United Lincolnshire Hospitals NHS Trust

Annual Report and Accounts 2010/11

Further information about us can be found at www.ulh.nhs.uk

Accessiblity

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

The facts
There are 168,145 attendances at our A&E departments each year
- that's 460 per day

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For further information about this report or the work of the Trust please contact the Communications Department at Lincoln County Hospital, Lincoln, LN2 4AX or telephone (01522) 573986.

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Chief Executive's and Chairman's foreword

We are pleased to welcome you to United Lincolnshire Hospitals NHS Trust's Annual Report for the year ending 31 March 2011.

The report is set against a backdrop of a challenging twelve months which has proven to be a period of transition for the organisation. Our Trust, like the rest of the NHS, is facing a tough economic climate in which it needs to reduce costs whilst continuing to improve the quality and safety of the care it provides.

The Trust recorded a £14.2 million deficit at the year-end and in 2011/12 it needs to reduce its costs to save £20 million. The report highlights some of the key steps taken during the year, as well as those planned for the future, which will lay the foundations for securing the Trust's long term provision of services to the residents of Lincolnshire.

High quality and safe patient care remains the first priority of the Trust and we are therefore very pleased to be able to feature in the report a number of examples where the Trust is continuing to lead the way in improving the experience of patients.

We are also pleased to report good progress on key quality indicators. The Trust continues to experience some of the lowest hospital infection rates nationally. During the year there were nine cases of MRSA and 94 cases of Clostridium difficile. These were 28% and 23% better than the already low rates from the previous year. The Trust's Standardised Mortality Ratio (HSMR) also improved and its figure of 100.1 at the end of March 2011 is in line with the national average.

Last year's report highlighted the need for further action to improve access times for patients and a great deal of work has been undertaken during 2010/11 which will support sustainable improvements to performance in the long term. The Trust met the A&E target for 95% of patients who attend the department being seen, treated and either admitted or discharged within 4 hours.

Joint working to reduce energy consumption

Lincolnshire's hospitals are fully committed to reducing their energy consumption and carbon emissions.

United Lincolnshire Hospitals NHS Trust has developed a strong partnership with energy and environmental efficiency specialists Cofely to promote energy saving awareness amongst staff and visitors. The initiative was Highly Commended at the prestigious 2010 Premises and Facilities Management Awards.

There was more of a mixed picture in respect of access times for admitted and non-admitted patients. For 2010/11, the Trust was required to achieve a target of at least 95% of admitted and 90% of non-admitted patients beginning definitive treatment within 18 weeks of referral by their GP. An additional measure of access, looking at the median and 95th percentile wait, was also introduced in June 2010. The Trust continued to experience difficulty in consistently achieving the necessary standards across these targets and a full picture of performance is given in the operating and financial review chapter of the report.

The board of ULHT firmly believes that achieving authorisation as an NHS Foundation Trust provides the best means to safeguard the future provision of comprehensive, high quality local hospital services for Lincolnshire residents. It has therefore given a clear commitment to lead the programme of work necessary to succeed in authorisation in 2013. The considerable work required to achieve this should not be underestimated, however significant steps have been completed during 2010/11.

The implementation of revised organisational management arrangements was completed by the year-end. These create a clinically-led, managerially supported organisation which is focused on providing effective and efficient healthcare and meeting the demands of the evolving NHS market environment. The substantive recruitment to six board posts during the year also brings much needed stability and senior experience to the board during these challenging times.

The Care Quality Commission announced in June 2011 that it was launching an investigation into the systems and procedures in place at Pilgrim Hospital to ensure that people are protected against the risk of inappropriate or unsafe care and treatment. Whilst this development sits outside the time period covered within the annual report, we both wanted to take this opportunity to reaffirm the organisation's full commitment to working with the CQC to ensure that patients experience consistently high standards of care and treatment."

Finally, we wish to recognise the continued hard work and dedication of all the staff and volunteers who play a vital role in supporting the Trust. Both of us have met a wide range of staff since joining the organisation and have consistently been encouraged by their commitment, diligence and enthusiasm.

This was best highlighted during the severe weather during the winter of 2010 where we saw examples of staff members walking for several hours in order to report for duty, and many others who remained in hospital overnight, worked additional shifts or covered extra duties in order to ensure we were able to continue to provide essential services to patients.

Our sincere thanks go to you all.

Board of directors report

About the Trust

United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest hospital trusts in the country. It provides secondary care services in both acute and community settings and operates out of three main hospital sites; Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital. Together the three sites have over 1,500 beds.

The Trust primarily serves the 750,000 residents of Lincolnshire, which is one of the fastest growing populations in England.

The Trust 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: County Hospital in Louth, John Coupland Hospital in Gainsborough, Johnson Community Hospital in Spalding and Skegness and District General Hospital.

In addition, the Trust provides a broad range of other clinical services including community services, population screening services, a comprehensive range of planned and unscheduled secondary care services together with research and development.

The Trust's vision and values

The Trust has developed a vision, mission and set of values which will underpin the achievement of its objectives.

Our vision: To deliver the highest quality care locally.

Our mission: We will listen to and learn from patients, staff and partners as we develop and deliver leading hospital services to the people of Lincolnshire.

Our values: Every employee of the Trust will:

- Put the patient and public at the centre of what they do every day
- Lead and take responsibility, not blame others
- Work together with others
- Seek to fully understand problems, their cause and find solutions to them
- Be responsive and flexible to enhance the experience of all those who use the Trust's services
- Be open and honest at all times

The facts

We offer 556,283 new and follow-up outpatient appointments each year- that's 1,524 per day

The Trust Board

The Trust 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 which supports it in driving the delivery of the principal objectives through a process of risk management, control and assurance.

Board membership comprises the Chairman 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 lay people, drawn from the local community and appointed by the Appointments Commission on behalf of the Secretary of State for Health.

The Chief Executive and executive directors are full time employees of the Trust. They are appointed on permanent contracts through open competition procedures. Their selection process includes an interview panel involving the Chairman, non-executive directors and independent advice.

New focus on patient safety in Lincolnshire

Patient safety is being given a new focus in Lincolnshire's hospitals with the appointment of two specialists in the area.

Dr Steve Cross was this year appointed as Patient Safety Manager for United Lincolnshire Hospitals NHS Trust. In this role he is now working on ensuring that people and systems work together to create safety in hospitals.

He has also been joined by another new member of staff- Safer Medicines Coordinator Lauren Hopkinson.

This new role has been put into place to reduce risk and improve patient safety as a matter of priority.

The remuneration of executive and associate directors is determined by a Remuneration and Terms of Service Committee. This committee consists of the Chairman plus two non-executive directors.

A Chief Executive-led review and consultation during the year culminated in the board approving revised clinical management arrangements for the Trust.

These became operational by the year-end and included changes to the portfolio of responsibilities, and hence titles, of some executive directors - further details of which are available on the Trust's website.

Board membership for 2010/11 was as follows:

Non-executive directors:

Paul Richardson – Chairman

Paul was appointed permanent Chairman of the board in December 2009. Following a successful international engineering career, Mr Richardson gained a wealth of NHS experience serving as a Non-Executive Director of the Scunthorpe Health Authority from 1990 and then Scunthorpe and Goole Hospitals Trust from 1993. He was Vice Chairman of Northern Lincolnshire and Goole Hospitals Foundation NHS Trust up to November 2008.

Interests declared: None
Term of office: December 2009 – December 2013

Tim Staniland - Vice Chairman

Tim has extensive senior experience in sales and marketing. His career began with Geest in Spalding, before moving to United Biscuits and later to Edinburgh based Buck Chemicals. He was appointed Sales Director for a UK division of German multi national Henkel in 2004. Tim then moved to award winning sales and marketing company Chartered Brands as a Business Unit Director. Most recently he established his own product development company in August 2006. He was reappointed for a second term as Non-Executive Director in March 2011.

Interests declared: Director, Innovation Deli Ltd
Term of office: March 2011 – March 2015

Keith Brown – Audit Committee Chair

Keith is a highly experienced accountant and was formerly the Chief Financial Officer of the London Borough of Southwark where he oversaw the spending of over £2bn per annum. He ran the council's internal audit section as well as running the council's efficiency audits and ensuring it brought in targeted savings each year. He has also previously worked at an Assistant Audit Manager for Deloitte, Haskins and Sells and as an Auditor for the District Audit Service in Kent, Sussex and London.

Interests declared: None
Term of Office: May 2008 - May 2012

Nick Muntz

Nick is Managing Director at Siemens Industrial Turbomachinery Ltd (SITL) in Lincoln where he is responsible for the overall performance of the business. He also leads the project implementation and change team in charge of the company's current multi-million pound relocation project. He held various roles in senior management at his last

company, Weir Pumps in Glasgow, before accepting his current position with Siemens in 2006.

Interests declared: Managing Director SITL; Governor University of Lincoln
Term of Office: July 2009 – July 2013

Penny Owston

Penny is a practicing solicitor in Scunthorpe specialising in childrens law and was previously the managing partner of a five-partner firm. She gained an MBA in Legal Practice Management at Nottingham Law School and is a member of the faculty. She has written extensively about law firm management and has provided training and consultancy in the field since 1997. She is a director of Brightwater Consultancy and Development Ltd and between 2000 - 2005 was the Law Society Council Member for Lincolnshire and a member of the society's Standards Board. Until recently, she also sat on the board of the Solicitors Regulation Authority.

Interests declared: None
Term of Office: May 2010 - May 2014

Keith Darwin

Keith's career started in 1966 with Plymouth Co-operative Society before moving to Lincoln Co-operative Society in 1973, where he went on to become Deputy Chief Executive in 1977 and Chief Executive in 1992, a post he held for eleven years. He is also the Chairman of Investors in Lincoln and the Lincolnshire Economic Action Partnership, a Trustee of St Barnabas Hospice Trust and a Governor of the University of Lincoln. He has been a Justice of the Peace since 1991 and is the Deputy Chair of People First International. He was awarded the OBE in 2000 and became an Honorary Doctor of Law in the same year.

Interests declared: Director Brayford Trust; Chairman Investors In Lincoln; Chairman Lincolnshire Economic Partnership; Chairman People First International; Trustee St Barnabas Hospice, Lincoln; Governor University of Lincoln
Term of Office: Nov 2010- Nov 2014

Executive directors:

Andrew North - Chief Executive

Andrew started as Chief Executive in August 2010, having joined from Northern Lincolnshire and Goole Hospitals NHS Foundation Trust where he had been Chief Executive for almost 13 years. Andrew's first Chief Executive position was with South Lincolnshire Community and Mental Health Services NHS Trust in 1993. A career NHS manager, Andrew has also previously worked at Pilgrim Hospital, Boston, Rotherham District and General Hospital and hospitals in London and Suffolk.

Interests declared: None

Jane Lewington - Director of Strategy and Performance/Deputy Chief Executive

Jane joined the Trust in December 2010 from North East Lincolnshire Primary Care Trust, where she was Chief Executive for ten years. In that role she oversaw the Trust's transformation into the country's first Care Trust Plus with responsibility for both the commissioning and provision of adult social care.

Prior to her role at North East Lincolnshire PCT, Jane enjoyed a career spanning a broad range of acute and mental health services in Lincolnshire.

Interests declared: Non-executive director NE Lincs Mental Health Community Interest Company; Non-executive director Big Life Health Board

Kevin Turner - Director of Finance, Procurement and Informatics

Kevin joined the Trust in January 2011. He first started in the NHS as a trainee accountant in his home town of Doncaster in 1979, where he completed his training before moving to Pilgrim Hospital, Boston to take up the position of Hospital Finance Manager. His first Director of Finance role was at Lincolnshire Health Authority, which he joined in the mid 1990's.

He has since held the position of Director of Finance at two successful Foundation Trusts, most recently at Doncaster and Bassetlaw Hospitals NHS Foundation Trust. Kevin is a member of the Chartered Institute of Public Finance and Accountancy, he has completed the NHS Strategic Financial Leadership Programme and is on the NHS Top Leaders Programme.

Interests declared: None

Sylvia Knight – Chief Nurse

Sylvia is a nurse by background and joined the Trust in August 2004 having spent the previous 13 years working in a variety of roles at Leeds Teaching Hospitals NHS Trust.

As well as senior professional leadership and operational management roles, Sylvia has also spent time during her post-registration career within research and development where she was able to develop her sub-specialist interests in pressure sore prevention and nutritional care.

Sylvia completed a Masters in Quality Assurance in Health and Social Care in 1995 at the Nuffield Institute for Health, Leeds, and is a trained facilitator having completed a year-long leadership programme.

Interests declared: None

Non-voting members:

Mike Speakman - Director of Estates and Facilities

Mike is an electrical engineer by profession and has worked in the NHS since 1984. He worked at Glenfield hospitals and Leicester Royal Infirmary before joining the High Security Rampton Hospital in 1994. Mike was appointed as Assistant Head of Facilities (Forensic) at Nottinghamshire Healthcare NHS Trust in 2001 and subsequently was appointed to the board in 2005, becoming Director of Facilities, Capital Projects and Business Development before joining ULHT in 2008.

His professional interests are in estates and facilities workforce development, modernisation and estates redevelopment. Amongst his professional qualifications, Mike holds an BEng (Hons) and is an MBA graduate. He has strong involvement with the Health Facilities Management Association, having previously been Regional Chair and a member of the national council. Mike participates in a number of regional and national advisory groups, related to health facilities, education and development and policy development

Interests declared: Managing Director Terrace House Management Ltd

Ros Edwards - Director of Human Resources

Ros is a former Head of Human Resources and Head of Customer Services for Marks and Spencer Financial Services. She joined the Trust in July 2008 from a position as Director of Human Resources at Sheffield Hallam University.

She led the university to the Times Higher Education Employer of the Year Award in 2005 and helped the university's HR team to be recognised for Excellence in the Public and not for Profit Sector in 2006 at the national HR Excellence Awards. She is Deputy Chair of the North East Region HR Directors Group which provides a networking opportunity for HR directors in higher education across the region.

