our reputation and help everyone in the fight against climate change
- ULHT continues to implement no cost and low cost solutions to reduce energy consumption
- Engaging with third party providers who are prepared to commit capital expenditure, to deliver energy solutions and guaranteed savings
- Ensuring that policies and practices in all aspects of the Trust's work reflect this commitment.

ULHT is committed to reduce its CO_2 emissions at least in line with NHS guidelines. Between 2009 and 2015 ULHT reduced its carbon footprint by 13% against the national target of 10%. The Trust is further committed to reduce its CO_2 emissions by 28% by 2021.

By investing in its infrastructure, increasing staff awareness, and by encouraging and embedding sustainable behaviours into the organisation, the Trust seeks to continue to be among leading NHS Trusts for its environmental and sustainability track record.

On October 4 2016 the Trust Board approved its sustainable development management plan (SDMP). This is a policy document outlining the Trust's commitment to ensuring that sustainable development becomes central to the way we do things in every aspect of the organisation.

It addresses our activities and progress in reducing waste and our carbon footprint and celebrates increased efficiencies, financial savings and reductions in waste and CO_{2e} emissions.

To demonstrate its commitment and enhance its reputation, during 2017 the Trust is working towards achieving a leading sustainability accreditation "Investors in the Environment". The certification manages and measures the hospital's environmental performance, but under the criteria, there is also a requirement to review and work towards its greater impacts – namely health and wellbeing of both patients and staff.

The SDMP contains an action plan to deliver a number of projects and activities which the Trust has identified as priority next steps and outlines our approach to partnership working with others in the health and care community together with other public and private sector partnerships.

The Trust is striving to achieve reductions in energy consumption of 10% - 15% through various capex initiatives, including an overarching "Energy Performance Contract" (EPC). Investing in the installation of energy efficient technologies and optimisation of all systems.

Contract negotiations and Trust approval should be complete later this year with construction works beginning in early 2018.

Extreme weather events are becoming more commonplace which climate scientists have been predicting for a number of years and it is likely that the frequency of such events will continue to increase. It is therefore important as a Trust that we examine the potential risks and ensure that we adapt our buildings, systems and processes to cope with the possible impacts of increased flooding, heat waves and storm damage.

Adaptation planning is an opportunity to ensure a cohesive approach to current and future planning. The process of developing these plans should integrate with the development and refinement of emergency preparedness and business continuity plans. Adaptation, in harmony with NHS national guidelines, forms an integral component of the Trusts Sustainable Development Management Plan (SDMP).

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.

For the 12 months ending December 2016, the Trust sickness absence rate was 4.67%, a slight increase from 4.57% during the 12 months ending December 2015. These figures compare to the Trust target sickness rate of 4% for 2016/17.

Overall performance shows a general trend of improvement over the last four years with the rate reducing from 5.12% in 2012/13. Further improvement will be a key focus for the Trust.

ESR (Electronic Staff Record) is able to provide statistical information on the basis of Fte days lost divided by Fte days available during the same period. Two sets of figures are provided on a monthly basis (monthly sickness rate and rolling 12 months) and within the Trust sickness absence is always reported one month in 'arrears' to allow for any late reporting.

The figures below show the average number of Fte days lost per employee during the year and were produced by NHS Digital. These figures have been verified by the Trust.

Staff Sickness Absence	Total Number	Total Prior Year Number
Total Days Lost	**67,643**	**66,534**
Total Staff Years	**6,302**	**6,260**
Average working Days Lost	10.73	10.63

Source: NHS Digital – Sickness Absence Publication – based on data from the ESR Data Warehouse.

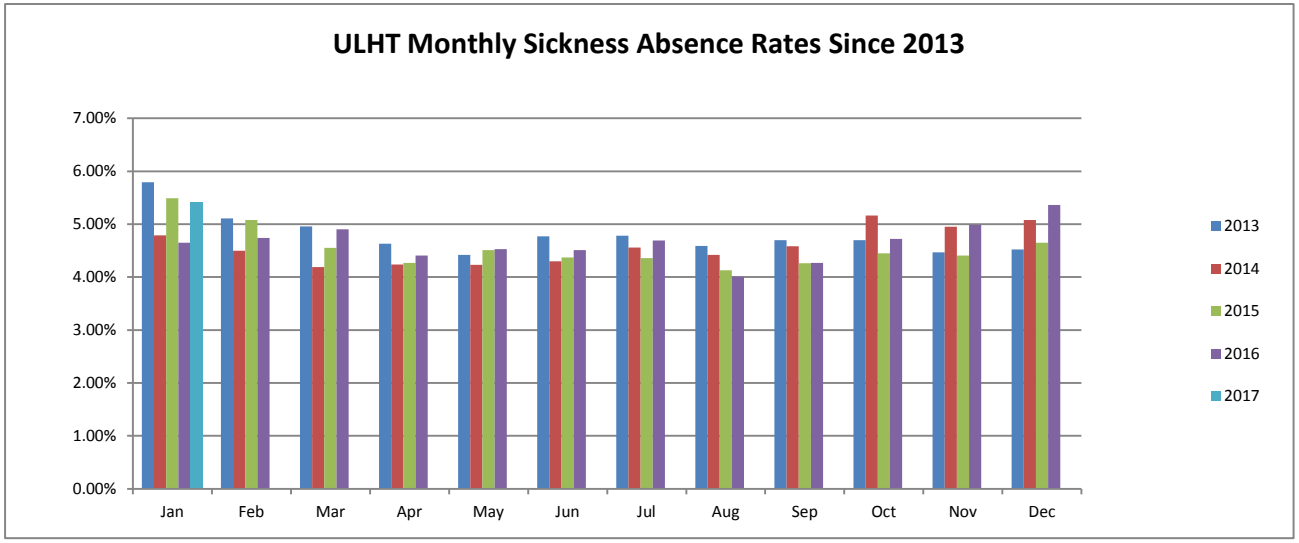
- Period covered: January to December 2016
- ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year.
- Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

Overall performance shows a general trend of improvement over the last five years with the rate reducing by 0.23% since 2011/12. Further improvement will be a key focus for the Trust.

Table 6: The actual monthly absence rates are shown in the table below:

UNITED LINCOLNSHIRE HOSPITALS MONTHLY PERCENTAGE SICKNESS ABSENCE RATES APRIL 2011 to FEBRUARY 2017												
Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17		Annual Rate
4.39%	4.53%	4.52%	4.68%	4.00%	4.29%	4.74%	5.00%	5.34%	5.32%	5.07%		4.72%

Table 7: shows the comparison of monthly sickness absence rates since 2013



Sickness absence rates are calculated using full time/whole time equivalent (WTE) and are based on calendar days, therefore include non-working days.

ESR (Electronic Staff Record) is able to provide statistical information on the basis of wte hours lost divided by wte hours available. Two sets of figures are provided on a monthly basis (monthly sickness rate and rolling 12 months) and sickness absence are always reported one month in 'arrears'.

Equality and diversity

We are fully committed to creating an organisational culture of equality, diversity and inclusion for patients, service users and staff. Everyone has a right to be treated fairly and equitably when accessing NHS services. All employees can expect to find fulfilment in their work and to be appreciated in the workplace. We recognise that everyone is different and value the unique contribution that diverse cultures, individual experiences, knowledge and skills make in delivering quality healthcare and becoming a model employer.

In the last 12 months, the Trust has reinvigorated its approach to integrating and embedding equality, diversity and inclusion into all areas of Trust business. Following a thorough review of equality, diversity and inclusion in the organisation, the Trust appointed a new equality, diversity and inclusion lead in September 2016.

An equality, diversity and inclusion forum, chaired by Chief Executive Jan Sobieraj, was established in September 2016, to provide the strategic and operational direction required to achieve improvement in this area. The forum recently published a five-year vision, aligned to the organisation's overall vision, to ensure equality, diversity and inclusion become a 'golden thread' through all aspects of the Trust's business which can be found on the Trust's website.

The Trust has made good progress in evidencing improved compliance with its statutory and mandatory duties in relation to equality, diversity and inclusion, as well as demonstrating practical improvements for patients, service users and staff.

The Trust's equality analysis documentation was revised and a new pack was approved by the executive team, piloted and implemented for all functions and activity in the Trust. From March 2017, it is a requirement that significant papers and decisions going to the Trust Board will be underpinned by an equality analysis. This enables the Board to be able to evidence due regard to the Equality Act and Public Sector Equality Duty in its decision making processes.

Of particular note is that the Trusts 2021 Plan is underpinned by a full equality analysis, demonstrating strong commitment to equality and diversity as we move forward as an organisation.

In August 2016 the Trust's executive team approved annual equality objectives, which are located on the Trust's website here.

The Trust published its workforce equality monitoring data and gender pay audit on the Trust website in January 2017.

In 2016 the Trust began a complete review of its NHS Equality Delivery System 2 (EDS2) work. In partnership with key clinical and professional groups, a detailed self-assessment was undertaken. In January 2017, it was peer-reviewed by the CCG equality assurance manager. Based on this analysis, the Trust is developing actions and priorities to improve performance in key areas. It is envisaged that during 2017-2018 further internal and external stakeholders will have the opportunity to contribute to EDS2. Additionally, it is proposed that the Trust's new equality, diversity and inclusion strategy 2021 will be designed around the EDS2 goals.

The Workforce Race Equality Standard (WRES) is also a mandatory requirement for the Trust and forms part of the national NHS Standard Contract.

The Trust published WRES data in 2015 and 2016, and an action plan for improvement in 2016. The actions are progressing and remain a priority for the Trust. These documents are available on the Trust website here.

In October 2016 the Trust hosted a race equality conference at which one of the NHS England WRES team leads, alongside regional and local speakers addressed 50 delegates from the Trust and other NHS provider organisations.

In 2016 the Trust began implementation of the accessible information standard (AIS). The work is focussed around developing the systems and processes to enable the Trust to meet the communication requirements of people living with disability in a structured, robust and automated manner; as well as a practical implementation of the standard in clinical areas.

The Trust is implementing significant improvements in information technology, information governance and choice and access to enable service user communication requirements to be met in a structure manner.

The Trust has focussed on practical improvements in the areas of ophthalmology, audiology and learning disability services. This work has led to improvements in these areas, which are feeding into the strategic plans to deliver the AIS across the Trust. This work has also enabled the Trust to strengthen excellent working relationships with Lincolnshire Sensory Services.

One significant project under the umbrella of the Trust's AIS work is the creation of a new eye clinic liaison officer service (ECLO), on the Boston, Grantham and Lincoln sites. This service is in advanced stages of planning and is a partnership between the RNIB Group, NHS England and the Trust. It is expected the service will begin in the summer of 2017 and will offer a significant improvement in care services for people living with visual impairment in Lincolnshire.

The Trust will continue to promote equality and challenge discrimination in all service provision, recognising and meeting the needs of the diverse communities we serve.

The Trust will not tolerate unlawful discrimination, victimisation, bullying or harassment based on race, ethnic or national origin, nationality, age, disability (both physical and hidden), gender, gender reassignment, sexual orientation, religion or belief, HIV status, marital status or caring responsibilities. Any action found to be in breach of any of these would be addressed in accordance with the Trust's policies and procedures.

In 2016 the Trust appointed a Freedom to Speak Up Guardian and adopted the national NHS Freedom to Speak Up Policy (whistleblowing). In early 2017 the organisation began a renewed campaign to promote a zero tolerance towards bullying and harassment.

Other key achievements in relation to equality, diversity and inclusion are:

- New equality, diversity and inclusion website presence
- New equality, diversity and inclusion induction for all staff
- Sponsoring of the Lincolnshire LGBT+ Conference, February 2017
- Signing of the Armed Forces Covenant in March 2017
- Began publishing equality matters monthly staff newsletter
- Planning began for staff equality networks
- Complete renovation of neo-natal services commenced at Lincoln

- New modular unit for some of maternity services at Boston
- Opening of new Scampton Ward at Lincoln for frail older people
- Ophthalmology clinic 8 at Lincoln refurbished
- New TV screens alerting patients introduced at Lincoln
- New ophthalmology unit and expanded service provision at Grantham
- Implementation of the carer's badge scheme
- Commenced fall prevention programme on wards 3b and 6b at Boston, a collaboration with 20 NHS Trusts
- Spiritual boxes introduced for end of life care through chaplaincy
- Dementia practitioners introduced on Lincoln and Boston Hospital sites to provide support to patients, carers and clinical areas

The Trust has a range of policies which set standards and promote improvement in a range of areas. These include the dignity in care policy, dignity at work policy, transgender policy and interpretation and translation policy. The Trust will publish an equality, diversity and inclusion strategy in 2017.

Becoming a model employer is a key goal for the Trust. Therefore, it is vital that the Trust is able to recruit the best staff and skills from across the whole of society. For example, this includes ensuring that transgender people are welcome and respected, and that policies in recruitment, retention and day-to-day employment do not unintentionally operate in ways that discriminate against transgender people.

The Trust takes pride in providing interpreters and translated information to patients and carers who speak English as a second language, have a hearing/visual impairment, or have a learning disability.

The Trust provides equality and diversity training to all members of staff. The training provides suitable information for all levels of employees and managers who need to be aware of the best equality and diversity workplace practices, furthermore the training provides an understanding of the employment legislation as well as employer and individual responsibilities.

Corporate responsibility for all aspects of the Equality Act and Public Sector Equality Duty lies with the director of human resources and organisational development. All board members have a responsibility for ensuring that the Public Sector Equality Duty is met and for promoting equality in the Trust's business. Responsibility for delivery rests with the identified lead for each of the outcome areas in the action plan and action/monitored at sites.

A full and detailed equality, diversity and inclusion annual report for 2016-2017 will be placed on the Trust's website in the first quarter of 2017-2018.

