United Lincolnshire Hospitals NHS
NHS Trust

Annual Report and Final Accounts 2012/13

Accessibility

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New vision to provide the best possible nursing care

Nurses and midwives in Lincolnshire have signed up to a new vision for the provision of compassionate, caring healthcare.

The Chief Nursing Officer for England recently launched a new three year vision and strategy for nursing, midwifery and care staff.

The vision is to ensure that the '6Cs' are at the heart of all nursing and midwifery care, they are:

Care, Compassion, Competence, Communication, Courage, Commitment

United Lincolnshire Hospitals NHS Trust was one of the first Trusts in the country to sign up to the new vision.

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Chairman's and Chief Executive's Foreword

It has been another year of challenge and achievement at United Lincolnshire Hospitals NHS Trust. In the face of significant operational and financial pressures, we have achieved notable successes through focussing on our top priority – the quality and safety of the care we provide for local people.

Our progress has been highlighted by the Care Quality Commission, which has reported dramatic improvements at both Lincoln and Pilgrim Hospitals during 2012/13. This has been achieved through a relentless pursuit of clinical excellence - promoting and encouraging best practice, whilst eradicating that which does not meet the high standards we have set ourselves.

The principles of challenge, transparency and accountability are ones we welcome and embrace. That is why we monitor the quality of our care and display the results on our wards.

Everything we do is motivated by the desire of our staff to do the very best for our patients. In 2012/13, this has driven the Trust to continue to meet national targets for treatment waiting times, invest in additional consultants and develop new services. All of this has been achieved while still balancing our budget, despite the financial constraints within the NHS.

The progress of the past year is the result of the hard work, dedication and skill of our staff, who continue to excel in often testing circumstances. They form the basis of our application to become an NHS Foundation Trust which we are continuing to build.

In commending this Annual Report for 2012/13 to you, we are already looking ahead. We may have made great strides on our journey of improvement, but we know that we still have much more to do. Our clinical vision is based upon safe, high-quality and viable services. This means continuing to develop both our staff and the wider organisation - and being prepared to embrace change where necessary.

Our philosophy of excellence is shaped by the knowledge that we and the people of Lincolnshire want nothing but the best. That is as it should be. We will continue to do everything in our power to meet that expectation

Jane Lewington
Chief Executive

Paul Richardson
Chairman

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 operating out of three main hospital sites; Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital. Together the three sites have over 1,400 beds.

The Trust primarily serves the 757,000 residents of Lincolnshire which is one of the fastest growing populations in England.

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

The Trust's vision and mission underpins the achievement of its objectives.

Our vision: **Is to deliver the highest quality healthcare locally.**

Our mission: **Is to listen and learn from patients, staff and partners as**

we develop and deliver leading hospital services to the people of Lincolnshire.

The Trust Board

The Board is responsible for setting the overall policy and strategy for the organisation and for ensuring the effective implementation of that strategy. It establishes a committee structure 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 people, drawn from the local community and in 2012/13 were 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, appointed through open competition procedures. Their selection process includes an interview panel involving the Chairman, non-executive directors and independent advice.

The remuneration of executive and associate directors is determined by a remuneration and terms of service committee. During 2012/13 this committee consisted of the Chairman plus two non-executive directors.

Board membership for 2012/13 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, he gained a wealth of NHS experience serving as Non-Executive Director at 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.

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 as Assistant Audit Manager for Deloitte, Haskins and Sells and as Auditor for the District Audit Service in Kent, Sussex and London.

Interests declared: None
Term of Office: June 2012 to May 2016

Penny Owston

Penny is a practicing solicitor in Scunthorpe specialising in children's 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: April 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: November 2010 - October 2014

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

Executive directors

Jane Lewington - Director of Strategy and Performance / Deputy Chief Executive. Chief Executive from December 2012

Jane joined the Trust in December 2010 from North East Lincolnshire Care Trust Plus, 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 that role, 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

Took over as Chief Executive in December 2012.