Interests declared: None

Michelle Rhodes - Interim Director of Service Delivery

Michelle is a nurse by background, having worked in both hospital and community nursing. She has previously worked for PCTs where she has extensive experience in commissioning.

More recently, Michelle worked as Chief Operating Officer at Nottingham University Hospitals NHS Trust and as Interim Chief Operating Officer for Mid Staffordshire NHS Foundation Trust.

Interests declared: None

Other board members during 2010/11:

There were a further six directors who served on the board for part of the year, as follows:

Bernard Chalk, Acting Chief Executive (and substantive Director of Finance)
- Left the Trust August 2010

Dr Richard Lendon, Acting Director of Performance
- Left the Trust October 2010

Dr Paul Dunning, Acting Medical Director
- Resumed substantive role within the Trust at the end of March 2011

Pen Anderson, Acting Director of Finance
- Resumed substantive role within the Trust January 2011

The facts
We care for 14,372 elective inpatients in our hospitals each year

Roger Long, Interim Director of Operations
– Left the Trust December 2010

Mike Cutt, Non-Executive Director
- Left the Trust September 2010

Board attendance

The board met formally on eleven occasions during 2010/11. Individual directors' attendance was as follows:

Board		
Voting members	**Attendance**	**% Attendance**
Paul Richardson	10/11	91
Tim Staniland	10/11	91
Keith Brown	9/11	82
Nick Muntz	7/11	64
Penny Owston	8/11	73
Keith Darwin	9/11	82
Mike Cutt	3/5	60
Andrew North	7/7	100
Jane Lewington	4/4	100
Kevin Turner	3/3	100
Sylvia Knight	10/11	91
Pen Andersen	7/8	88
Bernard Chalk	3/4	75
Paul Dunning	10/11	91

Roger Long	6/7	86
Non-voting members	**Attendance**	**% Attendance**
Mike Speakman	11/11	100
Michelle Rhodes	5/5	100
Ros Edwards	10/11	91
Richard Lendon	4/7	57

The Audit Committee

The Audit Committee is a statutory committee of the board. It is responsible for providing independent assurance on the processes operating within the Trust for risk, control and governance. Its specific functions are laid down within the national Audit Committee Handbook.

It assesses the adequacy of assurances that are available with respect to financial, corporate, clinical and information governance. In so doing it considers the information available from independent sources, such as internal/external audit, Monitor and the Care Quality Commission (CQC) as well as from internal sources, such as the other committees of the board and executive officers/senior managers.

Audit Committee membership comprises three independent non-executive directors, one of whom will have considerable financial expertise.

The committee met on six occasions during the year with attendance as follows:

Audit Committee		
Members	**Attendance**	**% Attendance**
Keith Brown - Chair	6/6	100
Keith Darwin	5/6	83
Penny Owston	5/6	83

The Governance Committee

This committee ensures that a robust risk and governance framework is maintained by the Trust, which is designed to ensure that systems, processes and controls are in place to manage risks. It is the coordinating committee for the management and mitigation of risks relevant to the corporate objectives and advises the board on matters of governance.

In order to do so the Governance Committee, where necessary, directs a hierarchical system of sub-committees and working groups established across the organisation to deliver specific elements of governance.

Membership comprises a mix of executive and non-executive directors. The committee met on four occasions during 2010/11, with the following attendance:

Governance Committee		
Voting members	**Attendance**	**% Attendance**
Tim Staniland – Chair	4/4	100
Keith Darwin	1/4	25
Nick Muntz	3/4	75
Pen Andersen	4/4	100
Bernard Chalk	1/2	50
Paul Dunning	1/4	25
Ros Edwards	3/4	75
Sylvia Knight	3/4	75
Roger Long	3/4	75
Andrew North	2/2	100
Mike Speakman	4/4	100

Patient who benefited from bowel cancer screening encourages others to take the test

A patient who was one of the first to benefit from a national screening programme in Lincolnshire is encouraging others to take part.

Arnold Offside from Alford did a test as part of the national Bowel Cancer Screening Programme, which resulted in him being diagnosed with an early cancer which has already been treated.

He says that he was very impressed by the screening service and the speed at which he was treated at Lincoln County Hospital, as he had no prior symptoms and the cancer could have been much more serious if it had been discovered at a later date.

The Bowel Cancer Screening was rolled out across Lincolnshire in December 2009. Mr Offside is one of more than 50 people have been diagnosed and treated for cancer through the programme since then.

Within the next two years, everyone in the county aged between 60 and 69 will be invited to undergo this bowel cancer screening. They will all have a test kit sent to their homes, which they then post back to a laboratory for testing.

Operating and financial review

Priorities for 2010/11

The priorities for 2010/11 were geared towards the commitments to patients and the public set out in the NHS Constitution and annual NHS Operating Framework, namely:

- Improving access
- Improving cleanliness and reducing infection
- Improving health and reducing health inequalities - comprising a focus on stroke, cancer, children and young people and maternity and neonatal services
- Patient experience, satisfaction and engagement
- Emergency preparedness

These priorities were set against a background of significant financial challenges in line with the wider economic outlook, with trusts being required to deliver surpluses as a precursor to NHS FT authorisation. 2010/11 also saw a series of changes to the national tariff for acute hospitals, including the introduction of best practice tariffs, payment supplements for the achievement of quality targets (CQUINS), penalties for the NPSA 'never events', restrictions to the acute tariff and marginal payments for emergency admissions over the 2008/09 baseline. In strategic terms, 2010/11 was the last year of net growth prior to more demanding settlements for the planning period to 2014.

Taken together, the national service priorities and financial planning assumptions represented a major challenge in continuing to improve quality whilst delivering significant improvements in productivity and performance against national and local standards.

The Trust's response to these priorities was framed into five strategic goals and 30 specific objectives as outlined in the Corporate Strategy 2010-2015. The key goals were:

1. Delivering high quality care
2. Demonstrating effective use of resources
3. Delivering flexible and responsive care
4. Developing an effective organisation
5. Providing an effective and safe environment

Year-on-year analysis across a broader range of performance indicators for the Trust is given further on in this section. The following is a summary across the five key goals.

Delivering high quality care

The Trust's strategic objective in relation to quality is to deliver the safest, most effective healthcare.

The facts
We carry out 64,897 day case procedures in our hospitals every year

The Trust has developed and implemented a range of plans and strategies that reflect the three domains of quality, namely; safety, patient experience and effectiveness of care. These strategies and plans are pulled together through a 2009-2011 Quality Plan which

describes the goals for quality improvement. These quality improvement goals have been developed to take account of the views of patients, staff and the Trust's commissioners.

The Trust publishes an annual Quality Account which is a formal and detailed report about the quality of services it provides. A full copy of the 2010/11 Quality Account is appended to this report.

Demonstrating effective use of resources

The Trust fell short of delivering its planned financial target in 2010/11. This was due to several factors, the foremost being under-delivery of the Cost Improvement Programme (CIP). Further pressure came from the dependence on agency medical staff which reflected an average 15% medical staff vacancy rate over the year and also from the loss of income relating to the application of 30% marginal price rate for emergency activity in excess of the level of emergency activity in 2008/09.

The Trust financial position in 2010/11 showed a deficit of £14.2m. This was achieved after significant one off actions taken by the Trust Board to restrict expenditure. Had these not been taken, the 'normalised' deficit for 2010/11 would have been £20.8m. Further details of the Trust's financial performance in 2010/11 are given later in this report.

Delivering flexible and responsive care

Significant efforts have been made over the past year to improve the responsiveness of services in line with the operating framework requirements across A&E, referral to treatment times (RTT), access to cancer services and cancelled operations. Success has been achieved in several areas but pressures in some specialties mean that performance remains marginal across some measures. Some of the variation in performance is driven by the continuing growth and variation in non-elective demand which has impacted on the delivery of planned care, including surgery.

The Trust has delivered an increased level of activity in 2010/11 across elective, non-elective and outpatient work over and above 2009/10 levels. Activity also reflects the planned shift from inpatient to day case activity and increased capacity for first outpatient attendances alongside the planned reduction in subsequent or 'follow up' attendances. The elective and day case activity increases have been achieved despite a very significant increase in unplanned emergency admissions which were 9.5% above plan and more than 16% above 2009/10 levels.

Activity type	09-10	10/11 plan	10-11 actual	Change 09/10 – 10/11
Elective inpatient spells	15,035	16,861	14,372	-4.41%
Day case spells	62,431	65,870	64,897	3.95%
All elective spells	77,466	82,731	79,269	2.33%
Non-elective spells (emergency)	68,053	72,469	79,335	16.58%

New outpatient attendances	163,178	181,799	168,981	3.56%
Subsequent outpatient attendances	393,873	352,934	387,096	-1.72%
A&E attendances (full year)	165,970	173,801	168,145	1.31%

Accident and Emergency

The target for Accident and Emergency (A&E) changed in July 2010 to a standard of at least 95% of patients to be seen, treated and either admitted or discharged within four hours. The Trust met this standard over the course of the year, recording a performance of 95.01%, despite an increased level of attendance particularly at Pilgrim Hospital, Boston. The overall performance of the Lincolnshire Health Economy (including the walk-in centre and the minor injuries units in the community hospitals) exceeded this standard.

Hospitals raising the profile of dignity in dementia care

Hospitals across Lincolnshire have been championing the importance of dignity in dementia care at a high profile conference.

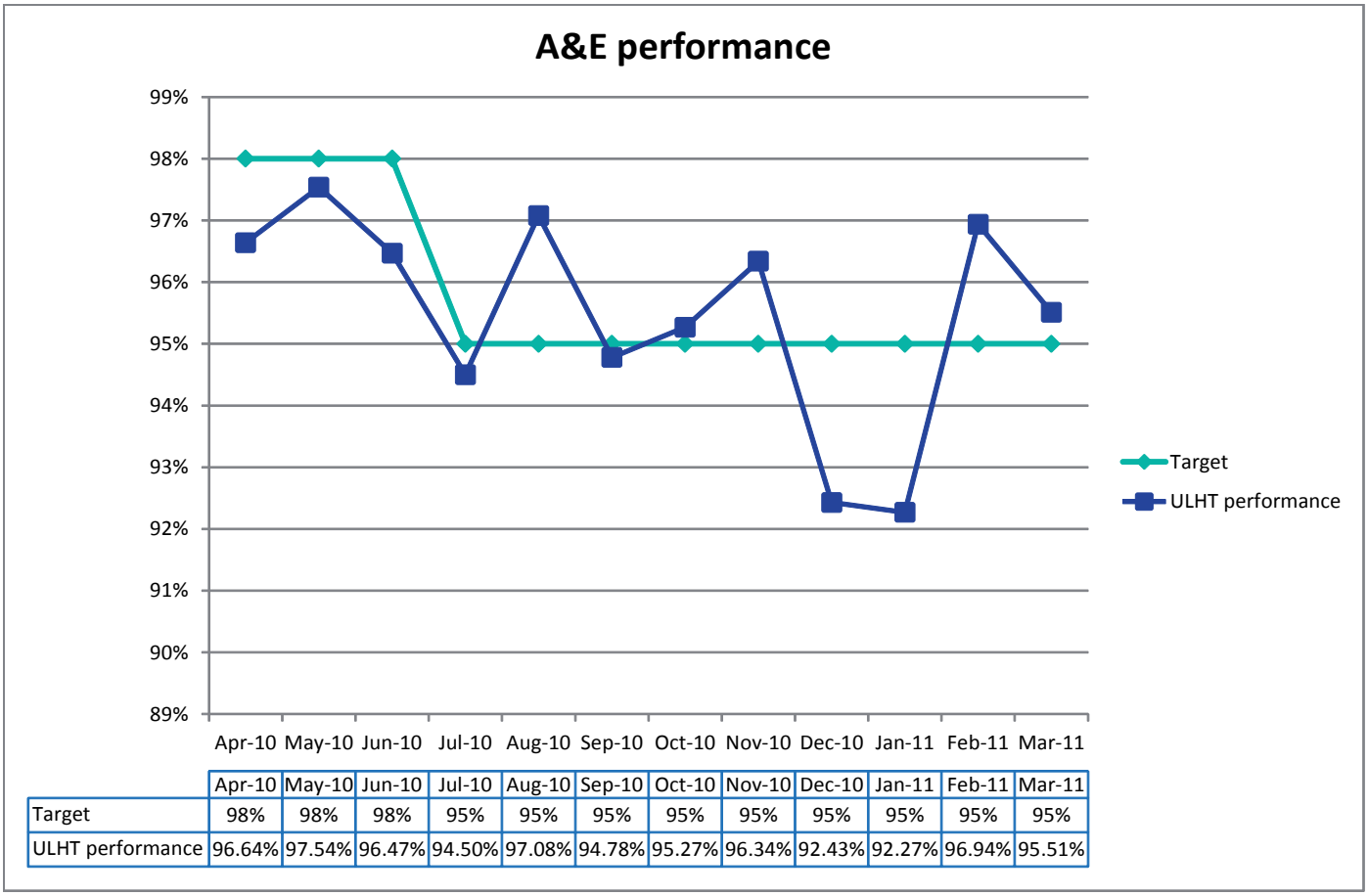
The Dignity in Dementia Care conference, held in February 2011, was designed for healthcare staff with the aim of helping them develop knowledge and skills in relation to providing dignity in dementia care.

The conference attracted 90 delegates, as well as respected national speakers, and included workshops and the opportunity to showcase exciting dignity in care projects underway in Lincolnshire's hospitals.

Work started during the year on a number of initiatives to further improve A&E performance, including the reduction of length of hospital stay to improve the availability of medical beds, an increased emergency physician input in the clinical decisions unit, increased emergency physician input in A&E at Lincoln and senior tracking of patients through A&E on both the Lincoln and Boston sites.