Looking ahead to 2017/18

The ambition for ULHT is to develop the potential to become a national, if not international, centre for rural health and care, working collaboratively with our partners and stakeholders to deliver transformation programmes, which will fully integrate partnership care pathways across primary and acute health and care systems. We will develop our research, innovation and education into centres of excellent working with key partners and universities to build capacity and capability of our current and future workforce to embrace and actively engage with research, innovation and improvement.

Through better engagement with all stakeholders we want to develop our organisational learning capability to enable the continuous improvement of services whilst at the same time embracing equality, diversity and inclusion. Not only do we want to deliver our commitment to developing talent and recognising difference but also to develop networks for information sharing and support and to ensure diversity is recognised and embraced.

ULHT, like many other NHS trusts, currently faces significant service and financial challenges and we have been developing our 2021 Strategy underpinned by six improvement priorities being managed through the 2021 programme, which aligns to the STP to achieve future sustainability.

There is a strong case for change across our health and care system, with the focus for ULHT being to provide specialist emergency or planned care from our hospitals, to do this we will work closely with our partner organisations and stakeholders to enable patients to return to their own community quickly. These changes will take into account the challenges Lincolnshire faces which include:

- A growing but ageing highly dispersed population.
- Inconsistent delivery of high quality services; fragile and dispersed delivery.
- Patient experience that varies from excellent to poor depending on service or geographic location.
- An outdated model of delivery based on response to crisis.
- Poor infrastructure and difficult travelling.
- A workforce challenge across all sectors; recruitment issues and an ageing workforce that is less engaged than it needs to be in many services.

- Financial challenges of a ULHT £56.9 million deficit in the wider context of a £73 million underlying system deficit in 2016/17.

The Lincolnshire STP sets out the vision for how health and care services are going to be transformed to deliver consistent, good quality care. Although there is, understandably, a lot of interest in what changes might look like for hospital services, the plan is much more.

The Accountability Report

The purpose of the accountability section of the annual report is to meet key accountability requirements to be dealt with in a directors' report, as set out in Chapter 5 of Part 15 of the Companies Act 2006.

Scope of responsibility

As accountable officer, and chief executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives whilst safeguarding public funds and the organisation's assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the organisation is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum which sets out my responsibilities of propriety and regulation of expenditure, and for putting in place effective management systems which safeguard public funds and allow for the keeping of proper accounts.

The Trust works in partnership with local health and social care community and is accountable for the delivery of its patient services through the contracts it holds with its commissioners. The majority of the Trust's contracted activity is commissioned, by the Lincolnshire clinical commissioning groups and by the area team for specialised services.

The governance framework of the organisation

The governance framework is designed to manage risk to a reasonable level rather than to eliminate all risk. It therefore provides reasonable rather than absolute assurance of effectiveness. The governance and system of internal control of the organisations is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- 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 2017 and up to the date of approval of the annual report and accounts.

Trust Board and Committee Structure

The Trust Board meets on a monthly basis and consists of a chair, five voting executive directors, including the Chief Executive and seven non-executive directors (currently one vacant post). Three non-voting executive directors, the chief operating officer, director of estates and facilities, and the director of human resources and organisational development also attend meetings of the Trust Board.

There have been some key personnel changes at executive and non-executive level during 2016/17 including the appointment of a new chair from April 2016 and the Trust has just completed a recruitment process to fill the one non-executive vacancy existing at the end of March 2017. The Board recognises the importance of measuring its own effectiveness and completed a self-assessment against the well led framework and this will be followed up by an external provider review during 2017/18. The chief executive and chair have set board level objectives for all Trust Board members.

The Trust Board focusses on strategic issues, whilst also receiving assurances in relation to the Trust performance on quality, the NHS constitutional standards and finance. It achieved this through the following

- Chief Executive and Chair updates on the internal and external environment at Trust Board.
- Monthly Board development sessions covering key strategic and development issues.
- Continuous review of committee structure.

The Trust can confirm that the arrangements in place for the discharge of statutory functions have been checked for any irregularities, and that they are legally compliant.

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with relevant principles of the Code is considered to be good practice. This Governance Statement is intended to demonstrate how the Trust had regard to the principles set out in the Code considered appropriate for Trusts.

Supporting Committee Structures

To support the Trust Board in carrying out its duties effectively, committees reporting to the Board are formally established with Board approved terms of reference. A review of the committee structure was completed in the year to ensure that it continued to deliver robust governance and assurance. Each Assurance committee of the Board has its own agreed sub structures and the Assurance Committees receive reports as outlined within their terms of reference and work programme, Each Committee provides an assurance and exception report to each meeting of the Trust Board.

The key committees for governance and assurance are as follows:

Audit Committee - delegated to approve the annual accounts on behalf of the board and provide assurance in relation to Internal and external audit, counter fraud and security management, financial reporting, integrated governance, risk management and internal control, and the annual governance statement. During 2016/17 key areas of work for the committee were:

- Reviewing and approving the annual accounts and annual governance statement
- Receiving the Integrated Strategic Risk Register/ Board Assurance Framework
- Agreeing internal and external audit plans and monitoring progress
- Receiving reports of waivers, losses and compensations
- Monitoring counter fraud investigations
- Assurance on Corporate Risk Register and Risk processes within the Trust and oversight of risk improvement plans

Quality Governance Assurance Committee – provides assurance to the Trust Board that appropriate and effective governance mechanisms are in place for all aspects of Quality Governance and risk. During 2016/17 key areas of work for the committee were:

- Review of the Board Assurance Framework/ Integrated Strategic Risk Register
- Receiving assurance reports from Health and Safety Committee, Safeguarding Committee, Infection Prevention and Control Committee
- Assurance on the Quality Account
- Review of complaints, patient experience and incidents

Finance, Service Improvement and Delivery Assurance Committee – provide assurances to the Trust Board on financial and performance issues. During 2016/17 key areas of work for the committee were:

- Assurance on Trust key financial duties
- Scrutiny of efficiency programmes

- Review of progress against capital programme
- Assurance on monitor compliance framework and performance
- Review of recovery actions against key duties and performance

Workforce and Organisational Development Assurance Committee - provides the Board with assurance concerning all aspects of workforce and organisational development.

- Assurance on key workforce plans and priorities
- Monitoring of workforce performance indicators
- Assurance on legal and regulatory requirements
- Development and delivery of workforce and OD strategy and the workforce culture

Table 8: Attendance at Board and Committees (Voting Membership)

Board/ Committee	Attendance
Trust Board	91%
Audit Committee	83%
Quality Governance Committee	64%
Finance, Service Improvement and Delivery Committee	73%
Workforce and OD Committee	80%

Risk assessment

The overall responsibility for risk management rests with all members of the Board. The Executive lead for risk management has transferred from the Director of Human Resources and Organisational Development to the Deputy Chief Executive. This has led to the development of an integrated Strategic Risk Register and Board Assurance Framework, together with an in improvement plan to strengthen the risk management strategy, policy and processes within the organisation. The Director of Finance has specific responsibility for financial risks within the Trust, with the Medical Director and Director of Nursing holding specific responsibilities for the management of clinical risks and adverse incidents.

There is a strengthened risk governance framework which defines the management, monitoring and reporting of risk, with a strategic risk management group to validate the corporate risk registers which are monitored through the Board committees and at Trust Board level. The corporate and operational risks are managed locally and through the local governance processes. The Trust operates and maintains an approved risk management strategy, policy and procedures that identifies the levels of accountability, roles and responsibilities for all staff within the organisation.

The Trust's risk management strategy, policy and procedures defines the types of risks that may impact the Trust and the overall Trusts approach to risk assessment. The Integrated strategic risk register and board assurance framework captures the Trusts risks in line with the delivery of objectives, and this forms part of the risk reports to the Board's committees together with the corporate risk register to escalate any strategic risks to the Board, together with forming part of the Trust Board's risk management agenda. Operational risks are captured within the business unit.

Risks are identified in the Trust and recorded onto the Datix system, they are reviewed by managers and the management of those risks identified with mitigation actions and a risk rating. This risk rating, which is defined in the Trusts risk management policy and procedures, is derived from evaluating the likelihood and severity of an occurrence that may impact on the Trusts objectives.

A review of the risks recorded onto the Trusts risk register over the last year has seen the number of open risks reduced considerably demonstrating a higher level of management of risks. This review has seen certain categories or risks reduced e.g. Estates and Facilities which are actively managing their local risk register. There has been a risk validation group, which challenges and validates risk ratings, mitigation actions and ownership.

The major risks to the Trust relate to financial stability and recovery, with the key mitigation actions being to develop a long term financial strategy which will be aligned to the sustainable transformation plan, two-year operational and financial plan and robust performance framework. There are risks to sustaining and adequate workforce, with key mitigation with a people strategy and workforce plans which will address recruitment and retention difficulties covering key skills across critical clinical skills. There are risks relating to estates statutory compliance. The major clinical risks relate to the management of care relating to sepsis and GI bleeds.

During 2016/17 the Board devoted a Board development workshop to review the governance arrangements for risk, and agree improvements to the risk framework. Each of the Board committees discuss and challenge the risk on the Corporate Risk Register, together with the strategic risk register aligned to the Trust's strategic objectives.

A review of risk has been undertaken which has a clear Improvement Plan which is overseen by the strategic risk management group with reporting the progress to the Trust committees and the Trust Board.

New and emerging risks, corporate, clinical and operational are identified from a variety of sources within the trust; learning from adverse events; the quality governance committee; the financial, service improvement and delivery committee; the workforce and organisational development committee; the integrated performance report; various dashboards; quality impact assessments; internal review audits; clinical areas business units.

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 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, Service Improvement and Delivery Assurance Committee throughout the year and within the outpatient improvement programme plan.

The Trust reported six data security breaches to the Information Commissioner in 2016/2017; which have now been closed with the agreement of the ICO. The Trust is compliant with all level 2 standards of the IG toolkit apart from the achievement of staff training in IG to 95%.

The risk and control framework

Managing risk is the responsibility of all employees and not just the role of specialists, managers or the Trust Board. All employees are responsible for identifying, reducing, reporting and eliminating risk where possible. A key element of the Trust's Risk Management Strategy is the integration of risk management into both the strategic and routine operational decision making processes within the Trust. The Strategy is designed for prevention and mitigation of risks, and the Board are committed to minimising risk through the use of the integrated strategic risk register and board assurance framework.

The Trust's risk management policy and procedures are in place which encourage staff to report adverse incidents and near misses in order to minimise risk and take action to prevent recurrence. During 2016/17 incident reporting and analysis has been reviewed as part of the risk review and improvements have been identified, which will be supported by a refreshed strategy, policy and procedures. The Trust has also introduced weekly Serious Incident review meetings chaired by the Medical Director and the Director of Nursing tracking action plans and lessons learned to be shared.

Through the risk review, there have been dedicated actions to ensure that the risk registers are validated and that there is better capture processes and systems for strategic, corporate and operational risks. There is further development to give key managers at all levels the facility to identify managers and escalate (where necessary) the main risks in their areas of work. Risk assessments contribute to the Trust's risk register and encompass both clinical and non-clinical risks.

For all risks recorded on the risk registers; the controls currently in place to manage the risk are described, as are the gaps in those controls to reduce the risk to as low as reasonably practicable. An action plan with a nominated "risk lead" is developed for every action to address those mitigations measures required and a review date for each action. The timeliness for the completion of actions is linked to the level of the risk score.

Risk management training commences at induction with further training in risk management provided through the mandatory training programme. The training reinforces individuals' accountabilities with respect to incident reporting and risk management and enables staff to assess and manage risks within their sphere of responsibility.

Specialised risk management training is provided to staff who have been identified as risk handlers to enable them to aggregate risks across their business unit or specialty and consider its impact upon the Trust's strategic objectives.

The Board is responsible for setting the organisation's aims and objectives and ensuring that an assurance framework identifies the principal risks to the organisation meeting these aims and objectives, as well as confirming the key controls in place to manage these risks.

The Board assurance framework identifies the source of independent assurance in relation to each objective and risk. The framework is dynamic to reflect changes in priorities and developments in the external environment. It is a strategic management tool to support the annual governance statement, not designed to show every risk, but to focus attention on those which are most significant.

The audit committee assess the overall adequacy of the assurance framework on behalf of the accountable officer and the Board, and advise the Board in relation to the systems, processes and controls in place in order to have co-ordinated and effective risk mitigation in achieving the Trust's objectives. This enables the Board to discharge its responsibilities for governance and understand the balance of clinical, operational and financial risk.

Throughout 2016/17, the Board has identified and monitored against key objectives within the integrated strategic risk register and the Board assurance framework. The controls and assurances in relation to the strategic objectives are reported to the Board each month with assurance from the Board committees on their parts of the assurance framework relevant to their Terms of Reference . The risk review identified improvements to the risk framework which is supported by the improved monitoring and reporting through to the board committees and the Trust Board.

Review of the effectiveness of risk management and internal control

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of internal audit's work. The overall head of internal audit opinion gave a limited assurance. The trust is continuing to work to improve control in those areas highlighted by audit and to strengthen the effectiveness of the board assurance framework. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. the assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by

- Care Quality Commission visits
- Delivery of Internal and External Audit Plans
- Friends and Family Test
- Staff Survey results

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, audit committee and the assurance committees. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The internal audit reviews undertaken during 2016/17 led to the head of internal audit providing a limited assurance opinion on the system of internal control in the Trust. In reaching this opinion the review assessed

- The design and operation of the assurance framework;
- The arrangements for the management of risk;
- The outcome of individual assignments within 2016/17 internal audit plan;
- The extent to which the Trust responded to audit recommendations as identified as part of our follow up work

The Trust has produced a quality account, and has taken steps to assure itself of the accuracy of this document by referencing information services within the organisation, the quality governance assurance committee and internal and external audit processes.