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 1990s. He was later appointed Director of Finance at North East Lincolnshire NHS Trust and 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

David Levy – Medical Director	Eiri Jones – Interim Director of Nursing
David joined ULHT in April 2011, having spent a period of time as President of the British Columbia Cancer Agency (BCCA), Canada. David qualified from the Royal London Hospital Medical School in 1984 and trained in clinical oncology in Oxford and Leeds. Following his training, he spent 18 months as a consultant in Northampton before moving to Sheffield as Director of Post-Graduate Medical Education. He has previously held roles as the Medical Director of the North Trent Cancer Network, National Clinical Lead for Cancer Modernisation and Medical Adviser for Cancer to the Department of Health.	Eiri Jones joined August 2012 as Interim Director of Nursing from Bedford Hospital. Eiri trained as a general nurse at Guy's Hospital, London and moved into critical care to undertake further training. Whilst working in a tertiary cardiac adult service she undertook a research role before moving to the National Heart Hospital. With an interest in paediatric cardiac services Eiri completed children's nurse training at Great Ormond Street and worked as a Senior Nurse at the Royal Brompton before working in paediatric cardiac intensive care and the cardiac specialist nursing service at Guy's Hospital. In 1999, Eiri moved back to Wales and developed a senior nursing and management career, firstly as a divisional nurse for integrated child and family services and then as an interim general manager. She was then seconded to the Welsh Assembly Government where she led a national programme of service change and improvement for children's specialist services. She was also later appointed to the NMC, the nursing regulator as a Council member. She has chaired Fitness to Practice for the past eight years. Eiri has an extensive qualitative research portfolio and has implemented her Masters research into developing ward sisters to be strong and visible clinical leaders.
Interests declared: None Left the Trust February 2013	

Nigel Myhill – Interim Director of Facilities Management

Nigel Myhill appointed as Interim Director of Facilities Management at United Lincolnshire Hospitals NHS Trust in October 2012, filling a joint post with Northern Lincolnshire and Goole Hospitals NHS Foundation Trust, where he has been Director of Facilities Management since January 2009.

He is a Chartered Engineer (C Eng) his previous post was Director of Estates and Facilities at Barnsley PCT, having previously worked for the National Blood Service and Norfolk Mental Health Care NHS Trust. Nigel has also spent time in the private sector, with Center Parcs and Anglian Water PLC.

He is Vice Chair of the Health Estates and Facilities Management Association (HefmA), which is a national organisation representing Estates and Facilities professionals in the NHS.

Ian Warren – Interim Director of Human Resources and Organisational Development

Ian Warren was appointed as Interim Director of Human Resources in February 2013, filling a joint post with Lincolnshire Community Health Services NHS Trust for a period of six months initially. Ian Warren joined LCHS in July 2009. Ian has many years' experience of running regional and national HR teams, whilst delivering successful improvements to HR services within various organisations within the private sector.

Following twelve years in the RAF in finance, personnel, intelligence and recruitment, Ian has worked as a Senior HR professional within the private sector.

As Director of Operational Performance in a nationwide role he covered all aspects of HR and Organisational Development with a focus on organisational design, employee development and process improvement. Ian has led successful programmes in staff engagement, communications cultural change within organisations and brings a wealth of experience in employee relations, conflict management, coaching and mentoring.

Ian holds an MSc in HR and is a Fellow of the Chartered Institute of Personnel and Development.

Michelle Rhodes - Director of Operations

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.

Michelle also 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 the year:

There were further directors who served on the Board for part of the year, as follows:
Andrew North - Chief Executive
Left the Trust December 2012

Mike Speakman – Director of Facilities Management
Left the Trust October 2012

Sylvia Knight – Director of Nursing and Patient Services
Left the Trust May 2012

Jaki Lowe – Interim Director of Human Resources
Left the Trust January 2013

Board members

Board
Voting members
Paul Richardson - Chairman
Tim Staniland
Keith Brown
Nick Muntz
Penny Owston
Keith Darwin
Andrew North (left December 2012)
Jane Lewington
Kevin Turner
David Levy (left February 2013)
Sylvia Knight (left May 2012)
Eiri Jones
Non-voting members
Mike Speakman (left October 2012) and Nigel Myhill
Michelle Rhodes
Jaki Lowe (left January 2013) and Ian Warren

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 and 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 and senior managers.

Audit Committee membership comprises three non-executive directors, one of whom will have considerable financial expertise. For 2012/13, membership was as follows:
Keith Brown – Chair of Committee
Keith Darwin
Penny Owston

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 oversees the activity and, where necessary, directs a hierarchical system of sub-committees and working groups across the organisation to deliver specific elements of governance.

Membership comprises a mix of executive and non-executive directors.