The following table and graphs show the Trust's performance against this target for quarter two onwards:

A&E attendances 2010/11	Attendances	Breaches	Performance
Skegness	19,424	108	99.44%
Grantham	22,186	381	98.28%
Boston	34,630	2,402	93.06%
Lincoln	47,481	3,284	93.08%
Trust (Q2- 4, reflecting national change in performance target)	123,721	6,175	95.01%



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Target	98%	98%	98%	95%	95%	95%	95%	95%	95%	95%	95%	95%
ULHT performance	96.64%	97.54%	96.47%	94.50%	97.08%	94.78%	95.27%	96.34%	92.43%	92.27%	96.94%	95.51%

Data source and calculations

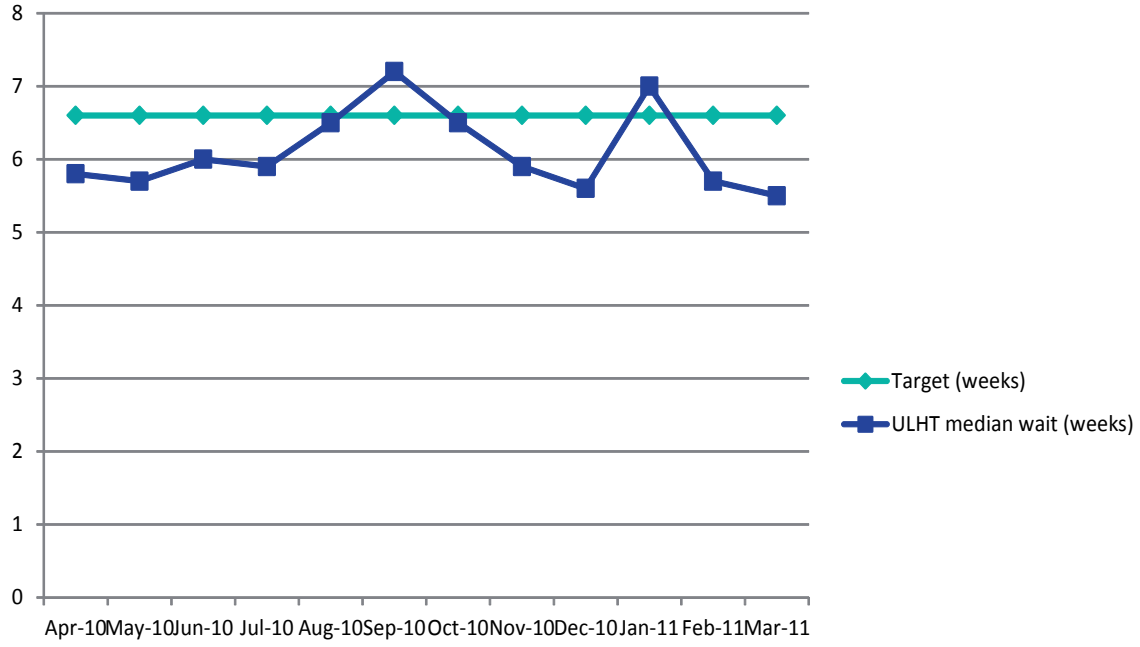
The data to calculate performance against A&E waiting times is taken from the Trust's Patient Administration System (PAS). Every patient is entered into this system with a start time and end time from when they arrive in the A&E Department to when they are seen. If this time is longer than four hours they are then recorded as a breach of the four hour national target. The total attendance is measured at the end of each month and the four hour breaches expressed as a percentage of the total attendances. This method of calculation is consistent with Department of Health guidance.

18 week referral to treatment - non admitted patients

The 18 week referral to treatment standard (RTT) states that 95% of patients will be treated within 18 weeks of referral. Additional measures were introduced nationally from June 2010 which measured both the median wait (standard 6.6 weeks) and the 95th percentile waiting time (18.3 weeks). The RTT measures provide a snapshot of performance in a particular month and are not reported as an annual average.

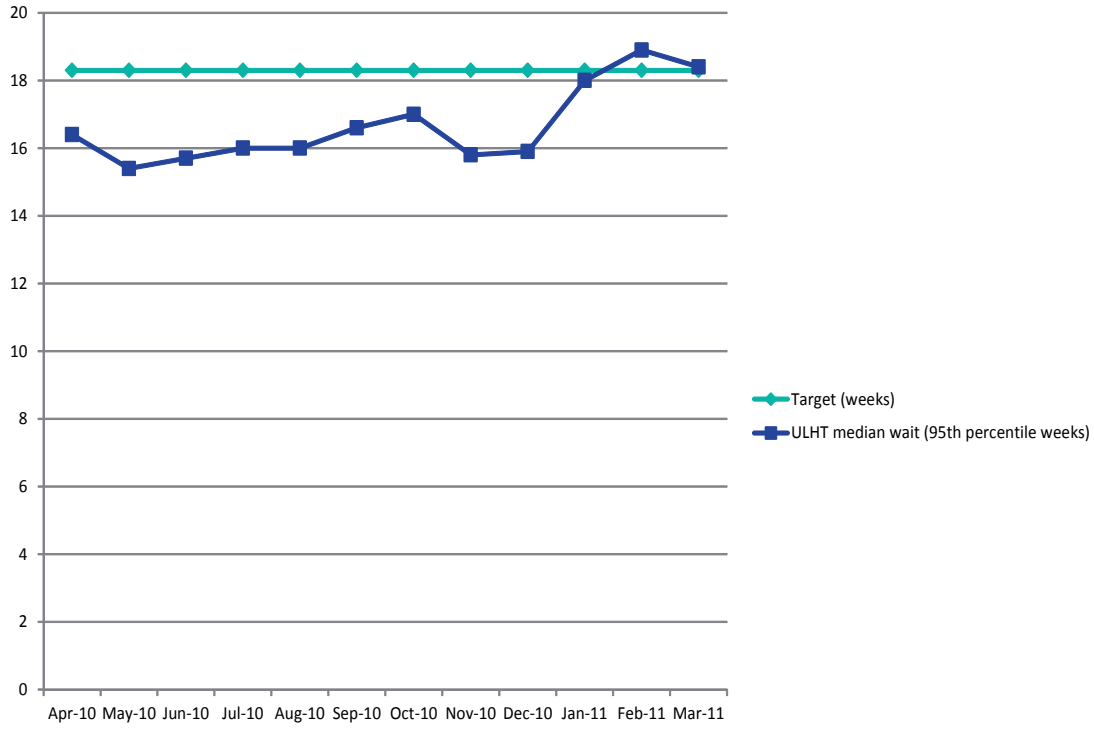
Overall, 18 week performance was sustained by the Trust during 2010 but pressure on capacity has resulted in a deterioration going into 2011. Generally the median wait standard has been met throughout the year. The Trust's capacity plans for 2011/12, particularly those for orthopaedics, general surgery and some medical specialities, are designed to recover this position in the early part of the current year.

18 weeks RTT- Non-admitted. Median wait

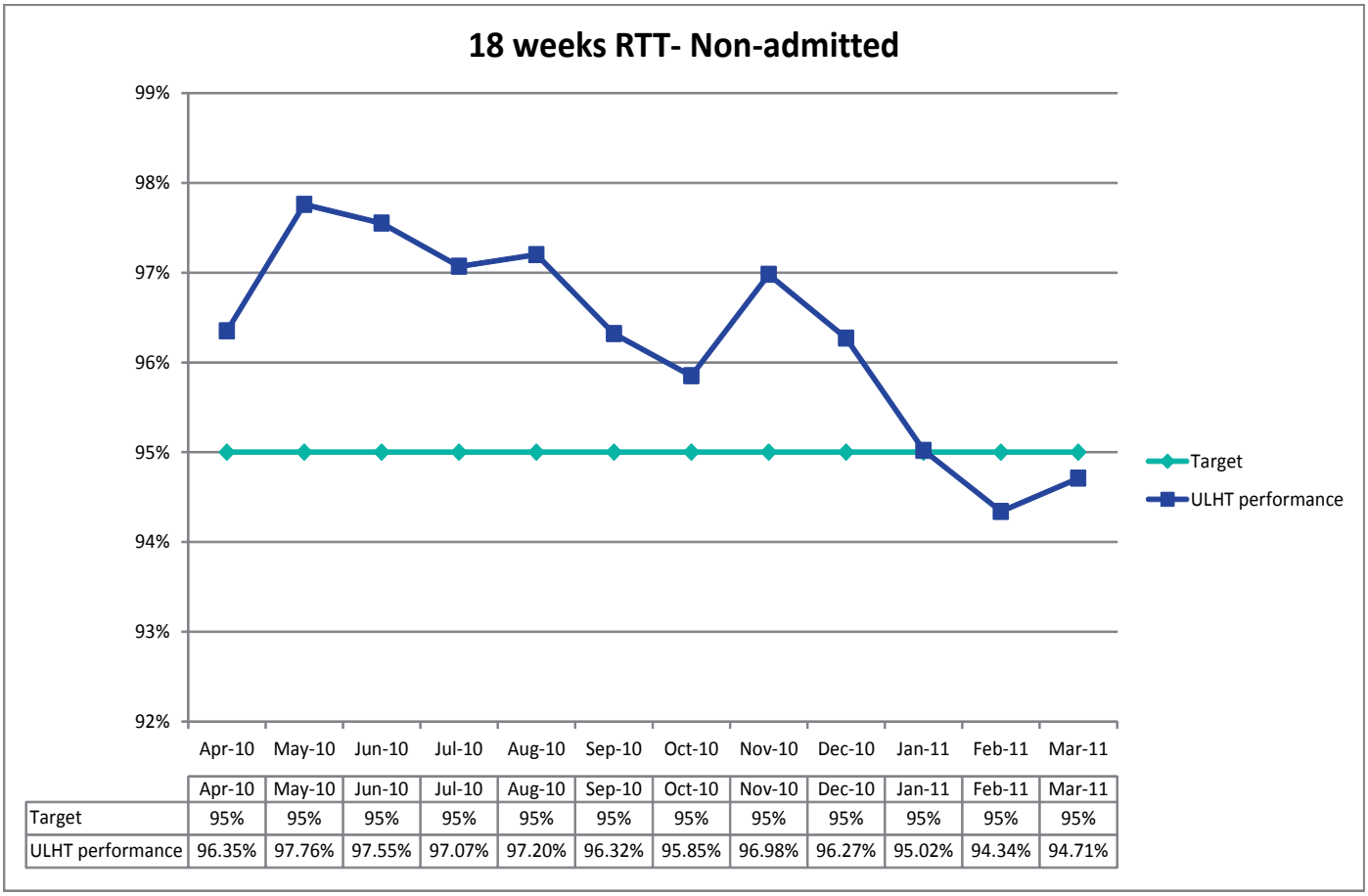


	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Target (weeks)	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6
ULHT median wait (weeks)	5.8	5.7	6.0	5.9	6.5	7.2	6.5	5.9	5.6	7.0	5.7	5.5

18 weeks RTT- Non-admitted. Median wait (95th percentile)



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Target (weeks)	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3
ULHT median wait (95th percentile weeks)	16.4	15.4	15.7	16.0	16.0	16.6	17.0	15.8	15.9	18.0	18.9	18.4



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
ULHT performance	96.35%	97.76%	97.55%	97.07%	97.20%	96.32%	95.85%	96.98%	96.27%	95.02%	94.34%	94.71%

18 week referral to treatment - admitted patients

The 18 week referral to treatment standard for admitted patients states that 90% of patients must be treated within 18 weeks of their referral. Additional measures were introduced in June 2010 in line with those for non-admitted patients. The median wait standard was 11.1 weeks and 95th percentile standard 27.7 weeks.

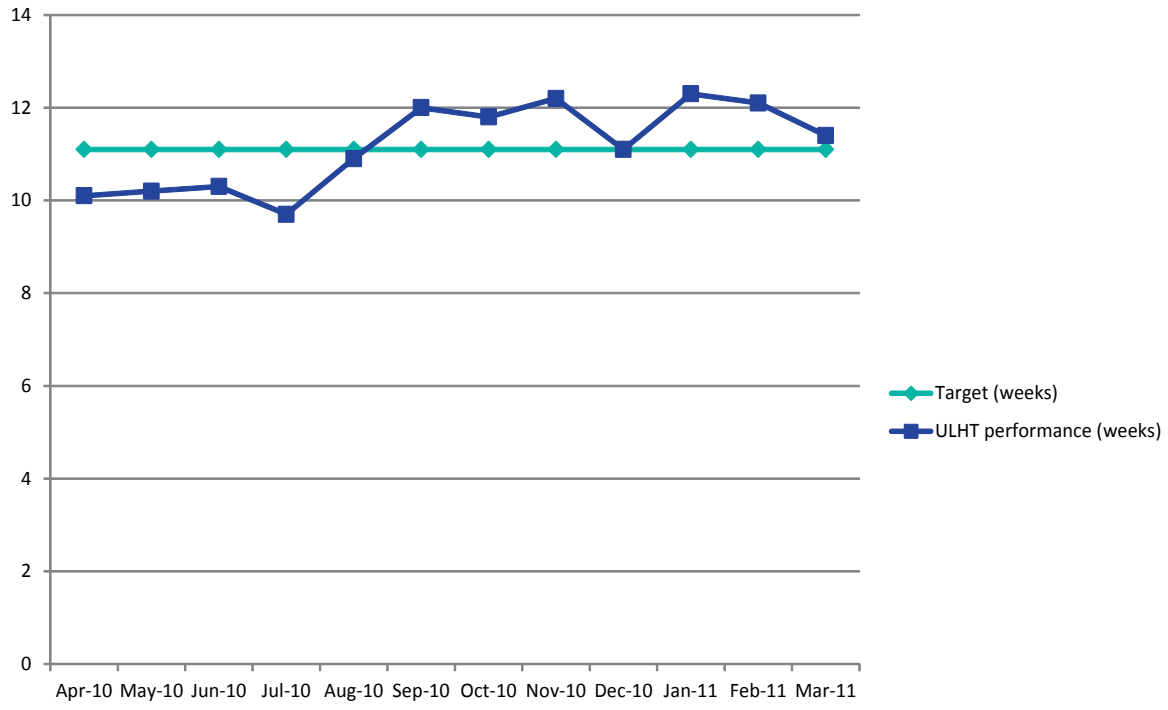
Overall the Trust has struggled to deliver against this target, with particular difficulties experienced in a number of specialties including orthopaedics and general surgery. The delivery of planned inpatient care was adversely affected by the growth in emergency demand over the year which disrupted bed and theatre availability. Plans are in place to reverse this trend so that the standards are fully met in 2011.