A detailed internal review of risk management was conducted during 2016 alongside a review by internal audit and an independent review following the CQC report and all recommended actions in improvement are being monitored through the strategic risk management group and audit committee.

Significant Issues
During the year the Trust identified the following significant control issues.
During October 2016 the CQC carried out a follow up inspection and found that the Trust had a range of issues which it needed to tackle. As a result of this the Trust was assessed as inadequate and placed in special measures in April 2017..

The CQC highlighted the following areas which required improvement

- Identifying and treating patients with sepsis
- Strengthening senior leadership at Pilgrim hospital
- Caring for patients with mental health problems
- Major incident planning

These areas have been a focus for immediate actions by the Trust since October and a further inspection is expected during 2017/18.

During the year the Trust has faced significant financial challenges, which are expected to continue during 2017/18. The Trust is operating in a difficult health economy and is working with commissioners, local health and social care partners and local authorities to review care pathways and explore alternative models of care in an attempt to address these challenges and deliver a sustainable five year plan linked to the Lincolnshire Sustainability Transformation Plan (STP).

Workforce remains a significant strategic and operational challenge. Plans for 2017/18 and beyond are focussing on improving retention, making Lincolnshire a more attractive place to work and reducing dependency on agency staff.

The Trust internal auditors provided the Trust with a limited assurance from the head of internal audit opinion for 2016/17 and highlighted the number of their reviews which had resulted in a limited assurance being provided.

One high risk issue was reported as a result of Internal Audits 2016/17 work. This related to the slippage in the planned timetable for identifying and agreeing efficiency schemes within the 2017-18 financial efficiency plan. The Trust has agreed to ensure robust governance processes and executive ownership and oversight provide for appropriate reporting and challenge.

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

Accountable Officer: Mr Jan Sobieraj, Chief Executive

Organisation: United Lincolnshire Hospitals NHS Trust

Signature: 

Date:

Trust Board and committees

Board changes

During the year we have seen some changes to the board. Ian Warren Director of human resources and organisational development left the Trust and Martin Rayson joined in September 2016. Tim Staniland non-executive director (NED) left in March 2017. Michelle Rhodes moved from director of operations to director of nursing and Mark Brassington was appointed as chief operating officer.

Table 9: Board membership for 2016/17

	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care or any connection with a voluntary or other organisation contracting for NHS services	Research funding / grants that may be received by an individual or their department	Interests in pooled funds that are under separate management	To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust including, but not limited to, lenders or banks	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
Professor Dean Fathers Chairman	Non Executive Director Finegreen Group	None	None	Chair – Nottinghamshire Healthcare NHS Foundation Trust East Midlands Leadership Academy – Board member	None	None	Shareholder Diagnostic Healthcare Professorial Fellow Institute of Mental Health University of Nottingham Visiting professor Cass Business School Visiting Professor Leeds Business School NHS Improvement Chairs Partnership Alliance Member Vice Chair NHS Confederation Mental health Network	Provision of workshop to Transpire / NDL Adhoc advisor to Kier Senior Independent Director Higos Insurance Senior Independent Director JRI Orthopaedic East Midlands Reserve Forces Employer Engagement Group Chair of Independent longitudinal Evaluation of Schwartz Rounds, Kings College London NHS WRES Advisory Group Member	Spouse-Action on Hearing loss

	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care or any connection with a voluntary or other organisation contracting for NHS services	Research funding / grants that may be received by an individual or their department	Interests in pooled funds that are under separate management	To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust including, but not limited to, lenders or banks	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
Mr Jan Sobieraj Chief Executive	None	None	None	Trustee- Combat Stress Charity Trustee – National Leadership Centre Charity	None	None	Hon Fellow Sheffield Hallam University Hon Professor DeMontford University Hon Professor Plymouth University Advisory Board Member Kings Fund	None	Spouse – Nurse Lecturer University of Lincoln
Mr Kevin Turner Deputy Chief Executive	None	None	None	None	None	None	None	None	None
Mr Paul Boocock Director of Estates and Facilities	None	None	None	None	None	None	None	None	None

	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care or any connection with a voluntary or other organisation contracting for NHS services	Research funding / grants that may be received by an individual or their department	Interests in pooled funds that are under separate management	To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust including, but not limited to, lenders or banks	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
Mr Mark Brassington Chief Operating Officer	None	None	None	None	None	None	None	None	None
Mrs Sarah Dunnett Non Executive Director				Trustee/ Hon Treasurer Health Quality Improvement Partnership Trustee The Miscarriage Association Non Executive Director Peterborough and Stamford Hospitals NHS Trust					

	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care or any connection with a voluntary or other organisation contracting for NHS services	Research funding / grants that may be received by an individual or their department	Interests in pooled funds that are under separate management	To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust including, but not limited to, lenders or banks	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
Dr Paul Grassby Non Executive Director	None	None	None	None	None	None	University of Lincoln – service level agreement for teacher practitioners and student placements	None	None
Mr Geoff Hayward Non Executive Director	None	None	None	None	None	None	None	None	Spouse - volunteer for Butterfly Hospice Boston
Dr Suneil Kapadia Medical Director	None	None	None	None	None	None	None	Member of the independent drug monitoring committee for trial with Sanofi-Pasteur	None
Mrs Penelope Owston Deputy Chair/Non Executive Director	None	None	None	None	None	None	None	None	None

	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care or any connection with a voluntary or other organisation contracting for NHS services	Research funding / grants that may be received by an individual or their department	Interests in pooled funds that are under separate management	To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust including, but not limited to, lenders or banks	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
Mrs Gill Ponder Non Executive Director	Non	None	None	None	None	None	None	Employed by Openreach	None
Mrs Michelle Rhodes Director of Nursing	None	None	None	None	None	None	None	None	Sister employed by Park Hospital Nottingham
Mrs Kate Truscott Non Executive Director	None	None	None	Trustee of Childrens' Links Charity	None	None	Associate Hospital Manager Lincolnshire Partnership NHS Foundation Trust	None	None

	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care or any connection with a voluntary or other organisation contracting for NHS services	Research funding / grants that may be received by an individual or their department	Interests in pooled funds that are under separate management	To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust including, but not limited to, lenders or banks	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
Mr Martin Rayson Director of Human Resources and Organisational Development	None	None	None	None	None	None	None	None	None
Mr Peter Hollinshead Interim Director of Finance	None	Partner Brandhill Financial Services Ltd	None	None	None	None	None	None	None

Audit committee membership comprises three non-executive directors, one of whom will have considerable financial expertise. For 2016/17, membership was as follows:

Audit committee members
Geoffrey Hayward Chair
Kate Truscott
Gill Ponder from December 2015 until October 2016
Penny Owston from October 2016
Tim Staniland from October 2016 Until March 2017

A Remuneration and Staff Report

ULHT had a difficult financial year. The Trust reported a year end deficit of £56.9 million.

More information on our financial performance can be found in section A and the full accounts.

Going concern

As part of the formal process to review and approve the Annual Accounts, the Trust's Audit Committee acting under delegated authority from the Board, evaluates the appropriateness of preparing the financial statements on a 'Going Concern' basis. The evaluation considers profitability and efficiency, liquidity, contracts, risks and national guidance. The key evidence supporting the 'Going Concern' conclusion is contained within the 'Department of Health Group Accounting Manual 2016-17' which states:
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.

Remuneration

Pension benefits , salaries and allowances are shown in the tables 16 and 17 on page 65 onwards.

Fair pay (pay multiples) (audited)

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

The banded remuneration of the highest paid director in United Lincolnshire Hospitals NHS Trust in the financial year 2016-17 was £185,000 (2015-16, £185,000). This was 7.92 times (2015-16, 8.17) the median remuneration of the workforce, which was £23,363 (2015-16, £22,636).

In 2016-17, zero (2015-16, zero) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £185,000 to £6,083 (2015-16 £181,800 to £3,000).

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

(Salary has been defined for the purposes of this calculation as basic salary which excludes overtime and enhancements).

Exit packages and severance payments

Tables 14 and 15 provide detail about payments on termination of employment with table 15 dealing with non-compulsory redundancies. These additional disclosures are required to strengthen accountability in the light of public and Parliamentary concern about the incidence and cost of these payments.

Table 10: Exit packages (audited)

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	1	6,951	23	53,062	24	60,013		
£10,000 - £25,000						0		
£25,001 - £50,000					0	0		
£50,001 - £100,000					0	0		
£100,001 - £150,000					0	0		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total	**1**	**6,951**	**23**	**53,062**	**24**	**60,013**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the Provisions of the NHS Agenda for Change and Medical and Dental Terms and Conditions of Service. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill health retirement costs are met by the NHS Pension Scheme and are not included in the table.

Table 11: Analysis of other departures (audited)

Other Exit packages - disclosures (Exclude Compulsory Redundancies)	Number of exit package Number	Total Value of agreements £s
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice	23	53,062
Exit payments following Employment Tribunals or court orders		
Non contractual payments requiring HMT approval *		
Total	**23**	**53,062**
Non-contractual payments 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 the note, the total number above will not necessarily match the numbers in table 14 which will be the number of individuals.

Zero non-contractual payments were made to individuals where the payment was more than 12 months of their annual salary.

Consultancy

Consultancy is narrowly defined within the Department of Health Group Accounting Manual 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."

Within the scope of this definition the total consultancy expenditure in 2016-17 was £4,000 as set out within note 7 to the accounts.

Salaries and allowances

Table 12: Salaries and allowances of Trust Board members for 2016/17 and 2015/16 (audited)

				2015/16				
Name and title	Notes	Term in post		Salary (bands of £5,000)	Expense payments - taxable (total to nearest £100)	All pension-related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total (bands of £5,000)
		Start	Finish	£000's	£00's	£000's	£00's	£000's
Prof D Fathers - Chair		Mar-16	Ongoing	0 - 5	0		0	0 - 5
Mr R Buchanan - Chair		Mar-14	Mar-16	40 - 45	6		5	40 - 45
Mrs P Owston - Non Executive Director		Apr-10	Ongoing	5 - 10	23		10	5 - 10
Mr T Staniland - Non Executive Director		Mar-07	Mar-17	5 - 10	3		2	5 - 10
Mr G Hayward - Non Executive Director		Jul-13	Ongoing	5 - 10	9		8	5 - 10
Mr P Grassby - Non Executive Director		Jul-13	Ongoing	5 - 10	3		1	5 - 10
Prof S Barnett - Non Executive Director		Mar-14	Dec-15	0 - 5	6		3	5 - 10
Mrs K Truscott - Non Executive Director		Mar-14	Ongoing	5 - 10	8		3	5 - 10
Mrs G Ponder - Non Executive Director		May-15	Ongoing	5 - 10	6		5	5 - 10
Mts S Dunnett - Non Executive Director		Jul-16	Ongoing					
Mr K Darwin - Associate Non Executive Director		Jan-10	Aug-16	0 - 5	6		6	0 - 5
Jan Sobieraj - Chief Executive		Dec-15	Ongoing	55 - 60	0	22.5 - 25	0	80 - 85
Kevin Turner - Deputy Chief Executive	1	Jan-11	Ongoing	145 - 150	0	62.5 - 65	0	210 - 215
Peter Hollinshead - Interim Director of Finance & Corporate Affairs	2	Jan-17	Ongoing	see note 2				
John Barber - Interim Director of Finance & Corporate Affairs		Jun-16	Jan-17					
Jason Burn - Interim Director of Finance & Corporate Affairs	3	Jan-16	Jun-16	see note 3				
David Pratt - Director of Finance & Corporate Affairs		Oct-13	Nov-16	135 - 140	13	22.5 - 25	0	160 - 165
Mark Brassington - Chief Operating Officer	4	Mar-16	Ongoing	110 - 115	13	115 - 117.5	0	230 - 235
Michelle Rhodes - Director of Nursing	5	Oct-10	Ongoing	115 - 120	7	7.5 - 10	0	125 - 130
Pauline Pratt - Acting Director of Nursing		May-14	Dec-15	85 - 90	9		0	85 - 90
Suneil Kapadia - Medical Director	6	Jul-13	Ongoing	185 - 190	8	67.5 - 70	0	255 - 260
Martin Rayson - Director of Human Resources & Organisational Devt		Sep-16	Ongoing					
Louise Ludgrove - Interim Director of Human Resources & Organisational Devt	7	Jul-16	Sep-16					
Ian Warren - Director of Human Resources & Organisational Devt		Feb-13	Jul-16	115 - 120		22.5 - 25	0	140 - 145
Paul Boocock - Director of Estates and Facilities		Oct-13	Ongoing	90 - 95	12	12.5 - 15	0	100 - 105