Governance Committee
Voting members
Tim Staniland – Chair of Committee
Keith Darwin
Nick Muntz
Penny Owston
Andrew North (left December 2012)
David Levy (left February 2013)
Kevin Turner
Sylvia Knight (left May 2012)
Jane Lewington
Mike Speakman (left October 2012)
Jaki Lowe (left January 2013)
Eiri Jones

Opening of the new Lincolnshire Heart Centre

A new £4.3 million Heart Centre to treat Lincolnshire patients suffering from heart attacks has opened at Lincoln County Hospital.

The development of a second cardiac catheter laboratory has seen the specialist unit more than double in size and has also provided a significant increase in the number of specialist staff.

This means that, in future, the centre will be able to provide emergency and planned invasive cardiac procedures for patients across the whole county on a 24/7 basis, 365 days a year.

The Lincolnshire Heart Centre offers primary angioplasty (PPCI) which is the best available treatment for people suffering a heart attack. The procedure uses a small balloon inserted into the heart from the arm or the leg to unblock a blocked artery which is usually the cause of a heart attack.

Operating and financial review

Priorities for 2012/13

2012/13 was a pivotal year for United Lincolnshire Hospitals NHS Trust and for the wider health economy across Lincolnshire. Planning for 2012/13 was built upon the foundations established in 2011/12 and the Trust engaged with the local health economy's service strategy as major changes took place in the NHS with the development of Clinical Commissioning Groups.

Plans also reflected the shift in national priorities towards securing the safety, quality, and effectiveness of clinical services rather than simply focussing on targets. Early in 2012 the impending publication of the inquiry by Robert Francis QC into the failings of Mid Staffordshire NHS Foundation Trust, and the review into mortality data by Professor Sir Bruce Keogh began to reshape the approach and emphasis embodied in the Trust's plans throughout the year.

The Operating Framework for the NHS in England 2012/13 made it clear that significant financial challenges faced the NHS in years to come. The financial settlement assumed that costs would be reduced with improved efficiency and effectiveness through the Quality, Innovation, Productivity and Prevention (QIPP) programmes. This represented a major challenge to the organisation given its current levels of service and financial performance.

The strategic direction for the Trust's major commissioner, NHS Lincolnshire was previously described in 'Shaping Health for Lincolnshire', but that document had reached the end of its narrative in 2012. The impending restructuring of the Lincolnshire PCT into what emerged as four Clinical Commissioning Groups promoted a further debate into the strategic clinical direction for Lincolnshire which began to take shape towards the end of the year.

The Trust's response to these priorities at the outset of 2012 was framed into six strategic goals as follows.

1) **To develop a range of integrated clinical services which are viable, safe, effective and efficient; and which meets the assessed needs of the population.**

2) **To deliver a positive patient experience in all contacts with our services.**

3) **To be here for the long term as part of a successful health community.**

4) **To secure and develop a committed, flexible, effective and productive workforce.**

5) **To deliver at each of our sites, commissioned services which comply with regulatory requirements, national targets and locally agreed standards.**

6) **To be respected as the provider of choice.**

Activity and performance

The following table details the planned and actual activity levels for 2012/13:

Activity type	12/13 plan	12/13 actual
Elective inpatient spells	14,052	12,951
Day case spells	55,173	61,032
All elective spells	69,225	73,983
Non-elective spells (emergency)	67,509	72,317
New outpatient attendances	209,004	197,165
Subsequent outpatient attendances	407,149	441,533
A&E attendances	143,180	158,157

Significant resources were invested in 2012/13 to work towards achieving the core standards within the operating framework on A&E, 18 week referral to treatment (RTT), access to cancer services and cancelled operations.

Both Lincoln and Grantham consistently achieved the four hour A&E standard during the year, with the Trust overall achieving 95.22%.

Continued improvements across the waiting times ensured that the Trust achieved both the admitted and non-admitted 18 week RTT standards for the year. The admitted standard was achieved in 11 of the 12 months and the non-admitted standard achieved in 10 of the 12 months.

Cancer standards improved again in 2012/13 with five of the eight core standards achieved consistently across the year. The 62 day standard has remained difficult to achieve consistently due mainly to capacity pressures over the winter period.

Overall the Trust saw or treated more patients than was planned through our contract with the local Primary Care Trust. Throughout Winter, like most NHS acute services we responded successfully to significant increases in demand for our emergency services.