Data source and calculations

The data to calculate performance against the 18 week waiting times is taken from the Trust's Patient Administration System (PAS). Every patient is entered into the system when details of their referral are received, either by paper from the GP or via the electronic Choose and Book system. This 'starts the clock' and the patient is offered an outpatient appointment. If no further treatment is required the clock stops and the time from referral to treatment is recorded.

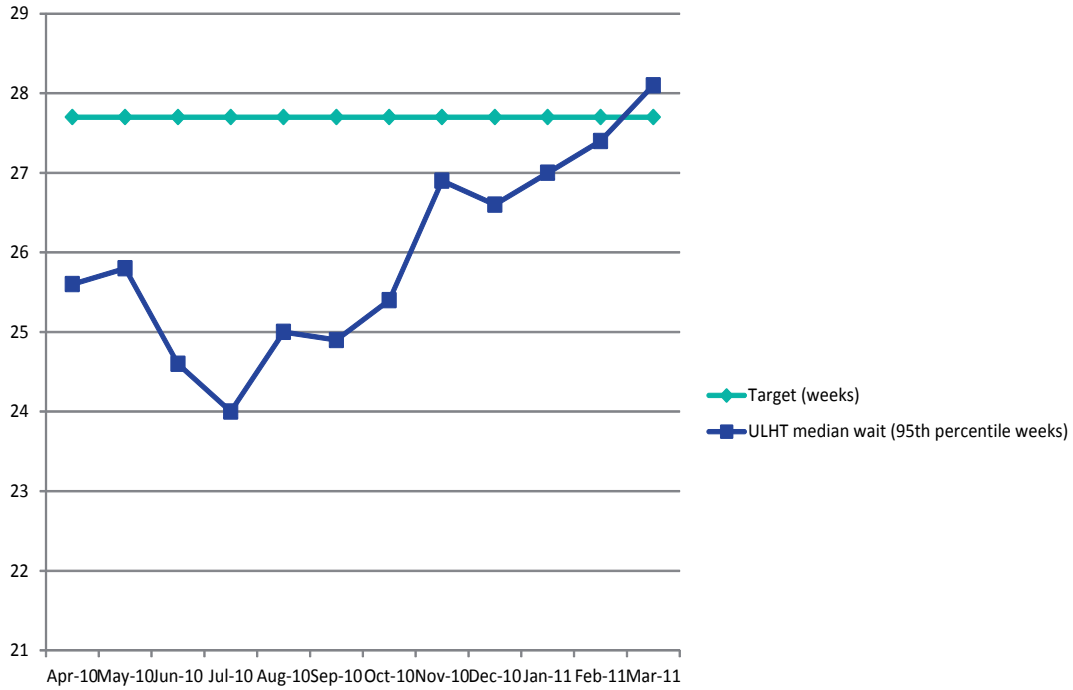
If the patient is referred on for diagnostic tests or is planned to be admitted to hospital, the clock continues until the clinician decides they have started their first definitive treatment. Each month the number of patients seen within 18 weeks is calculated as a percentage of the total number on the 18 week pathway. This method of calculation is consistent with Department of Health guidance.

18 weeks RTT- Admitted. Median wait

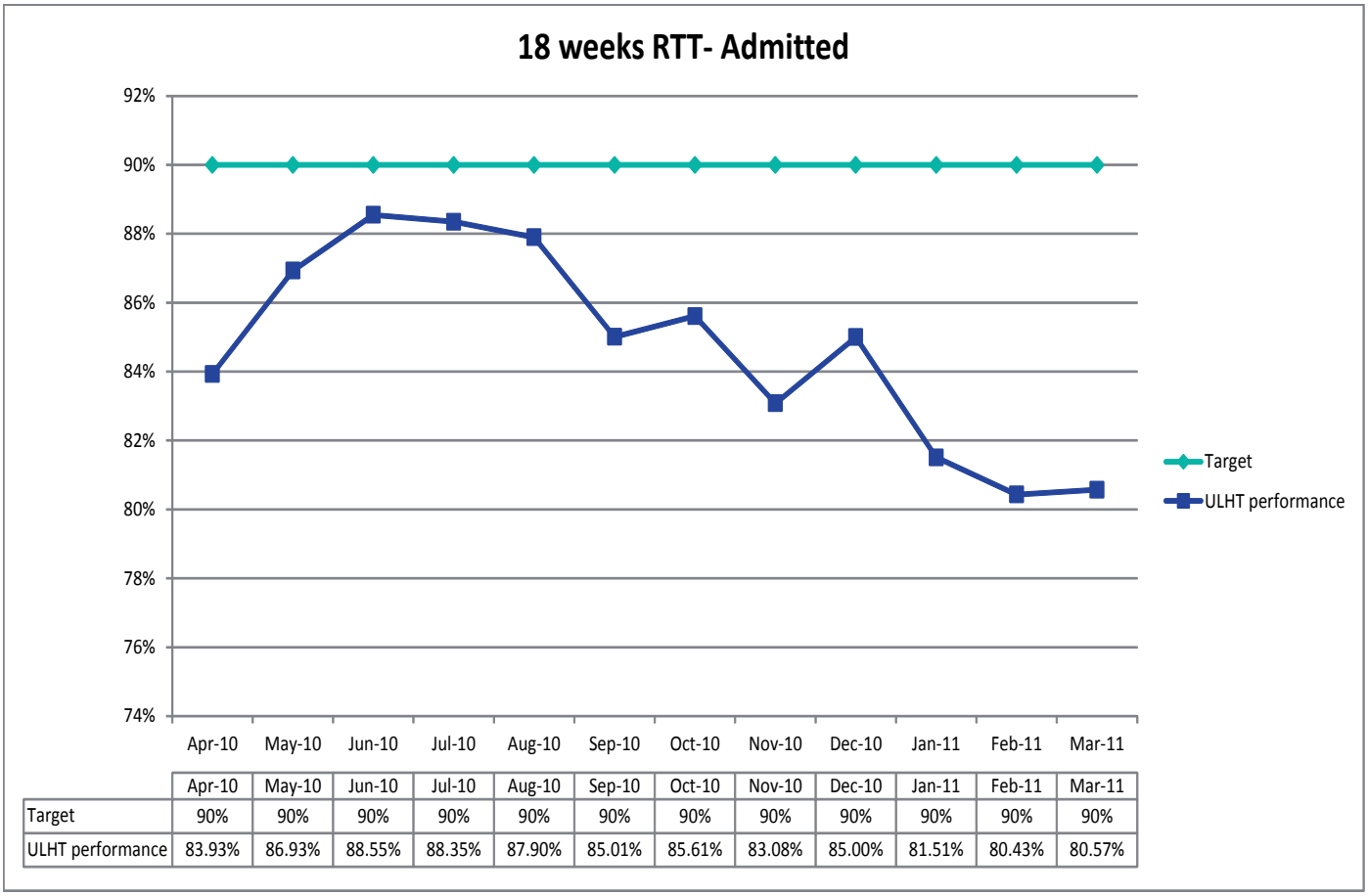


	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Target (weeks)	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1
ULHT performance (weeks)	10.1	10.2	10.3	9.7	10.9	12.0	11.8	12.2	11.1	12.3	12.1	11.4

18 week RTT- Admitted. Median wait (95th percentile)



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Target (weeks)	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7
ULHT median wait (95th percentile weeks)	25.6	25.8	24.6	24.0	25.0	24.9	25.4	26.9	26.6	27.0	27.4	28.1



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
ULHT performance	83.93%	86.93%	88.55%	88.35%	87.90%	85.01%	85.61%	83.08%	85.00%	81.51%	80.43%	80.57%

Cancer standards

New standards were introduced from January 2010 for routine breast referrals and from December 2010 for subsequent 31 day radiotherapy treatments. The Trust's progress up to February 2011 against these standards can be seen in the table below:

Measure	Standard	Trust performance (to Feb 11)
2 week wait suspected cancer	93%	93.4%
2 week wait symptomatic breast	93%	90.0%
31 day decision to treat to treatment	96%	95.8%
62 day referral to treatment	85%	81.6%
31 day subsequent drug therapy	98%	98.7%
31 day subsequent surgery	94%	98.5%
62 day screening	90%	82.5%

In recognition of the importance of delivering timely cancer services, particular focus has been given to these standards in 2010/11. Cancer-specific capacity plans have been developed over the last quarter of the year, alongside refinements to the patient pathways and relationships with tertiary centres who support the service in Lincolnshire. Deficiencies in diagnostic capacity have also been addressed. The introduction of the national bowel

screening programme in Lincolnshire during the year has placed additional pressure on cancer services due to the high take up rate within the programme. Further work will need to be done in this area particularly given that the age eligibility is due to be extended next year. The Trust is working hard to secure improvements to cancer performance as a result of these actions.

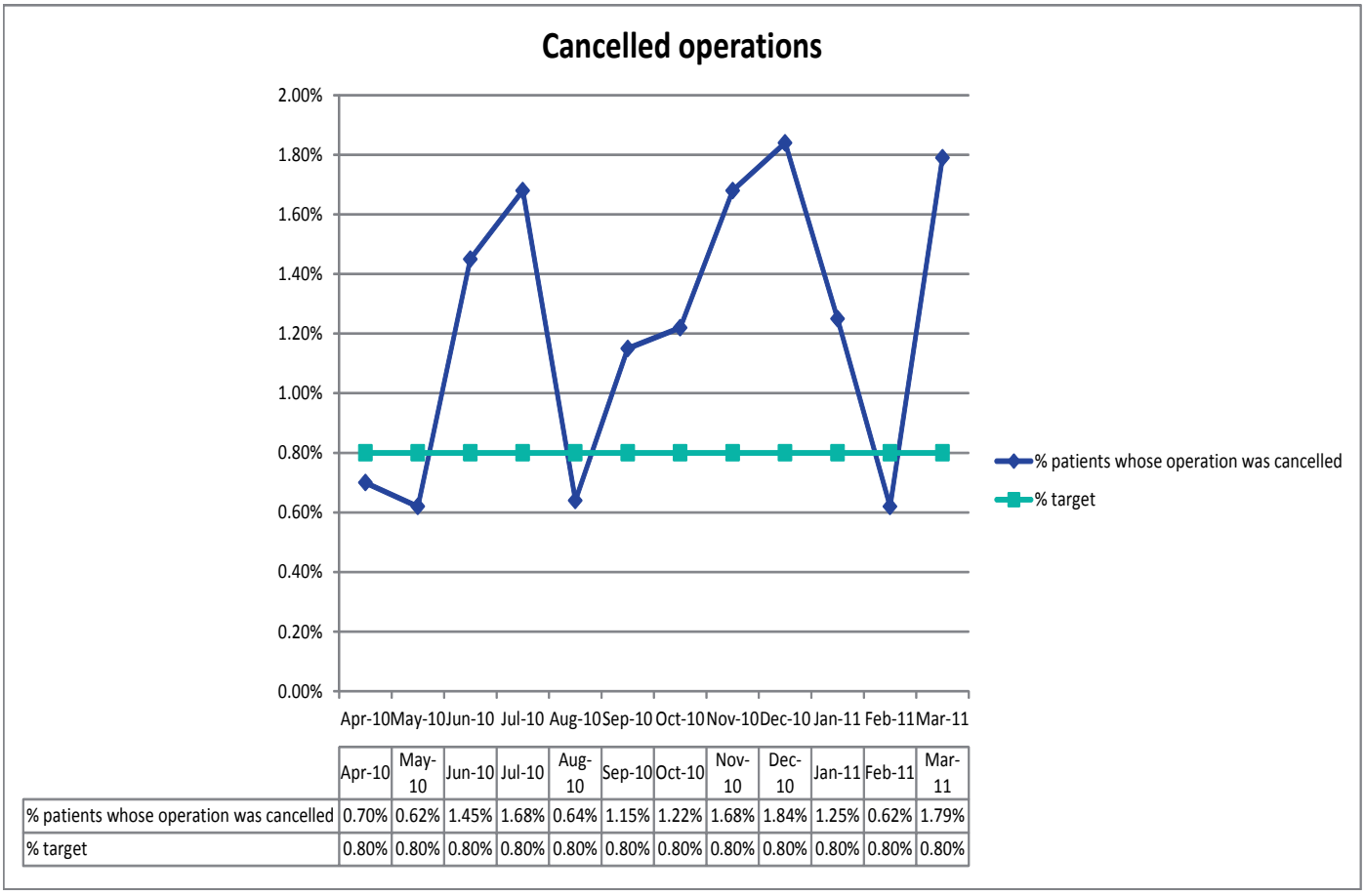
Data source and calculations

The data to calculate performance against cancer waiting times is taken from the Trust's Patient Administration System (PAS) and radiology system. The information is pulled together into a cancer database to track patients on their pathways. The number of breaches is subtracted from the total number on the pathway and those seen within the required timescales are calculated as a percentage. This methodology is consistent with guidance from the Department of Health.

Cancelled operations

The short notice cancellation of operations standard for 2010/11 was to achieve a cancellation rate of no higher than 0.8% and to ensure that patients who receive such a cancellation have their operation within 28 days of their original postponement.