				2016/17		
Name and title	Notes	Term in post		Salary (bands of £5,000)	Expense payments - taxable (total to nearest £100)	All pension-related benefits (bands of £2,500)
		Start	Finish	£000's	£00's	£000's
Prof D Fathers - Chair		Mar-16	Ongoing	35 - 40	22	
Mr R Buchanan - Chair		Mar-14	Mar-16			
Mrs P Owston - Non Executive Director		Apr-10	Ongoing	5 - 10	21	
Mr T Staniland - Non Executive Director		Mar-07	Mar-17	5 - 10	0	
Mr G Hayward - Non Executive Director		Jul-13	Ongoing	5 - 10	11	
Mr P Grassby - Non Executive Director		Jul-13	Ongoing	5 - 10	0	
Prof S Barnett - Non Executive Director		Mar-14	Dec-15			
Mrs K Truscott - Non Executive Director		Mar-14	Ongoing	5 - 10	6	
Mrs G Ponder - Non Executive Director		May-15	Ongoing	5 - 10	7	
Mts S Dunnett - Non Executive Director		Jul-16	Ongoing	0 - 5	0	
Mr K Darwin - Associate Non Executive Director		Jan-10	Aug-16	0 - 5	4	
Jan Sobieraj - Chief Executive		Dec-15	Ongoing	185 - 190	9	120-122.5
Kevin Turner - Deputy Chief Executive	1	Jan-11	Ongoing	140 - 145	4	0
Peter Hollinshead - Interim Director of Finance & Corporate Affairs	2	Jan-17	Ongoing	25 - 30	0	0
John Barber - Interim Director of Finance & Corporate Affairs		Jun-16	Jan-17	75 - 80	0	0
Jason Burn - Interim Director of Finance & Corporate Affairs	3	Jan-16	Jun-16			see note 3
David Pratt - Director of Finance & Corporate Affairs		Oct-13	Nov-16	85 - 90	109	30 - 32.5
Mark Brassington - Chief Operating Officer	4	Mar-16	Ongoing	120 - 125	23	0
Michelle Rhodes - Director of Nursing	5	Oct-10	Ongoing	120 - 125	26	47.5 - 50
Pauline Pratt - Acting Director of Nursing		May-14	Dec-15			
Suneil Kapadia - Medical Director	6	Jul-13	Ongoing	180 - 185	47	5 - 7.5
Martin Rayson - Director of Human Resources & Organisational Devt		Sep-16	Ongoing	45 - 50	2	10 - 12.5
Louise Ludgrove - Interim Director of Human Resources & Organisational Devt	7	Jul-16	Sep-16			see note 7
Ian Warren - Director of Human Resources & Organisational Devt		Feb-13	Jul-16	35 - 40	0	12.5 - 15
Paul Boocock - Director of Estates and Facilities		Oct-13	Ongoing	85 - 90	14	32.5-35

Notes:

1. Kevin Turner was acting Chief Executive in 2015/16 between August – December 2015.
2. Peter Hollinshead was employed as Interim Director of Finance in 2015/16 from October 2015 – January 2016 and in 2016/17 from January – March 2017. Remuneration earned in 2015/16 was paid to the trading company Brandhill Financial Services Ltd at a commercial rate covering all away from home expenses, business overheads and VAT. As a result of the payments being made to a trading company the Trust did not incur any additional costs (such as tax, national insurance, pension payments). The liability for making such payments rests with the trading company, Brandhill Financial Services Ltd.

The total paid between October 2015 – January 2016 was £102,634.
Remuneration earned in 2016/17 was paid via the Trust payroll and is disclosed above.

3. Jason Burn was employed during 2016/17 through interim recruitment specialists Allen Lane Ltd at a cost of £64,567.99 (2015/16 : £53,856)
4. Mark Brassington was Acting Director of Performance Improvement between April – December 2015 before being appointed as Chief Operating Officer in December 2015.
5. Michelle Rhodes was Director of Operations prior to December 2015 when she was appointed Director of Nursing.
6. Suneil Kapadia was Acting Deputy Chief Executive in 2015/16 between August – December 2015.
7. Louise Ludgrove was employed through recruitment specialists IRG Advisors LLP at a cost of £45,309.60.

Definitions:

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

Taxable benefits
Expense Payments relate to reimbursement for travel, subsistence and where appropriate re-location expenses. Figures presented are shown gross, before tax.

Benefits in kind
These relate to tax paid by the Trust for home to base travel on behalf of non-executive directors.

Pensions related benefits in kind
Pension related benefits disclosed arise from membership of the NHS Pensions defined benefit scheme. They are not remuneration paid, but are the increase in pension benefit net of inflation for the current year calculated by applying a prescribed formula as set out within the Finance Act (2004). For those Senior Managers who have served in post part year, the increase in pension related benefits for the full year have been adjusted pro rata. Further details of the Boards pension benefits are disclosed in the pension benefits table 17.

No performance related pay or bonus payments have been made in 2015/16 or 2016/17.

Table 13: Pension benefits 2016/17 (audited)

Name and title	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 2017 (bands of £5,000) £000's	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £000's	Cash Equivalent Transfer Value at 1 April 2016 £000's	Real increase in Cash Equivalent Transfer Value £000's	Cash Equivalent Transfer Value at 31 March 2017 £000's	Employer's contribution to stakeholder pension £000's
Jan Sobieraj - Chief Executive		5 - 7.5	17.5 - 20	80 - 85	240 - 245	1,657	215	1,872	
Kevin Turner - Deputy Chief Executive		-	-	65 - 70	195 - 200	1,370	22	1,391	
Mark Brassington - Chief Operating Officer		-	-	20 - 25	60 - 65	327	0	319	
David Pratt - Director of Finance & Corporate Affairs		2.5 - 5	0 - 2.5	35 - 40	90 - 95	541	49	619	
Peter Hollinshead - Interim Director of Finance and Corporate Affairs	1	-	-	10 - 15	30 - 35	0	0	0	
John Barber - Interim Director of Finance and Corporate Affairs	2	-	-	-	-	0	0	0	
Jason Burn - Interim Director of Finance and Corporate Affairs	3	-	-	-	-	0	0	0	
Michelle Rhodes - Director of Nursing		2.5 - 5	7.5 - 10	35 - 40	110 - 115	582	70	652	
Suneil Kapedia - Medical Director		0 - 2.5	0 - 2.5	80 - 85	250 - 255	1,760	63	1,823	
Martin Rayson - Director of Human Resources & Organisational Development		0 - 2.5	-	0 - 5	-	0	11	11	
Louise Ludgrove - Interim Director of Human Resources & Organisational Development	4	-	-	-	-	0	0	0	
Ian Warren - Director of Human Resources & Organisational Development	5	0 - 2.5	-	15 - 20	-	161	12	198	
Paul Boocock - Director of Estates and Facilities		0 - 2.5	0 - 2.5	30 - 35	85 - 90	463	59	522	

Notes:

1. No CETV is shown for Peter Hollinshead as the member is over 60 with 'frozen benefits' in the NHS 1995 scheme and cannot re-join the scheme.
2. Greenbury only applies to members who contributed to one of the NHS Pension Schemes at any time during the period 01/04/16 - 31/03/17. John Barber was not a member during 2016/17.
3. Jason Burn was employed through Allen Lane Ltd and was not a member of the NHS Pension Scheme.
4. Louise Ludgrove was employed through IRG Advisors LLP and was not a member of the NHS Pension Scheme.
5. Ian Warren has only been a member of the NHS Pension Scheme under the 2008 section rules. Under this scheme no automatic lump sum is payable.

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 the Occupational Pension Schemes (Transfer Values) Regulations 2008.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension Scheme are based on the previous discount rate and have not been recalculated.

Real Increase in CETV
This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the chief secretary to the Treasury on 23 May 2012, public sector bodies must publish information on their highly paid and/or senior off-payroll engagements.

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).

Table 14: Off-payroll engagements Table 1 for all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	5
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for more than 4 years at the time of reporting	2

All existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 15: Off-payroll engagements for all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	3
Number of new engagements which include contractual clauses giving the United Lincolnshire Hospitals NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	2
Number for whom assurance has been requested	2
Of which:	
assurance has been received	2
assurance has not been received	0
Engagements terminated as a result of assurance not being received	0

Table 16: Off-payroll engagements for any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	2
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure includes both on payroll and off-payroll engagements.	13

Staff numbers

Table 17: Average staff numbers (audited)

Average Staff Numbers	Total YTD Number	Permanently Employed Number	Other Number
Medical and dental	942	796	146
Ambulance staff	0	0	0
Administration and estates	1,195	1,150	45
Healthcare assistants and other support staff	814	756	58
Nursing, midwifery and health visiting staff	3,112	2,775	337
Nursing, midwifery and health visiting learners	6	6	0
Scientific, therapeutic and technical staff	777	754	23
Social Care Staff	1	1	0
Healthcare Science Staff	158	154	4
Other	0	0	0
TOTAL	**7,005**	**6,392**	**613**
Staff engaged on capital projects (included above)	50	28	22

Table 18: Staff costs (audited)

Staff Costs s	Total YTD £000	Permanently Employed £000	Total other £000	Other £000	Agency £000
Medical and dental	101,370	77,847	23,524	8,027	15,497
Ambulance staff	0	0	0	0	0
Administration and estates	36,974	35,313	1,661	578	1,084
Healthcare assistants and other support staff	19,380	18,009	1,371	1,235	136
Nursing, midwifery and health visiting staff	120,699	103,844	16,855	5,753	11,102
Nursing, midwifery and health visiting learners	139	139	0	0	0

Scientific, therapeutic and technical staff	29,812	28,317	1,495	244	1,251
Social Care Staff	56	56	0	0	0
Healthcare Science Staff	6,702	6,338	364	41	324
Other	0	0	0	0	0
TOTAL	**315,132**	**269,862**	**45,270**	**15,876**	**29,393**

United LincoInshire Hospitals NHS Trust

Annual Accounts for the period

1 April 2016 to 31 March 2017

CONTENTS

FOREWORD TO THE ACCOUNTS

Financial Review - year ended 31 March 2017

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. Our performance against these targets is set out in the table below:

Financial Target	Actual Performance		
	2016-17		2015-16
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)	(56,798)	Surplus / (Deficit)	(65,800)
	1,075	Impairments	8048
	(1,436)	IFRIC 12 adjustments	623
	268	Other adjustments	212
	(56,891)	Reported Performance	(56,917)
	(162,865)	Cumulative position against breakeven duty surplus / (deficit)	(105,974)
To achieve a capital cost absorption rate of between 3% and 4%	3.5%		3.5%
To operate within an External Financing Limit set by the Department of Health	£0.38m	Undershoot	£0.17m
To operate within a Capital Resource Limit set by the Department of Health	£1.12m	Underspent	£0.05m
To pay 95% of creditor invoices within 30 days (by number of invoices)	82%	Trade (Non NHS)	85%
	72%	NHS	70%

Karen Brown
Interim Director of Finance and Corporate Affairs
May 2017

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

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

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

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

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

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

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

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

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

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

Signed **Jan Sobieraj** **Chief Executive**

Date: **26th May 2017**

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

By order of the Board

Signed **Jan Sobieraj** **Chief Executive**

Signed **Karen Brown** **Interim Director of Finance and Corporate Affairs**

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF UNITED LINCOLNSHIRE HOSPITALS NHS TRUST

We have audited the financial statements of United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2017 on pages 11 to 50 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 5, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2017 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Other matters on which we report by exception – referral to Secretary of State

We have a duty under the Local Audit and Accountability Act 2014 (the 2014 Act) to refer a matter to the Secretary of State if we have reason to believe that the Trust has, taking into account the NHS Finance Manual *Guidance on Breakeven Duty and Provisions*, breached its 'breakeven duty' set out at paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

On 23 May 2017 we referred a mater to the Secretary of State under section 30 (1)(a) of the 2014 Act in relation to the breach of the Trust's breakeven duty due to the reported in year deficit of £56.9 million, and a cumulative deficit of £162.865 million which has led to this breach.

Other matters on which we report by exception - adequacy of arrangements to secure value for money

Basis for qualified conclusion

We are required to report by exception if we conclude that we are not satisfied that the Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2017.

In considering the Trust's arrangements for securing sustainable resource deployment, we identified the following matters:

- the Trust has delivered a deficit of £56.9 million in 2016/17, higher than its operational plan deficit of £47.9 million; and
- the Trust has failed to deliver a number of operational targets for the year, including the targets for waiting times for Accident and Emergency, cancer treatment and referral to treatment.

We have also noted that the Care Quality Commission inspected the trust in October 2016, and in April 2017 issued the Trust with an overall rating of inadequate. The report included concerns in respect of quality, safety and staffing levels. The Trust was placed in special measures by NHS Improvement in April 2017.

On the basis of our work, the matters reported in the basis for qualified conclusion paragraph above prevent us from being satisfied that in all material respects United Lincolnshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017.

Emphasis of Matter – Going concern

In forming our opinion on the financial statements which is not modified, we have considered the adequacy of disclosures made in note 1.1 in the financial statements which describe the Trust's going concern basis for the accounts preparation. The Trust has been reliant on cash support from the Department of Health in meeting its payment obligations and has drawn down a total of £110.548m at 31 March 2017. Of the revenue support loans, £35.62m is repayable in November 2018. The Department of Health is yet to advise of the refinancing arrangements regarding this loan. This condition, along with other matters also explained in note 1.1 in the financial statements, indicate the existence of an uncertainty which may cast significant doubt on the Trust's ability to continue as a going concern.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the Department of Health Group Accounting Manual 2016/17; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

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

Certificate

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

Tony Crawley
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
31 Park Row
Nottingham
NG1 6FQ

30 May 2017

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Gross employee benefits	9.1	**(315,131)**	(305,876)
Other operating costs	7	**(173,870)**	(177,208)
Revenue from patient care activities	4	**392,427**	386,840
Other operating revenue	5	**44,897**	36,588
Operating surplus/(deficit)		**(51,677)**	(59,656)
Investment revenue	11	**47**	70
Other gains and (losses)	12	**(51)**	(50)
Finance costs	13	**(1,963)**	(906)
Surplus/(deficit) for the financial year		**(53,644)**	(60,542)
Public dividend capital dividends payable		**(3,154)**	(5,258)
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(56,798)**	(65,800)

Other Comprehensive Income

	2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	**571**	(16,558)
Net gain/(loss) on revaluation of property, plant & equipment	**1,380**	2,913
Total comprehensive income for the year	**(54,847)**	(79,445)

Financial performance for the year

Retained surplus/(deficit) for the year	**(56,798)**	(65,800)
IFRIC 12 adjustment (including IFRIC 12 impairments)	**(1,436)**	623
Impairments (excluding IFRIC 12 impairments)	**1,075**	8,048
Adjustments in respect of donated gov't grant asset reserve elimination	**268**	212
Adjusted retained surplus/(deficit)	**(56,891)**	(56,917)

Since the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trusts' financial performance measurement must 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 financial 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.