Performance against the key indicators for 2012/13 was as follows:

Accident and Emergency

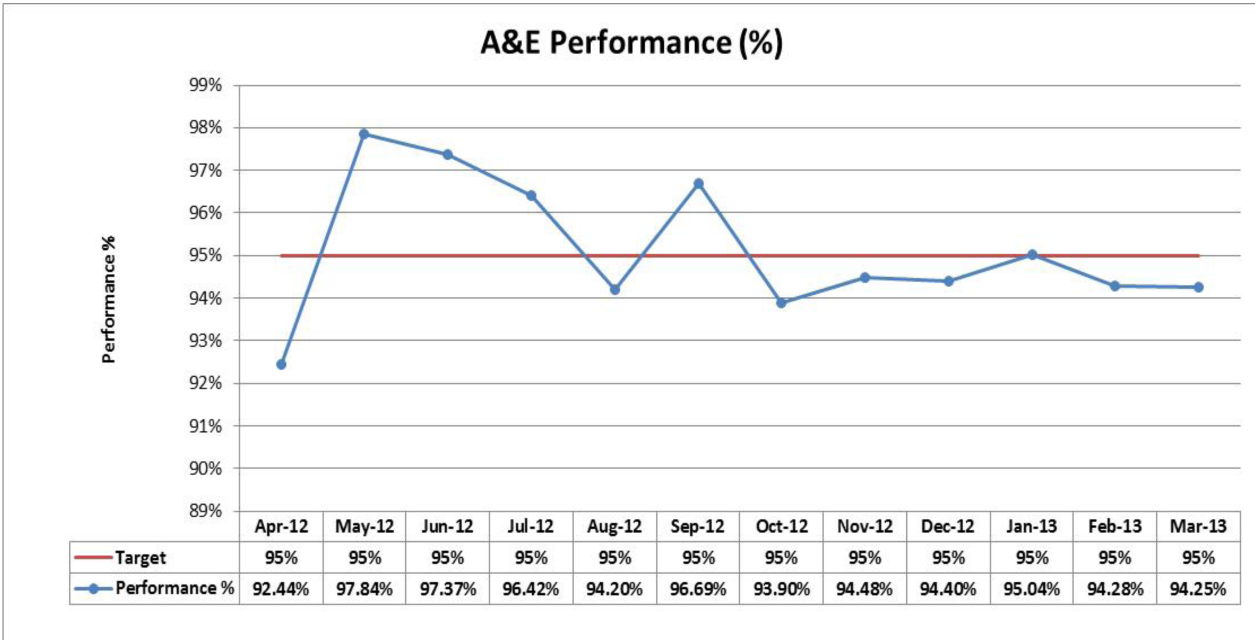
The target for Accident and Emergency (A&E) is for at least 95% of patients to be seen, treated and either admitted or discharged within four hours. The Trust met this standard over the course of the year, recording a year to date performance of 95.22%.

The following table and graph show the Trust's performance against this target.

A&E attendances 2012/13	Attendances	Breaches	Performance
Grantham	34078	1,067	96.87%
Pilgrim Boston	54167	2962	94.24%
Lincoln County	72612	3162	95.65%
Trust	158,157	7,191	95.22%

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.