The incidence of cancelled operations continues to remain too high within the Trust. This is partially a reflection of the emergency pressures identified earlier, but further work also needs to be undertaken to improve the organisation, scheduling and use of theatres themselves. A programme of such work is being undertaken during the current year.



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
% patients whose operation was cancelled	0.70%	0.62%	1.45%	1.68%	0.64%	1.15%	1.22%	1.68%	1.84%	1.25%	0.62%	1.79%
% target	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%

Developing an effective organisation

Plans for improving underlying organisational effectiveness in 2010/11 centred on the expansion of the leadership development programme 'Performance Plus' and progressing plans for a new clinically-led, managerially supported organisational structure.

The structural changes were successfully completed by the end of the financial year and a comprehensive development programme introduced to support successful implementation of the new arrangements.

Providing an effective and safe environment

2010/11 saw further significant investments in improving the environment for patient care. Major projects for 2010/11 included:

- A replacement magnetic resonance image (MRI) scanner at Lincoln County Hospital
- Preparing the redevelopment of the intensive care unit at Pilgrim Hospital, Boston
- A replacement interventional room at Pilgrim Hospital, Boston
- Advancing plans for the relocation of paediatric services at Lincoln County Hospital
- Securing the development of stroke and primary catheterisation services in preparation for capital development in 2011/12
- Continuing equipment replacement programmes

Heart attack patients see the benefits of new treatment

Patients suffering a heart attack have access to a new emergency treatment in Lincoln for the first time.

Lincoln County Hospital this year began offering Primary Percutaneous Coronary Intervention (PPCI) for all eligible heart attack patients from the Lincoln area who present to the hospital as an emergency between 8am and 6pm Monday to Friday.

The procedure uses a balloon to open up blocked arteries in patients suffering the most severe form of heart attack, but until now has only been offered to a limited number of urgent patients in Lincolnshire.

The programme will further expand over the next year, ultimately aiming to offer PPCI to all Lincolnshire patients 24 hours a day and seven days a week.

A patient whose heart stopped nine times before being saved by PPCI has supported the development of the service.

Graham Watson from Lincoln said: "This procedure is amazing, I know that without it I wouldn't be here now. The team at the hospital saved my life and I'm so grateful to them."

Year-on-year performance analysis

Indicator (2009/10)	Achieve	Fail	2009/10
Total time in A&E: 4 hours or less	98%	97%	97.33%
Referral to treatment times milestones - Admitted	90%	85%	88.40%
Referral to treatment times milestones - Non-admitted	95%	90%	95.70%
Waiting times for diagnostic tests (Excluding audiology)	10	30	1076
Number of inpatients waiting longer than the 26 week standard	0.03%	0.15%	7
			0.01%
Number of outpatients waiting longer than the 13 week standard	0.03%	0.15%	5
			0.00%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93%	90%	93.50%
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	97%	94%	98.60%
Maximum waiting time of 62 days from all referrals to treatment for all cancers	85%	80%	85.20%
(Cancelled ops) Number of patients whose operation was cancelled, by the hospital, for non clinical reasons, on the day of or after admission	0.80%	1.50%	1129
			1.48%
(Cancelled ops) Not treated within 28 days. (Breach)	5%	15%	54
			4.78%
Delayed transfers of care	3.50%	5.00%	5.83%
MRSA bacteraemia (All)	<31	31>	23
Clostridium difficile (Post 72)	<211	211>	159
Thrombolysis - 60 minute call to needle time (Oct 09-Dec 09)	68%	48%	N/A
Waiting times for Rapid Access Chest Pain Clinic (2wk Wait)	98%	95%	100%
Patients waiting longer than three months (13 weeks) for revascularisation	0.1%	0.2%	0
Data quality on ethnic group	>=85%	<60%	>=85%
Experience of patients	Pass	Fail	Satisfactory
Infant health and inequalities: smoking during pregnancy and breastfeeding initiation	Pass	Fail	
Engagement in clinical audits	Pass	Fail	Yes

Indicator (2010/11)	Achieve	Fail	Year to date	Current Position	Trend	
Total time in A&E: 4 hours or less	95%	95%	95.01%	95.51%	↔	Jul 10 - Mar 11
Referral to treatment times - Admitted - median wait	11.1 weeks	NA	NA	11.4 weeks	↑	*
Referral to treatment times - Admitted - 95th percentile	27.7 weeks	NA	NA	28.1 weeks	↓	*
Referral to treatment times - non admitted - median wait	6.6 weeks	NA	NA	5.5 weeks	↔	*
Referral to treatment times - non admitted - 95th percentile	18.3 weeks	NA	NA	18.4 weeks	↑	*
Waiting times for diagnostic tests (Excluding Audiology)	10	30	1023	42	↑	*
Number of inpatients waiting longer than the 26 week standard	0.03%	0.15%	380 0.48%	72 1.02%	↔	*
Number of outpatients waiting longer than the 13 week standard	0.03%	0.15%	1151 0.7%	46 0.31%	↑	*
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93%	90%	93.4%	97.1%	↑	**
2 week standard for non-suspected (symptomatic) breast referrals	93%	90%	90.0%	97.7%	↑	**
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	96%	94%	95.8%	96.5%	↑	**
31 day subsequent drug treatments	98%		98.7%	100.0%	↑	**
32 day subsequent surgery treatments	94%		98.5%	94.3%	↑	**
33 day subsequent radiotherapy treatments	94%		64.6%	96.2%	↑	**
Maximum waiting time of 62 days from all referrals to treatment for all cancers	85%	80%	81.60%	77.40%	↑	**

62 day standard from screening programmes	90%		82.50%	90.30%	↑	**
(Cancelled ops) Number of patients whose operation was cancelled, by the hospital, for non clinical reasons, on the day of or after admission	0.80%	1.50%	966	127	↓	*
			1.22%	1.79%		
(Cancelled ops) Not treated within 28 days. (Breach)	5%	15%	100	19	↓	*
			10.35%	14.96%		
Delayed transfers of care	3.50%	5.00%	4.06%	3.32%	↔	*
MRSA Bacteraemia (post 48 hrs)	<31	31>	9	0	↑	*
Clostridium difficile (Post 72)	<211	211>	94	4	↔	*
Thrombolysis - 60 minute call to needle time (Oct 09-Dec 09)	68%	48%	62.32%	61.76%	↔	Jul-Sep 10
Waiting times for Rapid Access Chest Pain Clinic (2wk Wait)	98%	95%	100%	100%	↔	**
Patients waiting longer than three months (13 weeks) for revascularisation	0.1%	0.2%	0%	0%	↔	*
Data quality on ethnic group	>=85%	<60%	98.1%	97.4%	↔	*
Experience of patients	Pass	Fail	Satisfactory	Satisfactory	↔	****
Infant health and inequalities: smoking during pregnancy and breastfeeding initiation	Pass	Fail			↔	****
Engagement in Clinical Audits	Pass	Fail	Yes	Yes	↔	****

* All figures as a March: ** All figures as at February: *** Last quarter: **** Annual Report

2010/11 was a year in which some notable performance successes were achieved, particularly amongst some quality indicators including the management of infection and an improvement to the Trust's Standardised Mortality Ratio (HSMR).

Performance against the cancer standards has been maintained overall, although more efforts continue to be made to reduce waiting for patients with cancer still further. For both admitted and non-admitted patients, new national measures of median and 95th percentile referral to treatment (RTT) waiting times were introduced during 2010/11.

The Trust has continued to experience difficulty in meeting the new standards although it is apparent that the main pressures on the system are limited to particular specialties,

primarily orthopaedics. That understanding has led to the development of specific specialty recovery plans which are being implemented in 2011. In orthopaedics, for example, the plan includes the creation of additional theatre capacity and changes to the management of trauma and elective surgery which will enable the service - and consequently the Trust - to meet the RTT standards.

The Trust met the A&E target for 95% of patients who attend the department being seen, treated and either admitted or discharged within 4 hours – recording a performance of 95.01% for the year.

Analysis of Trust performance over the last two years presents a mixed picture of partial improvement in the areas mentioned above, combined with difficulty maintaining standards in others. The previous methods of improvement are unlikely to make the step change required to enable the Trust to perform consistently ahead of the standards and consequently a shift in approach has seen the establishment of a Transformation Programme focussing on the twin areas of planned and unscheduled care.

Forward look – overview of Trust strategy for 2011/12

Organisational and service development in 2011/12 has a strong focus on placing the Trust on a sound service and financial footing, in turn supporting the achievement of Foundation Trust status in 2013/14. Achieving this aim will require intensive focus on improving the experience of patients, access to services and specific qualitative improvements across all aspects of clinical and non-clinical services. Compliance with the full range of performance standards is also an essential pre-requisite. The strategy will also deliver stronger financial performance, ensuring long term financial viability and providing a sound basis for developing clinical services into the future.

The progress of the Trust over the last two to three years has been characterised by relatively small scale change, responding to pressures as they emerge and develop. It is unlikely that continuing this approach will be sufficient to bring about the scale and pace of change required if the Trust is to meet its goals and objectives over the next three years.

Consequently the main elements of the 2011/12 strategy include:

- Significant transformational change being delivered through a structured and performance managed Transformation Programme, incorporating:
    - Clinical strategy review
    - Implementation of the agreed service priorities of stroke (Lincoln and Pilgrim) PPCI (Lincoln), endoscopy (all sites), critical care and interventional room (Pilgrim) and decontamination (Lincoln)
    - Care pathway redesign in both planned and unscheduled care
    - Service quality improvements including the full achievement of CQUIN standards and associated income
    - Productivity improvements

- Significant cost base reduction in the early years of the strategy, exceeding the implied national efficiency requirement of 4% per annum

- Increasing the Trust's market share. Since 2007 the Trust has experienced significant growth in non-elective demand, effectively displacing the Trust's elective capacity

- Controlling and reducing non elective demand. A strategy jointly agreed with NHS Lincolnshire will redesign services and care pathways and implement commissioner demand management initiatives so as to return emergency demand by the end of 2012/13 to those levels experienced in 2008/9

- Enhanced business intelligence and availability of operational information through improved data collection, data management and improved data quality

- Rigorous performance and programme mangement to ensure the delivery of service and financial objectives, including the delivery of CIPs and service line profitability. Particular attention will be given to the avoidance of contractual penalties and fines, and recovery of supplementary income linked to performance improvement

- Increased management capability and clinical engagement as a result of the new management arrangements implementedin April 2011

Hospital endoscopy units awarded for high standards of care

Endoscopy units in Lincolnshire's hospitals have been awarded a national accreditation for the high standards of care that they provide.

The endoscopy units at Pilgrim Hospital, Boston, Grantham and District Hospital and County Hospital, Louth were all given JAG accreditation in early 2011, which is a national award set up to ensure high standards of care in clinical quality, quality of patient experience, training and workforce.

The unit at Lincoln County Hospital gained their award in 2009.

Trust goals and objectives

The Trust has set a series of objectives for 2011/12 which are designed to support achievement of its six long term goals. The objectives also incorporate the requirements of the NHS Operating Framework. The goals and objectives are as follows:

Goal	Objectives
To develop a range of clinical services which are viable, safe, effective and efficient, and which meet the assessed needs of the population	Develop the ULHT clinical strategy with key stakeholders, taking into account the shaping health initiatives across the community
	Deliver agreed priority service developments
To deliver a positive patient experience in all contacts with our services	Ensure that services are accessible and that waiting is minimised
	Provide services which respond to patient choice
	Deliver care in a clean, safe environment
	Develop systems to measure patient experience
To be here for the long term	Achieve improved efficiency and effectiveness through service transformation
	Optimise the cost base through the delivery of a planned cost improvement programme
	Develop plans to increase market share in future years
	Develop an effective performance management framework alongside the implementation of service line management processes and the development of business metrics
	Improve business intelligence
	Deliver the 5 year financial plan
	Optimise the use of, and investment in, the estate, facilities and major equipment
To secure and develop a committed, flexible, effective and productive workforce	Improve leadership and management capability through structured development programmes for the board, executive and managers
	Develop and implement a workforce strategy that maximises the contribution of the workforce
	Develop and implement a workforce strategy to maximise recruitment and retention opportunities
	Increase workforce flexibility

To deliver commissioned services which comply with regulatory requirements, national targets and locally agreed standards	Ensure compliance with the national standards relating to A&E, coronary syndromes and cancer (domain 2 of the ULHT performance framework)
	Maintain CQC registration without restrictive conditions
	Ensure effective arrangements are in place to continually monitor the effectiveness of healthcare provided to patients
To be respected and have a great reputation	Develop positive business relationship with commissioning partners
	Deliver our service contract activity and work programme requirements
	Improve the public and business relations profile of ULHT

Key performance indicators 2011/12

The key performance indicators for the Trust are summarised in the revised performance framework which was introduced from April 2011. These are aligned with the Trust goals and objectives described above and together form the core of the Trust's Board Assurance Framework (BAF).

The performance framework will be managed through a series of performance clinics, the intensity and frequency of which will be proportionate to actual performance and future risk. A scorecard has been developed for each business unit and directorate with the principle of a balanced view across three domains as follows:

Domain 1: Service quality -
Including hospital standardised mortality ratios (HMSRs), CQUIN standards, MINAP (cardiac) standards, maternity specific standards, NICE appraisals and implementation, access to services, in-hospital experience, effective discharge and listening to and acting on feedback including complaints.

Domain 2: Service performance –
Cancer waiting times, A&E standards and the delivery of services for acute coronary syndromes (ACS) including stroke and PPCI.

Domain 3: Use of resources –
Indicators of productivity and throughput, financial management and human resources management.

Hospitals achieve national standard for information

Lincolnshire's hospitals have been recognised as providing reliable and trustworthy health and social care information, by achieving The Information Standard - which is a new certification for health and social care information.