Note that prior year performance is not re-assessed following accounting restatements.

The notes on pages 16 to 50 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	15	**221,161**	215,768
Intangible assets	16	**6,052**	5,607
Trade and other receivables	20.1	**1,211**	1,477
Total non-current assets		**228,424**	222,852
Current assets:			
Inventories	19	**7,769**	7,130
Trade and other receivables	20.1	**24,280**	21,127
Cash and cash equivalents	21	**1,675**	1,166
Sub-total current assets		**33,724**	29,423
Non-current assets held for sale	22	**1,251**	1,075
Total current assets		**34,975**	30,498
Total assets		**263,399**	253,350
Current liabilities			
Trade and other payables	23	**(46,340)**	(42,020)
Other liabilities	24	**(503)**	(503)
Provisions	29	**(1,516)**	(1,364)
Borrowings	25	**(284)**	(299)
DH revenue support loan	25	**0**	0
DH capital loan	25	**0**	0
Total current liabilities		**(48,643)**	(44,186)
Net current assets/(liabilities)		**(13,668)**	(13,688)
Total assets less current liabilities		**214,756**	209,164
Non-current liabilities			
Trade and other payables	23	**0**	0
Other liabilities	24	**(14,088)**	(14,591)
Provisions	29	**(2,926)**	(2,484)
Borrowings	25	**(212)**	(178)
DH revenue support loan	25	**(110,548)**	(54,000)
DH capital loan	25	**0**	0
Total non-current liabilities		**(127,774)**	(71,253)
Total assets employed:		**86,982**	137,911
FINANCED BY:			
Public Dividend Capital		**255,663**	251,746
Retained earnings		**(212,874)**	(157,029)
Revaluation reserve		**44,003**	43,004
Other reserves		**190**	190
Total Taxpayers' Equity:		**86,982**	137,911

The notes on pages 16 to 50 form part of this account.

The financial statements on pages *11 to 50* were approved by the Board on *26 May 2017* and signed on its behalf by:

Chief Executive: **Jan Sobieraj** Date: **26 May 2017**

Interim Director of Finance and Corporate Affairs **Karen Brown** Date: **26 May 2017**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2016	**251,746**	**(157,029)**	**43,004**	**190**	**137,911**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year		(56,798)			**(56,798)**
Net gain / (loss) on revaluation of property, plant, equipment			1,380		**1,380**
Impairments and reversals			571		**571**
Transfers between reserves		952	(952)	0	**0**
Temporary and permanent PDC received - cash	6,735				**6,735**
Temporary and permanent PDC repaid in year	(2,818)				**(2,818)**
Other movements	0	1	0	0	**1**
Net recognised revenue/(expense) for the year	**3,917**	**(55,845)**	**999**	**0**	**(50,929)**
Balance at 31 March 2017	**255,663**	**(212,874)**	**44,003**	**190**	**86,982**
Balance at 1 April 2015	**242,724**	**(92,640)**	**58,061**	**190**	**208,335**
Changes in taxpayers' equity for the year ended 31 March 2016					
Retained surplus/(deficit) for the year		(65,800)			(65,800)
Net gain / (loss) on revaluation of property, plant, equipment			2,913		2,913
Impairments and reversals			(16,558)		(16,558)
Transfers between reserves		1,411	(1,411)	0	0
New PDC received - cash	9,022				9,022
Other movements	0	0	(1)	0	(1)
Net recognised revenue/(expense) for the year	**9,022**	**(64,389)**	**(15,057)**	**0**	**(70,424)**
Balance at 31 March 2016	**251,746**	**(157,029)**	**43,004**	**190**	**137,911**

Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Trust or NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend.

2 **Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the NHS Trust.

3 **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.

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

Statement of Cash Flows for the year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(51,677)**	(59,656)
Depreciation and amortisation	7	**11,733**	11,448
Impairments and reversals	17	**(509)**	8,557
Donated Assets received credited to revenue but non-cash	5	**(35)**	(138)
(Increase)/Decrease in Inventories		**(639)**	608
(Increase)/Decrease in Trade and Other Receivables		**(2,887)**	319
Increase/(Decrease) in Trade and Other Payables		**3,247**	5,877
(Increase)/Decrease in Other Current Liabilities		**(503)**	(503)
Provisions utilised		**(724)**	(1,230)
Increase/(Decrease) in movement in non cash provisions		**966**	247
Net Cash Inflow/(Outflow) from Operating Activities		**(41,028)**	(34,471)
Cash Flows from Investing Activities			
Interest Received		**48**	70
(Payments) for Property, Plant and Equipment		**(13,215)**	(21,167)
(Payments) for Intangible Assets		**(1,460)**	(852)
Proceeds of disposal of assets held for sale (PPE)		**24**	114
Net Cash Inflow/(Outflow) from Investing Activities		**(14,603)**	(21,835)
Net Cash Inform / (outflow) before Financing		**(55,631)**	(56,306)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**6,735**	9,022
Gross Temporary and Permanent PDC Repaid		**(2,818)**	0
Loans received from DH - New Revenue Support Loans		**56,548**	85,403
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**0**	(31,403)
Other Loans Repaid		**(118)**	(118)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**137**	(164)
Interest paid		**(1,424)**	(681)
PDC Dividend (paid)/refunded		**(2,920)**	(5,597)
Net Cash Inflow/(Outflow) from Financing Activities		**56,140**	56,462
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**509**	156
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,166**	1,010
Cash and Cash Equivalents (and Bank Overdraft) at year end	21	**1,675**	1,166

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

Going Concern

These accounts have been prepared on a going concern basis.

Financial Position

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue .as a going concern. In the context of non-trading entities in the public sector, as defined within the Government Financial Reporting Manual (FReM), the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors has considered the Trust's overall financial position against the requirements of IAS1.

Continuity of Service

The Trust recorded a deficit of £56.9m which was £9.0m below the planned deficit of £47.9m in 2016-17. This position included core STF funding of £9.7m received as the Trust met its STF financial trajectories for the first three quarters, operational trajectories were not achieved. Further, the Trust delivered £17.1m, of which £8.6m was recurrent, of its challenging CIP programme.

The Board of Directors and NHS Improvement approved the Trust's two-year plan of £48.6m deficit in 2017/18 and £48.1m deficit in 2018/19. The Trust continues to receive the majority of its patient care income from Lincolnshire Clinical Commissioning Groups. The plan also recognises risks to its delivery such as the ability to flex capacity to meet the demand during the year and delivery of the STF finance and performance targets. Non-recurrent STF funding of £14. 7m is included In each of the two years. The plans include CIP programme delivery of £18.0m in 2017/18 and £16.2m in 2018/19.

Further, the new five year Sustainability and Transformation Plan (STP) has been published for Lincolnshire. This is a nationally required five year health and care plan for the whole of Lincolnshire to improve health, wellbeing and quality, as well as bring the whole health system back into financial balance by 2021.

The STP is an evolution of previous collaborative work undertaken with other Lincolnshire NHS and Social Care organisations under the title ‘Lincolnshire Health and Care’ (LHAC), the key aim of which was to assess the county wide strategic provision of services across all health and social care bodies. In turn offering the potential for large scale service reconfiguration and rationalisation and therefore reduced costs through improved efficiency and a reduction in duplication.

In parallel with the STP the Trust is developing its own five year plan called the 2021 Strategy. This is the practical application of STP themes to the transformation of services delivered by this Trust.

The approved plans supported by the publication of the STP and five year plans offer a clear signal and constitute reasonable evidence that the NHS intends that the Trust will continue to provide healthcare services to the people of Lincolnshire.

Financing:

The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006,s42a) to continue to deliver the full range of mandatory services for the foreseeable future. The Trust has been reliant on cash support from the Department of Health in meeting its payment obligations and has drawn down a total of £110.548m at 31 March 2017.

Of the revenue support loans, £35.62m is repayable in November 2018. The Department of Health is yet to advise of refinancing arrangements regarding this loan however the uncertainty about the refinancing does not of itself affect the Trust's going concern basis.

The Board of Directors has therefore satisfied itself that on the basis that the Trust will continue to provide healthcare services and that its cash requirements will be supported by the Department of Health, it considers it appropriate that the accounts for the year ended 31 March 2017 should be prepared on a Going Concern basis.

1.2 Charitable Funds

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.

NOTES TO THE ACCOUNTS

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

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

Completed activity under Payment by Results is billed one month in arrears. Any disputed activity must then be queried and that query resolved within 2 months. The Trust has assumed that all invoiced activity recorded as income as at 31 March 2017 will be paid in full.

1.3.2 Key sources of estimation uncertainty

Management do not consider that there are any estimates which create a significant risk of causing a material uncertainty. However, the following are areas of estimation or judgement which have a major effect on the amounts recognised in the financial statements:

Property Plant and Equipment Valuations:
An annual revaluation of Trust Property, Plant and Equipment is conducted by Cushman & Wakefield formerly (DTZ Debenham Tie Leung Ltd (DTZ)). 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. The value of land, buildings and dwellings post revaluation was £189.9m and is detailed at note 15.1.

The Trust entered into a contract with a third party in 2006 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 under-occupancy charges have been estimated for the relevant properties based upon trends over the preceding 6, 12 and 24 months (after excluding any identified short term fluctuations) ending February 2016. The assets associated with this 'onerous' contract are impaired based upon this assessment.

Pension Costs:
Details of the actuarial assumptions used in calculating the Trust's pension liabilities are provided in note 9.3.

Income estimates:
Included in the income figure is an estimate for partially completed spells, i.e. treatment for admitted patients which is ongoing at the 31 March each year. This income is estimated based on the average speciality tariff applicable to each spell and adjusted for the portion of work completed at the end of the financial year.
For patients occupying a bed as at 31 March 2017, the estimated income from partially completed spells was £3.6m (31 March 2016: £4.8m). Similarly income received for the period of antenatal care has been deferred where this provision has not been completed, this totalled £2.2m (31 March 2016: £1.5m).

Provisions:
Assumptions around the timing of cash flows relating to provisions are based on information from the NHS Pensions Agency, expert legal opinion within the Trust and external advisors regarding when and how litigation issues may be settled.

Provisions recognised by the Trust at 31 March 2017 include legal actions against the Trust in relation to employers and public liability claims as well as employment, commercial and 'regulatory' litigation. The outcome of each individual case is uncertain and will only be determined through future legal proceedings. Key sources of information in determining the appropriate provision to recognise are reports from the NHS Litigation Authority and Trust solicitor detailing ongoing claims against the Trust and which provide an assessment of the probable outcome and costs. Total provisions recognised at 31 March 2017 were £4.4m (31 March 2016: £3.8m). See note 29.

Contingent Liabilities:
Reports from the Trust solicitor are utilised to assess potential outcome and costs. Where the potential for the claim succeeding is less than 50% but considered not to be remote, a contingent liability is recorded. These total £3.0m at 31 March 2017 (31 March 2016: £0.3m). See note 30.

Inventories:
The Trust information systems are unable to accurately identify the figures for 'Inventories recognised as expenses' under Note 19. The Trust has therefore estimated this figure using data extracted from the Ascribe stock system for drugs (£39.5m) and purchases through NHS Supply Chain (£11.2m).

Trade and other payables:
Outstanding pay liabilities incorporate estimates for:
• Annual Leave - based upon average pay rates for 2016-17 and leave carried forward as assessed through a Trust wide sample and reports extracted from the Trust Rostering system.
• Overtime and enhancements relating to March 2017 - based upon actual payments for a 'similar' accounting period.
• Agency - based upon details of unclaimed 'booked' shifts going back 3 months.

NOTES TO THE ACCOUNTS

1.4 Revenue

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

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

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

1.5 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

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

1.6 Other expenses

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

NOTES TO THE ACCOUNTS

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives (< 10 years) or low values (< £1m) or both, as this is not considered to be materially different from current value in existing use.
Above this threshold, assets are carried at current value with full professional valuations obtained every five years with interim professional valuations in year three.
Assets purchased under a finance lease are held at the net present value of the minimum lease payments discounted using the implicit interest rate.
Equipment surplus to requirements is valued at net recoverable amount.

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

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

1.8 Intangible assets

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

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

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

1.9 Depreciation, amortisation and impairments

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

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

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

NOTES TO THE ACCOUNTS

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

1.10 Donated assets

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

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

1.13 Leases

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

The Trust as lessee

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

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

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

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

The Trust as lessor

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

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

1.14 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability. The nature of the PFI held by United Lincolnshire Hospitals means that no operating expenses are recorded.

PFI Asset

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

PFI liability

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

NOTES TO THE ACCOUNTS

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Trust through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.15 Inventories

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

1.16 Cash and cash equivalents

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

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

1.17 Provisions

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

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

All percentages are in real terms.

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

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

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 29.

1.19 Non-clinical risk pooling

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

1.20 Contingencies

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

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

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

1.21 Financial liabilities

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

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

1.22 Value Added Tax

NOTES TO THE ACCOUNTS

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

1.23 Foreign currencies

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

1.24 Third party assets

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

1.25 Public Dividend Capital (PDC) and PDC dividend

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

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

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

1.26 Losses and Special Payments

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

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

1.27 Research and Development

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

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

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

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

1.29 Gifts

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

2. Operating segments

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

Revenue from activities (medical treatment of patients) is analysed by customer type in note 4 to the financial statements.
Other operating revenue is analysed in note 5 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.

	2016-17		2015-16	
	£000s	**%**	£000s	%
Revenue from whole HM Government	**425,345**	**97.3**	411,686	97.2
Revenue from non HM Government sources	**11,979**	**2.7**	11,742	2.8
Total	**437,324**	**100.0**	423,428	100.0

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - aggregate of all schemes	**2016-17 £000s**	2015-16 £000s
Income	4,740	4,461
Full cost	2,591	2,645
Surplus/(deficit)	**2,149**	1,816

2016-17 and 2015-16 figures comprise catering and car parking income from the public and staff.

Catering	**2016-17 £000s**	2015-16 £000s
Income	**2,111**	1,936
Full cost	**(1,936)**	(2,062)
Surplus/(deficit)	**175**	(126)

Car Parking	**2016-17 £000s**	2015-16 £000s
Income	**2,629**	2,525
Full cost	**(655)**	(583)
Surplus/(deficit)	**1,974**	1,942

4. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	307	361
NHS England	61,593	61,726
Clinical Commissioning Groups	326,804	316,286
Foundation Trusts	66	52
Department of Health	29	16
NHS Other (including Public Health England and Prop Co)	188	254
Additional income for delivery of healthcare services	0	5,000
Non-NHS:		
Private patients	551	536
Overseas patients (non-reciprocal)	177	34
Injury costs recovery	1,542	1,420
Other	1,170	1,155
Total Revenue from patient care activities	**392,427**	386,840

Additional income for delivery of healthcare services in 2015-16 related to a transfer from capital to revenue.

5. Other operating revenue

	2016-17 £000s	2015-16 £000s

Recoveries in respect of employee benefits	2,312	2,179
Education, training and research	18,530	18,528
Receipt of charitable donations for capital acquisitions	35	138
Non-patient care services to other bodies	5,204	6,553
Sustainability & Transformation Fund Income	9,660	0
Income generation (Other fees and charges)	4,740	4,461
Rental revenue from finance leases	173	161
Rental revenue from operating leases	433	485
Other revenue	3,810	4,083
Total Other Operating Revenue	**44,897**	36,588
Total Operating Revenue	**437,324**	423,428

6. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**177**	**34**
Cash payments received in-year (re receivables at 31 March 2016)	**16**	**11**
Cash payments received in-year (iro invoices issued 2016-17)	**62**	**13**
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**4**	**0**
Amounts added to provision for impairment of receivables (iro invoices issued 2016-17)	**74**	**6**
Amounts written off in-year (irrespective of year of recognition)	**4**	**6**

7. Operating expenses

	2016-17 £000s	2015-16 £000s
Purchase of healthcare from non-NHS bodies*	**1,342**	0
Trust Chair and Non-executive Directors	**87**	93
Supplies and services - clinical	**105,787**	105,138
Supplies and services - general	**7,396**	7,268
Consultancy services	**4**	283
Establishment	**5,304**	4,998
Transport	**915**	909
Business rates paid to local authorities	**1,939**	1,633
Premises	**14,313**	16,035
Hospitality	**9**	9
Insurance	**46**	40
Legal Fees	**460**	279
Impairments and Reversals of Receivables	**99**	52
Inventories write down	**88**	541
Depreciation	**10,328**	10,242
Amortisation	**1,405**	1,206
Impairments and reversals of property, plant and equipment	**(509)**	8,557
Internal Audit Fees	**171**	137
Audit fees	**110**	110
Other auditor's remuneration	**12**	12
Clinical negligence	**19,959**	17,655
Education and Training	**1,306**	1,035
Change in Discount Rate	**315**	(10)
Other	**2,984**	986
Total Operating expenses (excluding employee benefits)	**173,870**	177,208
Employee Benefits*		
Employee benefits excluding Board members	313,684	304,584
Board members	1,447	1,292
Total Employee Benefits	**315,131**	305,876
Total Operating Expenses	**489,001**	483,084

*Purchase of Healthcare costs from non-NHS bodies of £0.9m were incorrectly included as Agency costs within Employee Benefits and £1.5m were incorrectly recorded in Supplies Clinical in 2015-16.

Audit fees are stated above inclusive of VAT. The VAT exclusive expenditure was £91,913.

Other auditor's remuneration relates to the assurance and audit work performed on the Trust's Quality Accounts. This is also stated inclusive of VAT. The VAT exclusive expenditure was £10,000.

8. Operating Leases

The majority of the Trust's leasing arrangements are for plant and equipment supplied under normal commercial terms by non-NHS suppliers. There is no contingent rent associated with the arrangements.

In 2011-12 the Trust entered into a short term operating lease for land on the Lincoln site. This lease expired in March 2016. The two parties are currently in negotiations to extend the lease on a twelve month rolling basis.

In 2012-13 the Trust entered into a short term operating lease for buildings at Louth. This lease expires in December 2018.

The Trust leases various items of medical equipment. These leases expire in the period to September 2021.
The Trust has numerous vehicles leased which expire before December 2020.

8.1. United Lincolnshire Hospitals NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense					
Minimum lease payments				1,519	1,618
Contingent rents				0	0
Sub-lease payments				0	0
Total				**1,519**	1,618
Payable:					
No later than one year	1,282	0	287	**1,569**	1,553
Between one and five years	962	0	272	**1,234**	2,570
After five years	0	0	0	**0**	0
Total	**2,244**	**0**	**559**	**2,803**	4,123
Total future sublease payments expected to be received:				0	0

8.2. United Lincolnshire Hospitals NHS Trust as lessor

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

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	191	427
Contingent rents	242	58
Total	**433**	485
Receivable:		
No later than one year	524	192
Between one and five years	968	315
After five years	1,374	585
Total	**2,866**	1,092

An error was identified in the 2015-16 reported receivables. Amended comparators are as follows:

No later than one year	£549,000
Between 1-5 years	£1,188,000
After 5 years	£1,498,000

9. Employee benefits

9.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**266,334**	262,341
Social security costs	**22,018**	17,008
Employer Contributions to NHS BSA - Pensions Division	**27,483**	26,607
Other pension costs	**26**	17
Termination benefits	**9**	271
Total employee benefits	**315,870**	306,244
Employee costs capitalised	**739**	368
Gross Employee Benefits excluding capitalised costs	**315,131**	305,876

'Other pension costs' relate to payments into the National Employment Savings Trust (NEST) defined benefit scheme.

9.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**4**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**247**	318

9.3. Pension costs

The Pensions Act 2008 introduced a new requirement for employers to automatically enrol workers into a workplace pension scheme if they:
- earn over £10,000 per annum
- are aged over 22
- are under state pension age

The majority of workers will be enrolled into the NHS Pension Scheme. However in limited circumstances, for example where an employee is already in receipt of an NHS Pension, an alternative is provided through the National Employment Savings Trust (NEST).

NHS Pension Scheme

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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 to meet their duty to enrol all eligible workers into a workplace pension automatically.
NEST is a defined contribution scheme.

10. Better Payment Practice Code

10.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**136,595**	**171,085**	124,975	168,197
Total Non-NHS Trade Invoices Paid Within Target	**112,444**	**132,918**	106,663	138,397
Percentage of NHS Trade Invoices Paid Within Target	**82.32%**	**77.69%**	85.35%	82.28%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,455**	**39,147**	1,929	**37,262**
Total NHS Trade Invoices Paid Within Target	**1,768**	**29,462**	1,345	**31,973**
Percentage of NHS Trade Invoices Paid Within Target	**72.02%**	**75.26%**	69.73%	85.81%

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 a valid invoice, whichever is later.

10.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**0**	1
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	1

11. Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**47**	70
Total investment revenue	**47**	70

12. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(71)**	**(76)**
Gain (Loss) on disposal of assets held for sale	**20**	**26**
Total	**(51)**	(50)

13. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**1,941**	**850**
Interest on obligations under finance leases*	**(15)**	**19**
Interest on late payment of commercial debt	**0**	**1**
Total interest expense	**1,926**	870
Provisions - unwinding of discount	**37**	**36**
Total	**1,963**	906

* See also Finance Leases note 27

14. Auditor Disclosures

14.1. Other auditor remuneration

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

15.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2016	12,186	153,841	23,159	5,891	53,760	774	9,242	406	**259,259**
Additions of Assets Under Construction				5,435					**5,435**
Additions Purchased	0	1,548	0		6,002	0	1,407	23	**8,980**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	15	0	8	6	**29**
Reclassifications	0	1,065	0	(4,804)	2,051	0	756	0	**(932)**
Reclassifications as Held for Sale and reversals	(61)	(115)	0	0	(672)	(23)	0	0	**(871)**
Disposals other than for sale	0	0	0	(36)	(3,038)	0	(2,794)	(72)	**(5,940)**
Revaluation	0	326	8	0	227	0	0	0	**561**
Impairments/reversals charged to operating expenses	0	(2,267)	1,549	0	0	0	0	0	**(718)**
Impairments/reversals charged to reserves	0	(1,053)	(322)	0	0	0	0	0	**(1,375)**
At 31 March 2017	**12,125**	**153,345**	**24,394**	**6,486**	**58,345**	**751**	**8,619**	**363**	**264,428**
Depreciation									
At 1 April 2016	0	0	0		37,630	528	5,131	202	**43,491**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0		(668)	(23)	0	0	**(691)**
Disposals other than for sale	0	0	0		(3,017)	0	(2,794)	(58)	**(5,869)**
Revaluation	0	(819)	0		0	0	0	0	**(819)**
Impairment/reversals charged to reserves	0	(1,648)	(298)		0	0	0	0	**(1,946)**
Impairments/reversals charged to operating expenses	0	(1,191)	(36)		0	0	0	0	**(1,227)**
Charged During the Year	0	3,658	334		4,745	47	1,495	49	**10,328**
At 31 March 2017	**0**	**0**	**0**	**0**	**38,690**	**552**	**3,832**	**193**	**43,267**
Net Book Value at 31 March 2017	**12,125**	**153,345**	**24,394**	**6,486**	**19,655**	**199**	**4,787**	**170**	**221,161**
Asset financing:									
Owned - Purchased	12,125	152,858	0	6,486	18,986	152	4,748	155	**195,510**
Owned - Donated	0	418	0	0	442	47	39	15	**961**
Owned - Government Granted	0	69	0	0	0	0	0	0	**69**
Held on finance lease	0	0	0	0	227	0	0	0	**227**
On-SOFP PFI contracts	0	0	24,394	0	0	0	0	0	**24,394**
Total at 31 March 2017	**12,125**	**153,345**	**24,394**	**6,486**	**19,655**	**199**	**4,787**	**170**	**221,161**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	2,679	31,039	9,267	0	19	0	0	0	**43,004**
Movements:									
Excess Depreciation	0	(794)	(172)	0	(18)	0	0	0	**(984)**
Revaluations / Impairments		1,740	16		227				**1,983**
At 31 March 2017	**2,679**	**31,985**	**9,111**	**0**	**228**	**0**	**0**	**0**	**44,003**

Additions to Assets Under Construction in 2016-17

Buildings excl Dwellings	4,405
Plant & Machinery	1,030
Balance as at YTD	**5,435**

15.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	11,985	160,825	23,668	10,582	51,770	819	9,024	370	**269,043**
Additions of Assets Under Construction				18,096					**18,096**
Additions Purchased	0	600	0		1,172	0	767	46	**2,585**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	138	0	0	0	**138**
Reclassifications	0	19,817	0	(22,786)	2,411	0	0	0	**(558)**
Reclassifications as Held for Sale and Reversals	(1,075)	0	0	0	(1,013)	(30)	0	0	**(2,118)**
Disposals other than for sale	0	(88)	0	(1)	(718)	(15)	(549)	(10)	**(1,381)**
Revaluation	1,276	485	0	0	0	0	0	0	**1,761**
Impairment/reversals charged to reserves	0	(9,155)	(509)	437	0	0	0	0	**(9,227)**
Impairments/reversals charged to operating expenses	0	(18,643)	0	(437)	0	0	0	0	**(19,080)**
At 31 March 2016	**12,186**	**153,841**	**23,159**	**5,891**	**53,760**	**774**	**9,242**	**406**	**259,259**
Depreciation									
At 1 April 2015	0	0	0		34,788	525	4,409	167	**39,889**
Reclassifications as Held for Sale and Reversals	0	0	0		(1,006)	(30)	0	0	**(1,036)**
Disposals other than for sale	0	(50)	0		(657)	(15)	(528)	(10)	**(1,260)**
Revaluation	0	(817)	(335)		0	0	0	0	**(1,152)**
Impairment/reversals charged to reserves	0	(2,522)	0		0	0	0	0	**(2,522)**
Impairments/reversals charged to operating expenses	0	(670)	0		0	0	0	0	**(670)**
Charged During the Year	0	4,059	335		4,505	48	1,250	45	**10,242**
At 31 March 2016	**0**	**0**	**0**	**0**	**37,630**	**528**	**5,131**	**202**	**43,491**
Net Book Value at 31 March 2016	**12,186**	**153,841**	**23,159**	**5,891**	**16,130**	**246**	**4,111**	**204**	**215,768**
Asset financing:									
Owned - Purchased	12,186	153,358	0	5,891	15,331	188	4,063	193	**191,210**
Owned - Donated	0	415	0	0	685	58	48	11	**1,217**
Owned - Government Granted	0	68	0	0	0	0	0	0	**68**
Held on finance lease	0	0	0	0	114	0	0	0	**114**
On-SOFP PFI contracts	0	0	23,159	0	0	0	0	0	**23,159**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2016	**12,186**	**153,841**	**23,159**	**5,891**	**16,130**	**246**	**4,111**	**204**	**215,768**

15.3. (cont). Property, plant and equipment

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

Donor description	**£000s**
United Lincolnshire Hospitals NHS Trust Charitable Fund	35
Total Donated assets received in 2016-17	**35**

The Trust wishes to thank those who have contributed to Charitable Funds during the year enabling the purchase of medical and other equipment. These items will be used to improve patient care and experience in hospital.