Publications by United Lincolnshire Hospitals NHS Trust can now carry the Information Standard mark, which shows that all patient information leaflets have been through a strict policy, as a mark of quality and reassurance to the public.

ULHT is the eighth NHS Trust to be awarded the mark in the country.

Emergency preparedness

The Trust is required to comply with legislation and standards regarding emergency preparedness and works closely with colleagues in the Primary Care Trust and other health providers to consider, plan and test the preparedness for the county.

It is also part of a multi-agency group reporting to the Lincolnshire Resilience Forum for emergency planning.

Plans are in place to deal with major incidents. These plans are regularly tested and updated. Exercises that have been undertaken this year include earthquake scenarios, widescale and local flooding, site lockdown and mass casualty planning.

Principles for remedy

The Trust is committed to resolving complaints efficiently and effectively with the minimum of bureaucracy. In doing so, every effort is made to ensure that any lessons are learned and a full explanation and apology is given, where appropriate. The Trust has designed its complaints system in accordance with the good practice outlined by the Health Service Ombudsman's 'Principles of Remedy' document.

The Trust aims to put the needs of the patient/complainant at the centre of every stage of its complaints procedure with open and honest responses. Complaint information is coordinated on a centralised database and used by the Trust to learn from complaints and improve the services provided. The Trust is committed to achieving the national standard of 80% of complaints responded to in an agreed timeframe. This was not met and the Trust has a number of actions in place including an improvement project to understand the cause of delays, frequent review of performance, improved governance to ensure accountability and ownership of complaints, training for those investigating and responding to complaints.

Serious untoward incidents- information governance

The confidentiality and security of patient data is paramount and the Trust is required to report to the Information Commissioner any serious untoward incidents involving the loss of personal data. For 2010/11 there were no such incidents reported.

Personal data related incidents in 2010-11 are summarised below:

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	3
V	Other	0

Environmental footprint

United Lincolnshire Hospitals NHS Trust aims to reduce its carbon dioxide (CO2) emissions by 30% by 2015. This will not only benefit the environment but is also expected to save the Trust in excess of £600,000 per annum.

Energy efficiency is an important part of our management policy, with initiatives such as the installation of biomass boilers and improved staff awareness. The Trust has installed a biomass boiler at Pilgrim Hospital, Boston which halved the hospital's annual CO2 emissions and it has continued to achieve excellent performance from this development. This Trust is now working with the Carbon Trust on a business case for a similar development at Grantham and District Hospital.

Raising awareness among staff of the impact of their individual behaviour is a priority. Energy champions are being recruited at each site, as well as the introduction of staff training days and the promotion of responsible energy use at staff induction sessions.

The Trust is a member of the Green Group, an environmental group with members from NHS Lincolnshire, Lincolnshire Partnership NHS Foundation Trust and Lincolnshire County Council. The members work collaboratively together on a wide range of energy and environmental projects, from allotments to boiler replacements.

The facts
We have a total of 1,562 beds across our hospital sites

Carbon management is being embedded in all process and purchasing decisions. The Trust has already begun to evaluate its suppliers' carbon reduction strategies and how their emissions may be reduced, looking at the CO2 emissions resulting from supplier partnerships and establishing reporting arrangements to keep track of improvements. Building design, waste management and water management have also been included in a comprehensive new approach.

The Trust participates in the EU Carbon Trading Scheme and its consistent high performance on carbon reduction has resulted in significant financial benefits that can be re-invested in services.

Sustainable sourcing of food

The Trust has long-standing arrangements in place to help promote the use of locally grown, seasonal foods within its catering operations.

It is a major purchaser of raw ingredients and food products and is committed to minimising waste, reducing food miles, reducing carbon emissions, support local companies and obtaining best value for money. All catering teams have the ability to select local suppliers where they meet the quality and value criteria, either on an annual contract basis or for seasonal produce.

The Trust aims to continue to increase the use of local suppliers wherever possible, ensuring that it embraces the Good Corporate Citizenship Scheme that promotes the use of locally produced goods.

Developments

The Trust continues to invest in energy-saving schemes and carbon reduction initiatives. It is working with waste contractors to increase the level of recycling to 50% over the next three years and in 2010/11 it entered into new waste management contracts to provide a range of recycling services to all sites.

The facts
We serve more than 1.3 million meals in our hospitals every year

Cardboard and paper is routinely recycled and there is also increasing recycling of plastic, aluminium, tin cans, glass, furniture and scrap metal.

Patient Environment Action Team (PEAT)

The Trust offers consistently high standards of food and respects the privacy and dignity of patients according to the results of a national assessment. The Patient Environment Action Team (PEAT) assessments for 2010/11 are below. All the Trust's hospitals achieved 'excellent' rating for food for the first time ever.

The results show significant improvements on last year. At Lincoln County Hospital both the food and privacy and dignity scores improved. At Pilgrim Hospital, Boston improvements have been made for privacy and dignity.

Site	Environment score	Food score	Privacy and dignity score
Grantham and District Hospital	Good	Excellent	Good
Lincoln County Hospital	Acceptable	Excellent	Good
County Hospital, Louth	Good	Excellent	Good
Pilgrim Hospital, Boston	Accceptable	Excellent	Good

During 2010/11, a programme of work was completed to transfer all ward-based housekeeping resources to become an integral part of the ward team, accountable to the ward manager.

Our staff

Making partnerships work

United Lincolnshire Hospitals NHS Trust is committed to positive partnership relations with staff and their representatives, to ensure that they are actively involved in any changes that affect them. The Trust aims to be recognised locally as a model employer and it is actively working with recognised staffside organisations to develop policies which support and engage staff. A new framework for consultation and negotiation has been implemented as part of the partnership agenda.

Training and development

During 2010/11, the Trust continued to develop its leadership and management capability through accredited and structured development programmes with a continued focus on mentoring and coaching.

Work has also continued to embed the behaviour framework and a culture of accountability through effective appraisal and personal development plans for an increased number of staff.

The Trust has successfully trained a number of qualified mediators to help support the resolution of problems raised by staff. The benefits are being seen in a reduced number of formal processes being initiated.

A new mandatory training framework has been developed and will be implemented during the current year.

Changing hospital culture to improve patient mealtimes

Protecting mealtimes for patients has been made a top priority with the introduction of a new programme into Lincolnshire's hospitals.

United Lincolnshire Hospitals NHS Trust has this year launched its Protected Mealtimes project.

This is aimed at ensuring that all hospital patients get the help and support they require to eat, by introducing dedicated periods of time in which all non-essential activities and tasks stop so that ward staff are available to do mealtime service and give the patients assistance and encouragement.

Protected mealtimes are now run on all hospital wards during lunch service from 12noon to 2pm and dinner service from 5pm to 6pm (5.30pm to 6.30pm at Pilgrim Hospital, Boston).

Disability policy

The Trust is signed up to the Job Centre Plus 'Positive About Disabled People' scheme. It has made a positive commitment regarding the employment, retention, training and career development of disabled people.

Specifically, it is committed to:

- Interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them based on their abilities
- Ensure there is a mechanism in place to discuss with disabled employees at any time, and at least once a year, what both parties can do to make sure they can develop and use their abilities to their full potential
- Make every effort to ensure employees are able to stay in employment if they become disabled
- Take action to ensure that all employees develop the appropriate level of disability awareness needed to make sure these commitments work
- Review these commitments each year and assess what has been achieved, plan ways to improve them and let employees and Jobcentre Plus know about progress and future plans

Equality and diversity

The Trust adopted the new NHS Equality Delivery Scheme in March 2011. This national scheme aims to improve performance against diversity targets and to strengthen compliance with statutory requirements. Close working with local interest groups underpins the initiative.

Equality is about creating a fairer society in which everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense.

United Lincolnshire Hospitals NHS Trust recognises that everyone is different and values the unique contribution that individual experiences, knowledge and skills make in delivering quality healthcare and becoming a model employer. It is committed to strengthening its organisational culture through the implementation of the Equality Delivery Scheme and other policies, such as dignity at work and the dignity in care.

The Trust will continue to promote equality and challenge discrimination in all service provision, recognising and meeting the needs of the diverse communities it serves. It will strive to provide an environment in which people want to work and to be a model employer leading in good employment practice. Each member of staff will be able to achieve their full potential in an environment characterised by dignity and mutual respect.

The Trust will not tolerate unlawful discrimination, victimisation, bullying or harassment based on race, ethnic or national origin, nationality, age, disability, 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 principles would be addressed in accordance with the Trust's policies and procedures.

New coordinators supporting hospital staff to help patients

The assessment of patients on arrival at hospital is being prioritised in Lincolnshire, with the appointment of three Venous Thromboembolism (VTE) Coordinators to county hospitals.

The VTE coordinator posts have been created to help in the prevention of VTE for all adult patients admitted to Grantham and District Hospital, Pilgrim Hospital, Boston and Lincoln County Hospital.

VTE is a condition in which a blood clot forms in a vein limiting blood flow through the vein, and which is more common among those who are in hospital.

The coordinators within United Lincolnshire Hospitals NHS Trust are in position to support staff who deal with the admission of patients in Lincolnshire's hospitals - raising awareness of the importance of completing thorough risk assessments for all adult patients admitted to hospital and promoting best practice in the management of VTE.

Building a world class workforce- Annual Staff Survey 2010

The Trust has made statistically significant improvements in some areas of staff engagement since 2009. Support from immediate managers, commitment to work-life balance and a reduction in staff intention to leave their jobs have all continued to improve.

A major achievement is the increased use of appraisal, which has

increased by 20% across the Trust. Communication remains a challenge but the Trust is committed to improving communication between senior managers and staff.

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 affecting their health.

The facts
We wash more than 4.5 million items of linen in our hospitals each year

A target for a 4.5% or lower monthly sickness rate was set for the year with a major sickness absence initiative launched in-year to support progress towards the target. As at 31 March 2011 a monthly rate of 4.7% had been achieved with a 5.1% average for the year.

Auditors and audit fee

The Audit Commission is the Trust's appointed external auditor and was paid £215,000 (Exc. VAT) in respect of statutory audit fees for the 2010/11 financial year. This does not include the fee for the audit of the Quality Account.

The range of audit services provided by the Audit Commission included statutory review and audit of the annual accounts, value for money assessment and review of the Trust's governance and financial arrangements.

The Audit Commission review of the 2010/11 financial statements resulted in an unqualified opinion on the accounts and a qualified (adverse) value for money conclusion.

The Trust uses Parkhill Internal Audit Service to provide internal audit services.

The Audit Committee receives the annual accounts, the annual audit letter and other reviews and reports completed by the external auditors during the year.

Charging for information

It is Government policy that much information about public services should be made available either free or at low cost in the public interest.

In common with most public organisations, ULHT regularly posts freely available information about their activities and services on the internet. The Trust also responds to specific queries under the Freedom of Information Act. In most instances this will be at no cost, however where information is not readily available the Trust may choose to charge for costs of preparing the information requested, but would only do so with the express agreement of the recipient.

The Trust therefore ensures compliance with the Treasury's guidance on setting charges for information.

Statement on internal control

1) Scope of responsibility

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

The Trust is accountable for the delivery of its patient services through the contract it has with its commissioners, the main commissioner being NHS Lincolnshire. The regulatory framework within which it is working is that of the Strategic Health Authority (NHS East Midlands) being responsible for the performance management of NHS Lincolnshire, who hold the Trust to account through the contract. The Trust reports through NHS East Midlands to the Department of Health on performance against national objectives.

2) The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the 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 2011 and up to the date of approval of the annual report and accounts.

3) Capacity to handle risk

Overall responsibility for risk management rests with all members of the board. For 2010/11, the Chief Nurse has an explicit responsibility for the risk management function within the organisation. The Director of Finance has specific responsibility for financial risks within the Trust. There is a defined structure for the management and ownership of governance, through the risk register and assurance framework which is regularly monitored in the board committees and at board level. The Trust operates and maintains a board-approved risk management strategy that identifies the levels of accountability and responsibility for all staff within the organisation.

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

risk management training is provided to staff in accordance with their role within the organisation

The Trust also has a sharing lessons learned framework which facilitates the dissemination of good practice across the organisation. The principle of sharing lessons learned is simple, in that key lessons to be learned from all of the various clinical governance activities and performance reviews are identified and presented to a forum chaired by the Chief Nurse. The forum considers learning reports and ensures that lessons to be learned are shared across the organisation.

4) The risk and control framework

Managing risk is the responsibility of all employees and not just the role of specialists, managers or the board. All employees are responsible for identifying, reducing 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.

Policies are in place which encourage staff to report adverse incidents and near misses in order to minimise risk and take action to prevent recurrence. This message is reinforced through the risk management strategy.

An organisational risk register is maintained which comprises information from all key managers who have identified the main risks in their area of work. Risk assessments contribute to the Trust's risk register and encompass both clinical and non-clinical risks. Risks are reviewed in respect of all reports presented to the board, along with the relevant equality impact assessment.

The Trust has developed an information assurance management policy to manage and control risks in relation to data security. Risks relating to information and data security have been recorded in the Trust risk register where necessary and the Governance Committee has during the year reviewed the assurances provided that risks were being mitigated. The Trust Information Governance Committee meets monthly and reports directly to the Governance Committee.

In line with the requirements of the White Paper "Equity and Excellence: Liberating the NHS" the Trust has reviewed its structures and developed proposals for change, which were consulted on during November and December 2010. New structures were implemented from April 2011.

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 Statement on Internal Control, not designed to show every risk, but to focus attention on those which are most significant.

The Governance Committee and Audit Committee assess the 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 coordinated 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 2010/11, the board has identified and monitored against eight key objectives within its Board Assurance Framework (BAF). The controls and assurances in relation to the objectives' risks were received by the board during the year. The framework identified gaps in control for some financial, operational and clinical measures and the Trust has taken and continues to take remedial action to address them. Any actions not complete will form part of the assurance framework for 2011/12. This is further supported by the implementation of new governance arrangements by the Trust.