The Trust commissioned a desktop revaluation of land, buildings and dwellings in March 2017. This revaluation was conducted by Mr D.M. Wilson MRICS of Cushman & Wakefield formerly (DTZ Debenham Tie Leung Ltd (DTZ)) and was based upon depreciated replacement cost using the modern equivalent basis of valuation.

Progress Care Housing Association Ltd accommodation units are valued at open market value based on existing use.

Land and Buildings which are no longer in operational use and are therefore 'surplus' have been valued as follows:

Restrictions on sale - Non specialised:	Wanta House, Boston
No restrictions on sale - Fair Value	Field, Lincoln
	Farmland, Boston
	Old hospital frontage, Grantham
Assets held for sale - Fair value	Welland Hospital site, Spalding
	Laundon House, Sleaford

The following table provides details of property valued on an open market	**2016-17**	2015-16
	£000s	£000s
Land	755	815
Dwellings	24,394	23,159
Buildings	0	116
Total	**25,149**	24,090

Accounting policies notes 1.3.2, 1.7 and 1.12 provide further information regarding the method of valuation.
The asset lives for intangibles and plant and equipment are calculated when the asset is initially recognised. The lives for buildings and dwellings are in accordance with the latest valuation report prepared by the external valuer.

The minimum and maximum asset lives by asset category are as follows:-

	Asset Life	
Intangibles	**Minimum**	**Maximum**
Software Licences	3	15
IT - in house & 3rd Party Software	5	5
Property, Plant and Equipment		
Buildings exc Dwellings	4	82
Dwellings	60	78
Plant and Machinery	2	15
Transport Equipment	5	11
Information Technology	3	10
Furniture and fittings	5	10

During 2016-17 there were two small fires on Trust properties.
The first of these was at Grantham in April 2016 and the second at Boston in March 2017.
In both cases the Trust is insured through the NHS Litigation Authority's Property Expenses Scheme. Estimates of the insurance monies due for buildings / contents and business interruption are included within the SOCI (Grantham £152,600, Boston £68,000).
The Grantham fire was located within the plantroom; this has subsequently been repaired.
The Boston fire was located on the top floor of the Tower Block. This is currently out of use and is impaired. Further details are provided within note 17.

The gross value of fully depreciated assets still in use is £10.58m (2015-16 £17.93m).

A number of buildings owned by the Trust are leased out under operating leases to other NHS bodies. The net book value of these assets at 31st March 2017 was £3.4m as set out in the table below:

	2016-17	2015-16
	£000s	£000s
Net book value 1 April	2,429	5,374
Additions	52	232
Disposals	(292)	(3,225)
Depreciation	(61)	(74)
Increase in valuation 31 March 2017	1,280	456
impairments	(3)	(334)
Net book value 31 March	**3,405**	**2,429**

16. Intangible non-current assets

16.1. Intangible non-current assets

	IT - in-house & 3rd party software	Computer Licenses	Intangible Assets Under Construction	Total
2016-17				
	£000's	**£000's**	**£000's**	**£000's**
At 1 April 2016	**20**	**9,962**	**0**	**9,982**
Additions of Assets Under Construction			391	**391**
Additions Purchased	0	521	0	**521**
Additions - Non Cash Donations (i.e. physical assets)	0	6	0	**6**
Reclassifications	0	932	0	**932**
Disposals other than by sale	0	(1,147)	0	**(1,147)**
At 31 March 2017	**20**	**10,274**	**391**	**10,685**
Amortisation				
At 1 April 2016	**20**	**4,355**		**4,375**
Disposals other than by sale	**0**	**(1,147)**		**(1,147)**
Charged During the Year	**0**	**1,405**		**1,405**
At 31 March 2017	**20**	**4,613**	**0**	**4,633**
Net Book Value at 31 March 2017	**0**	**5,661**	**391**	**6,052**
Asset Financing: Net book value at 31 March 2017 comprises:				
Purchased	0	5,635	391	**6,026**
Donated	0	26	0	**26**
Total at 31 March 2017	**0**	**5,661**	**391**	**6,052**

Revaluation reserve balance for intangible non-current assets

	£000's	**£000's**	**£000's**	**£000's**
At 1 April 2016	0	0	0	**0**
Movements	0	0	0	**0**
At 31 March 2017	**0**	**0**	**0**	**0**

16.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software	Computer Licenses	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's
Cost or valuation:				
At 1 April 2015	20	9,122	0	**9,142**
Additions - purchased	0	478	0	**478**
Reclassifications	0	558	0	**558**
Disposals other than by sale	0	(196)	0	**(196)**
At 31 March 2016	**20**	**9,962**	**0**	**9,982**
Amortisation				
At 1 April 2015	20	3,345	0	**3,365**
Disposals other than by sale	0	(196)	0	**(196)**
Charged during the year	0	1,206	0	**1,206**
At 31 March 2016	**20**	**4,355**	**0**	**4,375**
Net book value at 31 March 2016	**0**	**5,607**	**0**	**5,607**
Net book value at 31 March 2016 comprises:				
Purchased	0	5581	0	**5,581**
Donated	0	26	0	**26**
Total at 31 March 2016	**0**	**5,607**	**0**	**5,607**

16.3. Intangible non-current assets

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 amoritised assets still in use and reported within Computer Licenses had an original purchase cost of £0.51m.

17. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment	Intangible Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI				
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**
Other	(63)	0	0	**(63)**
Changes in market price	(446)	0	0	**(446)**
Total charged to Annually Managed Expenditure	**(509)**	**0**	**0**	**(509)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(509)**	**0**	**0**	**(509)**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

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

	£000s	£000s
Reversals of impairments charged to SOCI in previous years		
Phase 2 Lincoln increase in valuation	(452)	
Other - buildings	(394)	
		(846)
Impairments charged to SOCI in current year		
Other buildings	400	
		400
		(446)

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

	£000s	£000s
Reversal of impairments charged to SOCI in previous years		
Progress Care Housing Association Onerous Contract net reversal (see below**)		(1,584)
Impairments Charged to SOCI in current year		
Pilgrim Tower Block 1st floor out of use due to improvement works	877	
Pilgrim Tower Block Stroke Unit temporarily out of use following fire (March 2017)	261	
Other buildings impaired due to obsolescence*	383	
		1,521
		(63)

* As part of the annual revaluation the Trust assesses functional and external obsolescence. This information is taken into account by the valuer and has resulted in a reduction in valuation on those properties where obsolescence has materially changed.

**As set out in notes 1.3.2 and 31, the Trust entered into a contract with a third party in 2006 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 assets associated with this 'onerous' contract are reviewed and impaired annually as appropriate based upon an assessment of future occupancy levels.

Impairments charged / (reversed) in 2016-17 against this contract were:

Site:	£000s
Lincoln	0
Boston	(2,220)
Grantham	636
Total	**(1,584)**

	2016-17 Total £000s
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Other	104
Changes in market price	(675)
Total impairments for PPE charged to reserves	**(571)**

18. Commitments

18.1. Capital commitments

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

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	1,696	2,655
Intangible assets	106	0
Total	**1,802**	2,655

19. Inventories

	Drugs	Consumables	Energy	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**2,611**	**4,502**	**17**	**7,130**	7,130
Additions	39,494	11,461	95	**51,050**	51,050
Inventories recognised as an expense in the period	(39,083)	(11,145)	(95)	**(50,323)**	(50,323)
Write-down of inventories (including losses)	(120)	(12)	0	**(132)**	(132)
Reversal of write-down previously taken to SOCI*	0	44	0	**44**	44
Balance at 31 March 2017	**2,902**	**4,850**	**17**	**7,769**	**7,769**

* Theatre inventories were written down in 2015-16 where it was anticipated that it would not be possible to use certain consumables. During 2016-17 some of the items have been utilised.

20.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**5,274**	3,107	**0**	0
NHS prepayments and accrued income	**10,973**	10,164	**0**	0
Non-NHS receivables - revenue	**1,064**	835	**0**	0
Non-NHS prepayments and accrued income	**4,023**	4,328	**0**	0
PDC Dividend prepaid to DH	**174**	408		
Provision for the impairment of receivables	**(506)**	(381)	**(361)**	(416)
VAT	**1,062**	880	**0**	0
Operating lease receivables	**112**	57	**0**	0
Other receivables	**2,104**	1,729	**1,572**	1,893
Total	**24,280**	21,127	**1,211**	1,477
Total current and non current	**25,491**	22,604		
Included in NHS receivables are prepaid pension contributions:	**0**			

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

Other receivables includes £3.1m (of which £1.6m is non current) relating to the injury cost recovery scheme administered by the Department of Work and Pensions.

20.2. Receivables past their due date but not impaired

	31 March 2017 £000s	31 March 2016 £000s
By up to three months	**2,067**	1,220
By three to six months	**385**	7
By more than six months	**446**	279
Total	**2,898**	1,506

NHS receivables past their due date account for £2.7m of the total.

20.3. Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	**(797)**	(768)
Amount written off during the year	**29**	23
Amount recovered during the year	**33**	107
(Increase)/decrease in receivables impaired	**(132)**	(159)
Balance at 31 March 2017	**(867)**	(797)

The provision for impairment of receivables incorporates two elements:
- a specific provision against invoiced receivables where the Trust believes that it is unlikely to receive payment: £153,000 (2015-16 £102,000)
- a general provision of 22.94% (2015-16: 21.99%) against income receivable from the Compensation Recovery Unit (CRU): £714,000 (2015-16 £695,000).

Amounts reported as written off or recovered represent invoiced receivables only.

21. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**1,166**	1,010
Net change in year	**509**	156
Closing balance	**1,675**	1,166
Made up of		
Cash with Government Banking Service	**1,665**	1,155
Cash in hand	**10**	11
Cash and cash equivalents as in statement of financial position	**1,675**	1,166
Cash and cash equivalents as in statement of cash flows	**1,675**	1,166
Third Party Assets - Monies on deposit	**0**	0

22. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Plant and Machinery	Total
	£000s	£000s	£000s	£000s
Balance at 1 April 2016	1,075	0	0	**1,075**
Plus assets classified as held for sale in the year	61	115	4	**180**
Less assets sold in the year	0	0	(4)	**(4)**
Balance at 31 March 2017	**1,136**	**115**	**0**	**1,251**
Liabilities associated with assets held for sale at 31 March 2017	**0**	**0**	**0**	**0**
Balance at 1 April 2015	0	0	0	**0**
Plus assets classified as held for sale in the year	1,075	0	7	**1,082**
Less assets sold in the year	0	0	(7)	**(7)**
Balance at 31 March 2016	**1,075**	**0**	**0**	**1,075**
Liabilities associated with assets held for sale at 31 March 2016	0	0	0	0

In 2016-17 the Trust has re-classified land and Buildings at Laundon House previously used as Hospital buildings as 'held for sale'. This is valued at market value less costs of sale at £0.176m.
The property is currently vacant and is being actively marketed and an offer has been accepted.

The Land at the site of the former Welland Hospital is held at £1.075m. As at the 31st March 2017 contracts for sale had been signed. Exchange is expected during 2017/18.

Equipment sold in 2016-17 related predominantly to various items of medical equipment, sold to external parties at a profit of £20,440.

23. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**3,528**	2,624	**0**	0
NHS accruals and deferred income	**2,165**	1,524	**0**	0
Non-NHS payables - revenue	**13,481**	12,715	**0**	0
Non-NHS payables - capital	**5,319**	4,667	**0**	0
Non-NHS accruals and deferred income	**11,326**	10,813	**0**	0
Social security costs	**3,412**	2,801		
Accrued Interest on DH Loans	**386**	199		
Tax	**2,674**	2,608		
Other	**4,049**	4,069	**0**	0
Total	**46,340**	42,020	**0**	0
Total payables (current and non-current)	**46,340**	**42,020**		
Included above:				
outstanding Pension Contributions at the year end	**3,767**	3,713		

24. Other liabilities

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Lease incentives	**24**	24	**679**	704
Other*	**479**	479	**13,409**	13,887
Total	**503**	503	**14,088**	14,591
Total other liabilities (current and non-current)	**14,591**	**15,094**		

*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.

25. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Loans from Department of Health	**0**	0	**110,548**	54,000
Loans from other entities	**118**	118	**60**	178
Finance lease liabilities	**166**	181	**152**	0
Total	**284**	**299**	**110,760**	**54,178**
Total other liabilities (current and non-current)	**111,044**	**54,477**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	0	284	**284**
1 - 2 Years	35,618	212	**35,830**
2 - 5 Years	74,930	0	**74,930**
Over 5 Years	0	0	**0**
TOTAL	**110,548**	**496**	**111,044**

26. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**2,331**	2,920	**0**	0
Deferred revenue addition	**3,075**	2,331	**0**	0
Transfer of deferred revenue	**(2,331)**	(2,920)	**0**	0
Current deferred Income at 31 March 2017	**3,075**	2,331	**0**	0
Total deferred income (current and non-current)	**3,075**	2,331		

27. Finance lease obligations as lessee

The Trust is party to a 15 year finance lease with Dalkia Utility Services PLC (now Veolia Energy & Utility Services UL PLC) for the provision of a combined heat and power system.
Dalkia also manage and maintain the equipment during the term of the lease.

The lease commenced in 2004 and will end in 2019 at which point the legal title to the equipment will transfer to the Trust.
Under the terms of the lease the unitary charge is increased by reference to RPI. Gas prices vary by reference to gas commodity indices.