The Trust has involved the Patient Council in managing the risks that affect the organisation. They are represented on the board, the Governance Committee and Quality Governance Committee and carry out periodic inspections within the Trust.

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

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

The Trust has undertaken a climate change risk assessment and developed an adaptation plan to support its emergency preparedness and civil contingency requirements, based on the UK Climate Projections 2009 (UKCP09), to ensure that the organisation's obligations under the Climate Change Act are met.

The Trust is not fully compliant with CQC essential standards of quality and safety. Following a visit to Pilgrim Hospital, Boston, the CQC found that the Trust was failing to comply with Regulation 9/Outcome 4: Care and welfare of people who use services and Regulation 14/Outcome 5: Meeting Nutritional Needs. At Lincoln County Hospital the CQC identified minor or moderate concerns for 5 of the 16 outcomes.

5) Review of effectiveness

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of Internal Audit's work. For 2010/11, the overall Head of Internal Audit Opinion gave significant assurance.

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 the Audit Commission, clinical audit, the royal colleges and the multi-professional Dean's visits, Dr Foster analysis and the Care Quality Commission (CQC).

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 Governance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that have been applied in maintaining and reviewing the effectiveness of internal control in 2010/11 are described below.

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 in meeting these aims and objectives and mapping the key controls in place to manage these risks.

Assurances about the system of internal control is given to the board both directly and indirectly through its committee structure, where issues of governance are considered by non-executive and executive directors, supported by officers of the Trust.

The Governance Committee assesses the adequacy of the assurance framework and advises the Audit Committee and the board in relation to the coordination and effectiveness of the systems, processes and controls in place to achieve delivery of the organisation's objectives and minimise risk. This enables the board to discharge its responsibilities for governance and understand the balance of clinical, operational and financial risks.

As accountable officer, I attend the Governance Committee which is chaired by a non-executive member of the board.

The Audit Committee monitors and receives assurances on the assurance framework and other compliance issues and provides assurance to the board.

The assurance framework brings together the evidence to support the SIC requirements. Internal Audit review highlighted that the Board Assurance Framework has been established which is designed to meet the requirements of the 2010-11 SIC and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation, but required better risks and control definitions, alignment of controls and assurances to risks and better cross-referencing.

The Trust Board has received limited assurance with regards to reviews of the cost improvement programme, recruitment and selection and the management of medical notes. Recommendations were agreed and actions are being taken to address weaknesses highlighted in these reviews.

Following registration with the CQC and as a result of a subsequent responsive review visit in June 2010 a number of minor/moderate concerns were identified. Remedial action plans to address the issues raised and ensure compliance with the above regulation have been agreed with the CQC and are being addressed.

The CQC undertook a planned review of compliance with the essential standards of quality and safety following an unannounced visit to both the Lincoln County Hospital and Pilgrim Hospital, Boston sites in early February 2011.

The Trust was issued with warning notices in relation to two outcomes at Pilgrim Hospital, Boston and asked to take corrective action. The CQC found that the Trust was failing to comply with Regulation 9/Outcome 4: Care and welfare of people who use services and Regulation 14/Outcome 5: Meeting Nutritional Needs. Remedial action plans to address these failures have been developed and are being addressed.

In 2010/11 the Trust recorded and reported no serious untoward incidents involving personal data.

There have been no cases of non compliance with equality and human rights legislation.

The Trust reported an income and expenditure deficit of £14.2m at the end of 2010/11. The deficit was due to a number of factors, including growth in non elective activity and high costs of locum cover and a failure to meet the CIP programme. The Trust has put in place plans to return to financial balance in 2011/12.

With the exception of the internal control 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 control issues have been or are being addressed.

Mr Andrew North
Chief Executive

Our finances

Overview

The outturn for the financial year ending 31 March 2011 showed an operating deficit of £13.9 million (after technical adjustments of £0.3 million relating to impairments which lie outside the Trust breakeven duty).

This deficit has compromised the delivery of the break even duty required of NHS trusts.

Looking forward, the Trust has developed a long term Transformation Programme which will underpin the financial recovery plan.

The Trust's long term financial plans deliver break even in 2011/12, and move to a sustainable underlying recovery during 2012/13 with financial surplus against the breakeven duty planned from 2014/15 onwards.

	Prior year accounts			Financial plans				
	Mar-09	Mar-10	Mar-11	Mar-12	Mar-13	Mar-14	Mar-15	Mar-16
Cumulative deficit against breakeven duty b'f	(1,116)	4,071	5,353	(8,527)	(8,523)	(7,307)	(3,280)	199
Net surplus/ (deficit) - including impairments	366	(4,002)	(14,177)	4	642	4,027	3,479	3,401
Impairments	4,821	5,284	297		574			
Net surplus/ (deficit) - excluding impairments - breakeven duty measurement	5,187	1,282	(13,880)	4	1,216	4,027	3,479	3,401
Cumulative deficit against breakeven duty c'f	4,071	5,353	(8,527)	(8,523)	(7,307)	(3,280)	**199**	3,600

Performance against the key financial targets during 2010/11 are summarised in the following table:

Target	2009/10	2010/11
Income and expenditure position against breakeven duty	£1.3 million surplus	**£13.9 million deficit**
Manage within External Financing Limit (EFL)	Achieved	**Achieved**
Manage within Capital Resource Limit (CRL)	Achieved	**Achieved**
Achieve a capital cost absorption duty of 3.5%	3.5%	**3.5%**
Management costs as a percentage of turnover*	3.49%	**3.70%**
Better Payment Practice code Invoices paid within 30 days (measured by volume)	77%	**79%**

*Management costs are defined on the Department of Health website at: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en

Trust income

The majority of the income in 2010/11 (£360.0 million or 92% of total income) was earned by providing clinical services to NHS patients under contracts with commissioners, principally Primary Care Trusts (PCTs). NHS Lincolnshire provides the most significant contract income from PCTs.

The Trust has once again provided a higher level of activity than that performed in previous years, or than the levels planned in relation to emergency activity. This has had an adverse impact on the delivery of elective activity and therefore the 18 week referral to treatment target for admitted patients. The levels of activity delivered in 2010/11 resulted in an over performance against the initial contract of £8.9 million (2.6%).

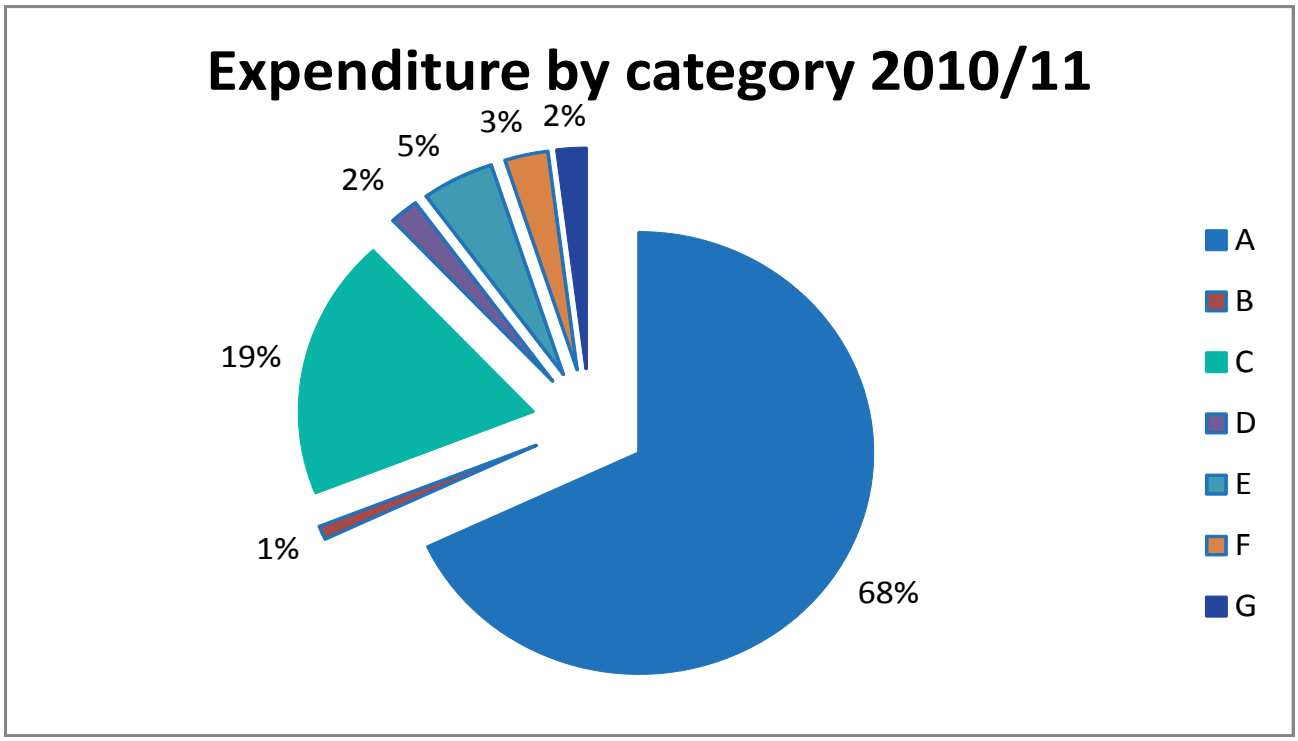
The Trust earned £19.0 million for education, training and research. The majority of this income came from East Midlands Strategic Health Authority Workforce Deanery and is provided as reimbursement for training of undergraduate doctors, junior doctors, nurses and technical staff.

Trust expenditure

The Trust incurs costs that are predominantly associated with the provision of clinical activity. The largest expenditure area is pay which accounts for 68% of the total expenditure.

Pay expenditure in 2010/11 exceeded the initial budget for the year due mainly to additional activity and increased use of agency staff, particularly medical staff where there is a national shortage. The impact of this national shortage is more significant in the Lincolnshire healthcare services than in many other areas.

The chart below breaks down the Trust expenditure across the main categories:



A - Pay – The Trust's largest cost each year is paying the salary of its 6,600 staff (whole time equivalent) and all the associated costs an employer needs to spend including national insurance and pension contributions. The pensions of the majority of NHS staff are administered through the NHS Pension Scheme, details of which can be found within the full accounts.

B - Public Dividend Capital – The Trust has to make a payment to the Department of Health equivalent to 3.5% of assets which is similar in nature to the payment companies would need to make to shareholders.

C - Drugs and medical equipment – The cost of patients' medication, dressings, syringes and other medical equipment.

D - Other

E - Maintenance – What the Trust spends on gas, electricity, water and telephone bills as well as business rates and minor repairs and maintenance programmes.

F - Depreciation – The reduced value of the Trust's buildings and equipment over time has to be accounted for each year. Included are impairments where valuation of land or buildings indicates a reduction in value.

G - Insurance – To cover the Trust against fire, theft and other liabilities, for example legal claims.

Cost Improvement Programme

The national tariff for 2010/11 had an implied efficiency of 3.5%, other contracts similarly utilised this figure.

The Trust needed to achieve savings of at least £18.3 million to deliver the planned surplus for the year of £1.1 million.

The Trust successfully delivered savings of £9.8 million; £5.3 million being cash releasing and the balance split between productivity improvements and cost avoidance.

Cash flow

The cash balance of £9.9 million on 31 March 2011 meant that cash and the Department of Health external financing limit target for 2010/11 was achieved.

The Trust's liquidity plans for 2011/12 and beyond are predicated on a 5 year working capital loan which will allow the Trust to manage the short-term cash implications of the 2010/11 operating deficit through the recovery period.

Management of cash is governed by the Trust's Treasury Management Policy, which sets out the parameters within which the Trust may invest any surplus cash on a temporary basis. As a non Foundation Trust, investment is restricted to deposits of cash made through the National Loans Fund. In 2010/11 due to the low interest rates, returns were limited to £44,000.

Capital

The Trust invested £12.4 million in the capital programme during the year. The table below summarises this by category:

	£ million
Buildings and estate	5.0
IT infrastructure	0.8
Medical equipment	6.6
Total	12.4

The capital programme was funded through internally generated resources and donated assets of £0.3 million.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Performance for 2010/11 against this target is summarised as follows:

	2010-11	
	Number	£000
Total non-NHS trade invoices paid in the year	105,519	98,891
Total non NHS trade invoices paid within target	83,137	73,273
Percentage of non-NHS trade invoices paid within target	79%	74%
Total NHS trade invoices paid in the year	2,820	58,507
Total NHS trade invoices paid within target	2,254	48,327
Percentage of NHS trade invoices paid within target	80%	83%

The Trust has applied to become a signatory of the 'Prompt Payment Code' set up by the Government and Institute of Credit Management. As an approved signatory the Trust would be undertaking to:

- **Pay suppliers on time:**

  - Within the terms agreed at the outset of the contract
  - Without attempting to change payment terms retrospectively
  - Without changing practice on length of payment for smaller companies on unreasonable grounds

- **Give clear guidance to suppliers:**

  - Providing suppliers with clear and easily accessible guidance on payment procedures
  - Ensuring there is a system for dealing with complaints and disputes which is communicated to suppliers
  - Advising them promptly if there is any reason why an invoice will not be paid to the agreed terms

- **Encourage good practice:**

  - By requesting that lead suppliers encourage adoption of the code throughout their own supply chains

Summary financial statements 2010/11

Statement of comprehensive income for the year ended 31 March 2011

	2010-11	2009-10
	£000	£000
Revenue:		
Revenue from patient care activities	**360,039**	353,458
Other operating revenue	**32,163**	37,683
Operating expenses	**(399,010)**	(388,115)
Operating surplus/(deficit)	**(6,808)**	3,026
Finance costs:		
Investment revenue	**44**	53
Other gains and losses	**(1,448)**	(455)
Finance costs	**(119)**	(142)
Surplus/(deficit) for the financial year	**(8,331)**	2,482
Public dividend capital dividends payable	**(5,846)**	(6,484)
Retained surplus/(deficit) for the year	**(14,177)**	(4,002)
Other comprehensive income:		
Impairments and reversals	**(3,265)**	(28,434)
Gains on revaluations	**8,580**	1,918
Receipt of donated/government granted assets	**572**	1,189
Net gains/(losses) on available for sale financial assets	**0**	0
Reclassification adjustments:		
- Transfers from donated and government grant reserves	**(664)**	(731)
- On disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year	**(8,954)**	(30,060)
Reported NHS financial performance position:		
Retained surplus/(deficit) for the year	**(14,177)**	(4,002)
Impairments	**297**	5,284
Reported NHS financial performance position [Adjusted retained surplus/(deficit)]	**(13,880)**	1,282

A Trust's reported NHS financial performance position is derived from its retained surplus/(deficit), for the year but adjusted for the following:

a) Impairments to Fixed Assets: 2009/10 was the final year for organisations to revalue their assets to a Modern Equivalent Asset (MEA) basis of valuation. An impairment charge is not considered part of the organisation's operating position.