The end date of the lease is January 2019, this had previously been reported in error as March 2017. Accounting entries have been passed in 2016-17 to correct this misstatement and are reflected within the primary statements and the following notes:

Note 13: Finance Costs - Interest on obligations under finance leases

Note 25: Borrowings - Finance lease liabilities

Note 27: Amounts payable under finance leases (other)

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Within one year	**183**	188	**166**	181
Between one and five years	**157**	0	**152**	0
After five years	**0**	0	**0**	0
Less future finance charges	**(22)**	(7)		
Minimum Lease Payments / Present value of minimum lease payments	**318**	181	**318**	181
Included in:				
Current borrowings			**166**	181
Non-current borrowings			**152**	0
			318	181

Finance leases as lessee	**31 March 2017 £000s**	31 March 2016 £000s
Future Sublease Payments Expected to be received	**0**	0
Contingent Rents Recognised as an Expense	**0**	0

28. Finance lease receivables as lessor

The Trust owns 3 properties where it has granted long leases to other NHS bodies.

Ambulance Station at Boston Pilgrim Hospital	125 Years from 1992, annual rent of 1 peppercorn
Manthorpe Centre at Grantham Hospital	80 Years from 1997, annual rent of 1 peppercorn
Adult Mental Illness Unit at Boston Pilgrim Hospital	125 Years from 1993, annual rent 1 peppercorn

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

Rental revenue	**31 March 2017**	31 March 2016
Contingent rent	**173**	**161**
Other	**0**	**0**

29. Provisions

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**3,848**	2,671	1,153	24
Arising during the year	**1,254**	313	919	22
Utilised during the year	**(724)**	(205)	(515)	(4)
Reversed unused	**(288)**	(10)	(269)	(9)
Unwinding of discount	**37**	37	0	0
Change in discount rate	**315**	315	0	0
Balance at 31 March 2017	**4,442**	**3,121**	**1,288**	**33**
Expected Timing of Cash Flows:				
No Later than One Year	**1,516**	195	1,288	33
Later than One Year and not later than Five Years	**777**	777	0	0
Later than Five Years	**2,149**	2,149	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2017	211,792
As at 31 March 2016	193,591

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.

The provision for Early Departure Costs (Pensions) has been assessed by discounting current pension costs and applying average life expectancies. The amount and timing of cash flows are thus uncertain.

The provision for legal claims relates to third party liability and property expense claims and claims made against the Trust in relation to employment, commercial and other litigation issues. In addition to the amount provided within the Trust's accounts, details of contingent liabilities and assets relating to these claims are given in note 30. The Trust's legal advisors have assessed each claim and a provision has been made based upon the expected outcome of the claim, the related probability and the expected settlement date.

Other provisions relate to costs associated relocation expenses.

30. Contingencies

	31 March 2017	31 March 2016
	£000s	£000s
Contingent liabilities		
Employment Tribunal and other employee related litigation	**(380)**	(240)
Other	**(2,641)**	(70)
Net value of contingent liabilities	**(3,021)**	(310)
Contingent assets		
Contingent assets	**0**	20
Net value of contingent assets	**0**	20

Other contingent liabilities reported above comprise the potential costs and fines in excess of those provided for within provisions (note 29). The most significant element relates to a charge brought by the Health and Safety Executive following an incident in 2014/15. A hearing is scheduled for April / May 2017.

Similarly a provision for legal claims brought against the Trust in relation to Employment issues has been disclosed at note 29. This provision is assessed based upon the most likely outcome. The contingent liability reported within this note takes account of the potential liability in the event the Trust assessment is underestimated.

The specific breakdown of contingent liabilities is not disclosed as this information could prejudice the position of the Trust in certain cases.

There are no other contingent gains or liabilities which require disclosure in the accounts.

31. PFI and LIFT - additional information

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

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 31st 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. An assessment of historic occupancy levels and trends is undertaken annually as a means to estimate the potential future liability. The estimated future value of this liability is offset against the value of the asset.

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'. This is amortised to the income and expenditure account over 40 years with an end date of 31st March 2046.

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

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2016-17	2015-16
	£000s	£000s
No Later than One Year	**503**	503
Later than One Year, No Later than Five Years	**2,012**	2,012
Later than Five Years	**12,076**	12,579
Subtotal	**14,591**	15,094
Less: Interest Element	**0**	0
Total	**14,591**	15,094

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2016-17**	2015-16
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**503**	503
Later than One Year, No Later than Five Years	**2,012**	2,012
Later than Five Years	**12,076**	12,579
Total	**14,591**	15,094

Number of on SOFP PFI Contracts	
Total Number of on PFI contracts	**1**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

Number of off SOFP PFI Contracts	
Total Number of off PFI contracts	**0**
Number of off PFI contracts which individually have a total commitments value in excess of £500m	**0**

32. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes in order to calculate the adjustment required between accounting for PFI/LIFT expenditure under IFRS and European Standard 2010 (ESA10), upon which the national accounts are based.

	2016-17		2015-16	
	Income £000s	**Expenditure £000s**	Income £000s	Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)				
Depreciation charges		**334**		335
Impairment charge - AME		**(1,584)**		509
Impairment charge - DEL		**0**		0
Revenue Receivable from subleasing	**(503)**		(503)	
Impact on PDC dividend payable		**317**		282
Total IFRS Expenditure (IFRIC12)	**(503)**	**(933)**	**(503)**	**1,126**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		**0**		0
Net IFRS change (IFRIC12)		**(1,436)**		**623**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		0		0
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		0		0

	2016-17 Income/ Expenditure IFRIC 12 YTD **£000s**	**2016-17** Income/ Expenditure ESA 10 YTD **£000s**	2015-16 Income/ Expenditure IFRIC 12 YTD **£000s**	2015-16 Income/ Expenditure ESA 10 YTD **£000s**
Revenue costs of IFRS12 compared with ESA10				
Depreciation charges	**334**		335	
Impairment charge - AME	**(1,584)**		509	
Impairment charge - DEL	**0**		0	
Impact on PDC Dividend Payable	**317**		282	
Total Revenue Cost under IFRIC12 vs ESA10	**(933)**	**0**	**1,126**	**0**
Revenue Receivable from subleasing	**(503)**	**0**	**(503)**	**0**
Net Revenue Cost/(income) under IFRIC12 vs ESA10	**(1,436)**	**0**	**623**	**0**

33. Financial Instruments

33.1. 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 Clinical Commissioning Groups (CCGs) and the way those CCGs 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

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

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 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The United Lincolnshire Hospitals NHS Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, 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.

33.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0			**0**
Receivables - NHS		16,232		**16,232**
Receivables - non-NHS		4,494		**4,494**
Cash at bank and in hand		1,675		**1,675**
Other financial assets	0	0	0	**0**
Total at 31 March 2017	**0**	**22,401**	**0**	**22,401**
Embedded derivatives	0			0
Receivables - NHS		13,253		13,253
Receivables - non-NHS		4,966		4,966
Cash at bank and in hand		1,166		1,166
Other financial assets	0	0	0	0
Total at 31 March 2016	0	19,385	0	19,385

33.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0		**0**
NHS payables		5,693	**5,693**
Non-NHS payables		34,561	**34,561**
Other borrowings		110,726	**110,726**
PFI & finance lease obligations		14,909	**14,909**
Other financial liabilities	0	3,656	**3,656**
Total at 31 March 2017	**0**	**169,545**	**169,545**
Embedded derivatives	0		0
NHS payables		4,148	4,148
Non-NHS payables		32,463	32,463
Other borrowings		54,296	54,296
PFI & finance lease obligations		15,275	15,275
Other financial liabilities	0	5,309	5,309
Total at 31 March 2016	0	111,491	111,491

34. Events after the end of the reporting period

Health and Safety Executive Prosecution
During April 2017 a hearing took place at Lincoln Crown Court for a breach of Section 3(1) of the Health and Safety at Work Act 1999. The prosecution was brought by the Health and Safety Executive following the death of a patient in 2012.
The Trust was found guilty. A further hearing has been scheduled for July 2017 at which sentencing will be considered and handed down.

Based upon an assessment of the range of potential outcomes, the Trust has provided for potential fines of up to £0.6m (note 29) with a further £2.5m recorded as a contingent liability (note 30).

Cyber attack
On Friday 12 May 2017, the Trust shut down all major IT systems following a worldwide IT systems cyber-attack. The implications of this were felt Trustwide with the cancellation of clinics and patient appointments.
A phased approach was adopted in bringing systems back online with a near full service back in place within a period of one week.

The financial impact of this will be recorded in 2017/18, with lost income due to cancellation of appointments and lost activity as well as costs incurred in restoring systems and building additional resilience against potential future attacks.

Care Quality Commission
During October 2016 the CQC carried out an inspection of the Trust. The overall rating, published on 11 April 2017 was 'Inadequate'.
The Trust has subsequently entered into special measures and will be receiving additional support from NHS Improvement.

35. Related party transactions

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 2016/17 between the Trust and Organisations with whom Trust Senior Executives / Management hold positions of influence.
The income / expenditure values quoted are those attributable to the named related party and do not represent earnings of the individual.

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Mr D Fathers - Chairman ULHT / Vice Chair Mental Health Network - NHS Confederation	10,691	0	5,735	0
Mr D Fathers - Chairman ULHT / Chair - Nottinghamshire Healthcare NHS Foundation Trust	47,548	0	0	0
Mr D Fathers - Chairman ULHT / Senior Independent Director - JRI Orthopaedics	29,849	0	648	0
Mr D Fathers - Chairman ULHT / Board Member - East Midlands Leadership Academy	1,419	0	0	0
Mrs S Dunnett - Non Executive Director ULHT / Trustee / Hon Treasurer - Health Quality Improvement Partnership	33,512	0	22,339	0
Mrs S Dunnett - Non Executive Director ULHT / Trustee / The Miscarriage Association	1,068	0	312	0
Mrs S Dunnett - Non Executive Director ULHT / Non Executive Director / Peterborough & Stamford NHS Foundation Trust	805,746	2,780	833,604	0
Mr K Darwin - Associate Non Executive Director ULHT / Trustee - St Barnabas Hospice	130,455	1,121,260	108,418	154,174
Mr K Darwin - Associate Non Executive Director ULHT / Governor - University of Lincoln	117,516	220,267	221,758	898
Mr K Darwin - Associate Non Executive Director ULHT / Chairman - Investors in Lincoln	11,321	0	0	0
Prof S Barnett - Non Executive Director ULHT / Chief Executive Officer Rotherham NHS FT (spouse)	0	561	0	206
Mr N Dudley -Principal Physicist ULHT / Partner - Multi Medix Ltd	912	0	0	0
Mr M Oko (ENT Consultant) / The Snoring Disorders Centre Ltd	2,776,922	0	160,645	0

The Trust employs a number of consultants who in addition to their NHS duties derive varying levels of income from their work at the Trust's private patient unit. In 2016-17 this amounted to £282,116.

The Department of Health 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 Department. For example :

CCGs
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority
NHS Improvement
NHS England

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the Department for Work and Pensions, HM Revenue and Customs, the National Insurance Fund, NHS Pension Scheme, Health Education England, NHS Property Services, NHS Blood and Transplant, the City of Lincoln, Boston, North Kesteven and South Kesteven District Councils and Lincolnshire County Council.

The Trust has also received donations of £34,878 (2015-16: £122,879) to fund capital acquisitions from a number of charitable funds, the Corporate Trustee of which is the Trust board.

36. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	250,631	34
Special payments	360,076	276
Total losses and special payments and gifts	610,707	310

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	562,910	57
Special payments	615,806	259
Total losses and special payments	1,178,716	316

Included within the losses figure are losses resulting from the disposal / write off of out of date and obsolete stocks £0.09m (2015-16 £0.54m).

Special payments incorporate :
- payments made to Progress Housing under occupancy guarantee £0.08m (2015-16 £0.2m).
- payments made through the NHSLA for Employers / Liability to third Party scheme claims and other compensation payments under legal obligation £0.1m (2015-16 £0.4m).

37. Financial performance targets

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

37.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	294,154	344,309	353,280	391,141	392,202	407,975	422,802	425,524	433,250	423,428	437,324
Retained surplus/(deficit) for the year	(13,761)	12,488	366	(4,002)	(14,177)	(7,060)	(5,207)	(26,160)	(15,278)	(65,800)	(56,798)
Adjustments for impairments	0	0	4,821	5,284	297	6,873	5,192	327	(2)	8,557	(509)
Adjustments for impact of policy change re donated/government grants assets						507	139	4	45	212	268
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	0	0	0	16	74	114	148
Other agreed adjustments	15,043	0	0	0	0	0	0	0	0	0	0
Break-even in-year position	**1,282**	**12,488**	**5,187**	**1,282**	**(13,880)**	**320**	**124**	**(25,813)**	**(15,161)**	**(56,917)**	**(56,891)**
Break-even cumulative position	**(13,604)**	**(1,116)**	**4,071**	**5,353**	**(8,527)**	**(8,207)**	**(8,083)**	**(33,896)**	**(49,057)**	**(105,974)**	**(162,865)**

* 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.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	0.44	3.63	1.47	0.33	(3.54)	0.08	0.03	(6.07)	(3.50)	(13.44)	(13.01)
Break-even cumulative position as a percentage of turnover	(4.62)	(0.32)	1.15	1.37	(2.17)	(2.01)	(1.91)	(7.97)	(11.32)	(25.03)	(37.24)

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

37.2. Capital cost absorption rate

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

37.3. External financing

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

		2016-17		2015-16
		£000s		£000s
External financing limit (EFL)		**60,353**		62,750
Cash flow financing	**59,975**		62,584	
External financing requirement		**59,975**		62,584
Under/(over) spend against EFL		**378**		166

37.4. Capital resource limit

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

	2016-17	2015-16
	£000s	£000s
Gross capital expenditure	15,362	21,297
Less: book value of assets disposed of	(75)	(128)
Less: donations towards the acquisition of non-current assets	(35)	(138)
Charge against the capital resource limit	**15,252**	21,031
Capital resource limit	16,429	21,081
(Over)/underspend against the capital resource limit	**1,177**	50