Statement of financial position as at 31 March 2011

	31 March 2011	31 March 2010	Restated 1 April 2009
	£000	£000	£000
Non-current assets:			
Property, plant and equipment	**208,390**	203,562	229,171
Intangible assets	**1,432**	1,433	1,688
Other financial assets	**0**	0	0
Trade and other receivables	**2,351**	1,928	1,730
Total non-current assets	**212,173**	206,923	232,589
Current assets:			
Inventories	**6,218**	5,849	5,154
Trade and other receivables	**10,927**	10,201	18,165
Other financial assets	**0**	0	0
Other current assets	**669**	358	183
Cash and cash equivalents	**9,865**	6,032	11,705
	27,679	22,440	35,207
Non-current assets held for sale	**355**	790	489
Total current assets	**28,034**	23,230	35,696
Total assets	**240,207**	230,153	268,285
Current liabilities:			
Trade and other payables	**(40,076)**	(24,999)	(32,830)
Other liabilities	**(504)**	(519)	(519)
Borrowings	**(109)**	(98)	(88)
Other financial liabilities	**0**	0	0
Provisions	**(5,716)**	(1,603)	(918)
Net current assets/(liabilities)	**(18,371)**	(3,989)	1,341
Total assets less current liabilities	**193,802**	202,934	233,930
Non-current liabilities:			
Borrowings	**(748)**	(857)	(940)
Trade and other payables	**0**	0	0
Other financial liabilities	**0**	0	0
Provisions	**(2,279)**	(2,333)	(2,378)
Other liabilities	**(17,132)**	(18,147)	(18,671)
Total assets employed	**173,643**	181,597	211,941
Financed by taxpayers' equity:			
Public dividend capital	**181,753**	180,753	181,037
Retained earnings	**(38,002)**	(24,934)	(24,530)
Revaluation reserve	**26,940**	22,758	52,671
Donated asset reserve	**2,234**	2,529	2,390
Government grant reserve	**528**	301	183
Other reserves	**190**	190	190
Total taxpayers' equity	**173,643**	181,597	211,941

Statement of changes in taxpayers' equity: Year ending 31 March 2011

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010-11:							
Balance at 1 April 2010	180,753	(24,934)	22,758	2,529	301	190	181,597
Total comprehensive income for the year							
Retained surplus/(deficit) for the year		(14,177)					(14,177)
Transfers between reserves		1,109	(1,109)	0	0	0	0
Impairments and reversals			(3,289)	20	4		(3,265)
Net gain on revaluation of property, plant, equipment			8,580	0	0		8,580
Net gain on revaluation of intangible assets			0	0	0		0
Net gain on revaluation of financial assets			0				0
Receipt of donated/government granted assets				347	225		572
Net gain/loss on other reserves (e.g. defined benefit pension scheme)						0	0
Movements in other reserves							0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve				(662)	(2)		(664)
- on disposal of available for sale financial assets			0				0
Reserves eliminated on dissolution		0	0	0	0	0	0
Originating capital for trust establishment in year	0						0
New PDC received	1,000						1,000
PDC repaid in year	0						0
PDC written off	0						0
Other movements in PDC in year	0						0
Balance at 31 March 2011	181,753	(38,002)	26,940	2,234	528	190	173,643

Statement of cash flows for the year ended 31 March 2011

	2010-11	2009-10
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit)	**(6,808)**	3,026
Depreciation and amortisation	**11,257**	11,060
Impairments and reversals	**297**	5,284
Net foreign exchange gains/(losses)	**0**	0
Transfer from donated asset reserve	**(662)**	(594)
Transfer from government grant reserve	**(2)**	(137)
Interest paid	**(64)**	(86)
Dividends paid	**(5,269)**	(7,009)
(Increase)/decrease in inventories	**(369)**	(695)
(Increase)/decrease in trade and other receivables	**(1,149)**	8,104
(Increase)/decrease in other current assets	**(84)**	183
Increase/(decrease) in trade and other payables	**12,423**	(6,709)
Increase/(decrease) in other current liabilities	**(818)**	(524)
Increase/(decrease) in provisions	**3,785**	584
Net cash inflow/(outflow) from operating activities	**12,537**	12,487
Cash flows from investing activities		
Interest received	**45**	53
(Payments) for property, plant and equipment	**(9,544)**	(18,785)
Proceeds from disposal of plant, property and equipment	**340**	1,124
(Payments) for intangible assets	**(447)**	(195)
Proceeds from disposal of intangible assets	**0**	0
(Payments) for investments with DH	**0**	0
(Payments) for other investments	**0**	0
Proceeds from disposal of investments with DH	**0**	0
Proceeds from disposal of other financial assets	**0**	0
Revenue rental income	**0**	0
Net cash inflow/(outflow) from investing activities	**(9,606)**	(17,803)
Net cash inflow/(outflow) before financing	**2,931**	(5,316)
Cash flows from financing activities		
Public dividend capital received	**1,000**	0
Public dividend capital repaid	**0**	(284)
Loans received from the DH	**0**	0
Other loans received	**0**	0
Loans repaid to the DH	**0**	0
Other loans repaid	**0**	0
Other capital receipts	**0**	0
Capital element of finance leases and PFI	**(98)**	(73)
Net cash inflow/(outflow) from financing	**902**	(357)

Net increase/(decrease) in cash and cash equivalents	**3,833**	(5,673)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**6,032**	11,705
Effect of exchange rate changes on the balance of cash held in foreign currencies	**0**	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**9,865**	6,032

Accounting policies

The accounts have been prepared in accordance with guidance issued by the Department of Health, and in line with International Financial Accounting Standards (IFRS). So far as the directors are aware, there is no relevant information of which the auditors are unaware.

Going concern

After making enquiries, the directors have a reasonable expectation that the NHS Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The summary financial statements are intended to provide an overview only and may not contain sufficient information to gain a full understanding of the Trust financial position and performance.

A full set of the Trust's accounts can be obtained from the Associate Director of Finance, Lincoln County Hospital, Greetwell Road, Lincoln or by emailing colin.hills@ulh.nhs.uk

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of the NHS 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 Department of Health. 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
- 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.

Signed..... Chief Executive

Date.....

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 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 ensure 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..... Chief Executive

Date.....

Signed..... Director of Finance

Date.....

Remuneration report

Introduction

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, require NHS bodies to prepare a remuneration report containing information about the remuneration of directors. In the NHS, the report will cover those senior managers "having authority or responsibility for directing or controlling the major activities of the NHS body". This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.

Salary and pension entitlements of senior managers

The Remuneration and Terms of Service Committee is a committee of the board which oversees the process for nomination of senior executive posts including the Chief Executive. Non-executive directors, including the Chairman, are independently appointed by the Appointments Commission on behalf of the Secretary of State for Health and are typically appointed for a standard term of four years.

The committee membership comprises the Trust Chairman and two other non-executive directors. The committee's policy on the remuneration of 'very senior managers' not covered by Agenda for Change has been to ensure that job roles are externally evaluated periodically using a recognised job evaluation system and comparative pay data intelligence.

The Trust does not currently have performance-related salaries for its executives and the terms and conditions of contracts for its senior managers are subject to the normal terms and conditions of other NHS staff. Any pay uplifts awarded are consistent with guidance issued by the Department of Health, mirroring the awards made to all other Trust employees.

One very senior manager received a redundancy payment during the course of 2010/11. The Remunerations and Terms of Service Committee applied the relevant Department of Health policy guidance to this payment.

All very senior managers were employed on permanent contracts and have a six month employer to employee notice period, with the exception of the Director of Service Delivery. This director has been seconded from another trust since 11 October 2011.

Pension benefits

The Trust's pension policies are described within Note 1 of the Trust's published annual financial statements (accounts) under the heading retirement benefit costs.

Cash Equivalent Transfer Values

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

secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

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

In his budget of 22 June 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfers factors. The new CETV factors have been used in calculations at 31 March 2011 and are lower than the previous factors used. As a result the value of the CETVs for some members has fallen since 31/03/2010.

Real Increase in CETV

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

Pension liabilities

Past and present Trust employees are covered by the provisions of the NHS Pensions Scheme. Within the annual accounts the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. Note 1.5 to the accounts describes the Trust Accounting Policy in respect of Retirement Benefit Costs.

Salaries and allowances

			2010/11			
Name and title	**Term in post**		**Salary (bands of £5,000)**	**Other Re-muneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind * (Rounded to the nearest £100)**
	Start	**Finish**	**£000's**	**£000's**	**£000's**	
Mr P Richardson – Chair	Jul-09	Ongoing	20 - 25			2200
Mr T Staniland - Non Executive Director	Mar-07	Ongoing	5 - 10			400
Mr K Brown - Non Executive Director	May-08	Ongoing	5 - 10			800
Mr N Muntz - Non Executive Director	Jul-09	Ongoing	5 - 10			
Mr K Darwin - Non Executive Director	Jan-10	Ongoing	5 - 10			200
Mrs P Owston - Non Executive Director	Apr-10	Ongoing	5 - 10			400
Andrew North - Chief Executive	Aug-10	Ongoing	120 - 125			
Bernard Chalk - Director of Finance/Acting Chief Executive	Jun-07	Jul-10	65 - 70			
Kevin Turner - Director of Finance	Jan-11	Ongoing	30 - 35			
Pen Andersen - Acting Director of Finance	Sep-09	Dec-10	55 - 60			
Michelle Rhodes - Director of Service Delivery	See Note 1					
Jane Lewington - Director of Strategy and Performance	Dec-10	Ongoing	45 - 50			
Roger Long - Interim Director of Operations	Nov-09	Dec-10	See Note 2			
Ros Edwards - Director of Human Resources	Aug-08	Ongoing	100 - 105			
Sylvia Knight - Chief Nurse	Jul-04	Ongoing	100 - 105			
Dr Richard Lendon - Interim Director of Performance and Information	Feb-09	Dec-10	75 - 80	65 - 70 (Note 3)		
Paul Dunning - Medical Director	Feb-10	Mar 11	145 - 150	50 - 55 (Note 4)		
Mike Speakman - Director of Estates and Facilities	May-08	Ongoing	95 - 100			

1. Michelle Rhodes was seconded from Nottingham City PCT in 2010/11 at a cost of £65,383
2. Roger Long was seconded from Heart of England NHS Trust in 2010/11 at a cost of £73,184
3. Richard Lendon received other remuneration in compensation for loss of office
4. Paul Dunning received other remuneration in relation to clinical duties unrelated to Medical Director responsibilities

* Benefit in kind relates to the reimbursement of travel expenses for non-executive directors

Pension benefits 2010/11

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real Increase/(decrease) in lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real increase/ (decrease) in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£100
Andrew North - Chief Executive	2.5 - 5	10 - 12.5	70 - 75	220 - 225	1,346	1,327	(24)	
Bernard Chalk - Director of Finance / Acting Chief Executive	0 - 2.5	0 - 2.5	55 - 60	165 - 170	1,232	1,238	(17)	
Kevin Turner - Director of Finance, Procurement and Informatics	0 - 2.5	0 - 2.5	50 - 55	150 - 155	855	892	(14)	
Pen Andersen - Acting Director of Finance	0 - 2.5	2.5 - 5	20 - 25	65 - 70	315	325	(14)	
Michelle Rhodes - Director of Service Delivery	See Note 1							
Jane Lewington - Director of Strategy and Performance	0 - 2.5	2.5 - 5	50 - 55	155 - 160	985	923	3	
Roger Long - Interim Director of Operations	See Note 2							
Ros Edwards - Director of Human Resources	0 - 2.5	-	0 - 5	-	53	39	9	
Sylvia Knight - Chief Nurse	(0 - 2.5)	(0 - 2.5)	25 - 30	85 - 90	341	391	(49)	
Dr Richard Lendon - Interim Director of Performance and Information	0 - 2.5	0 - 2.5	15 - 20	50 - 55	253	273	(19)	
Paul Dunning- Medical Director	7.5 - 10	25 - 27.5	45 - 50	135 - 140	704	610	43	
Mike Speakman - Director of Estates and Facilities	0 - 2.5	0 - 2.5	20 - 25	65 - 70	276	311	(36)	

The salaries and allowances and pension benefits tables shown on pages 57 and 58 have been subject to formal Audit review

Independent Auditor's report to the directors of United Lincolnshire Hospitals NHS Trust

I have examined the summary financial statement for the year ended 31 March 2011 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of changes in taxpayers' equity and the Statement of cash flows.

This report is made solely to the Board of Directors of United Lincolnshire Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements. I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2011. I have not considered the effects of any events between the date on which I signed my report on the statutory financial statements, 9 June 2011, and the date of this statement.

Ian Sadd
Officer of the Audit Commission

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15 July 2011