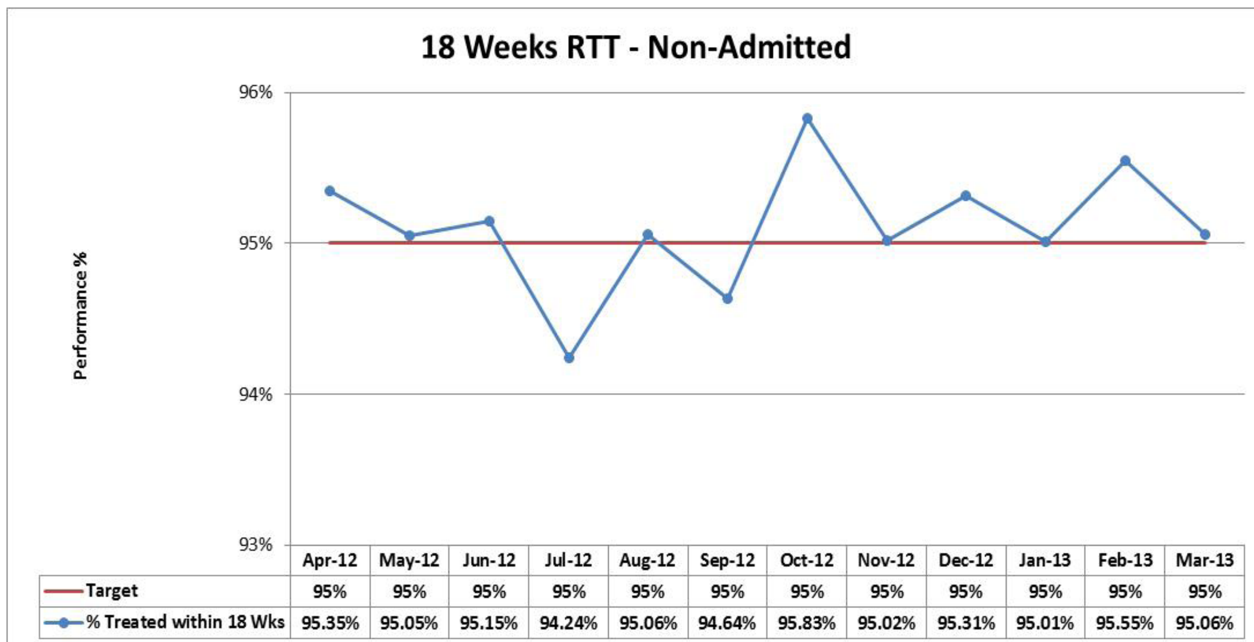


	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Performance %	92.44%	97.84%	97.37%	96.42%	94.20%	96.69%	93.90%	94.48%	94.40%	95.04%	94.28%	94.25%

18 week referral to treatment - non admitted patients

The 18 week referral to treatment standard (RTT) for non-admitted states that 95% of patients will be treated within 18 weeks of referral.The RTT measures provide a snapshot of performance in a particular month and are not reported as an annual average.

The Trust achieved the standard of 95% at the end of the year.

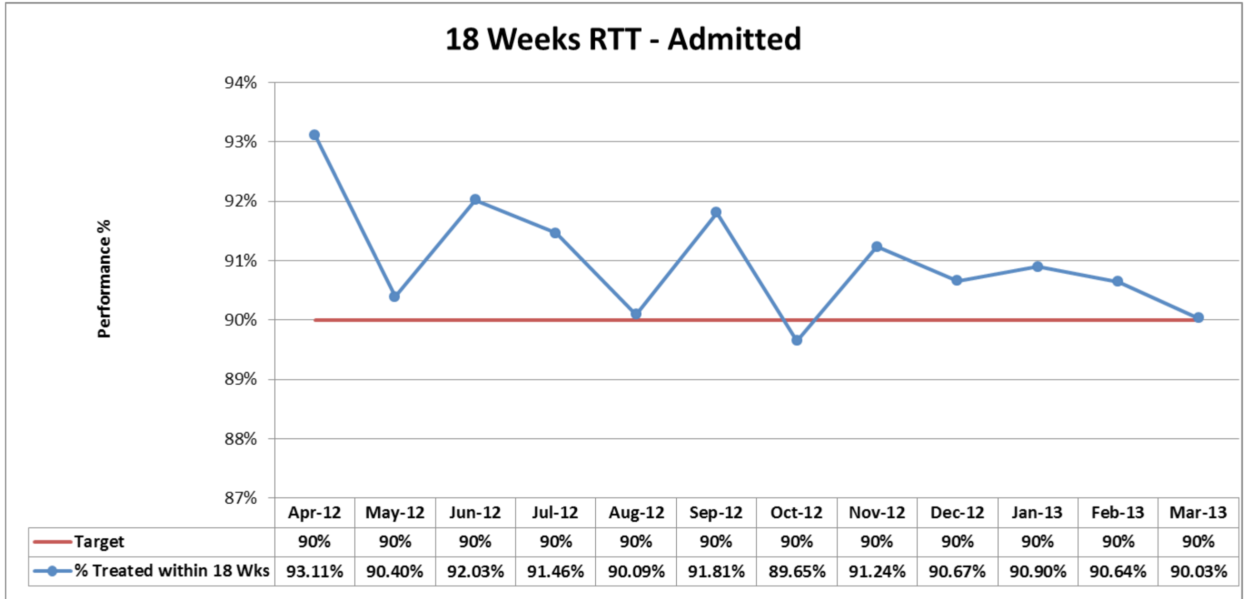


	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
% Treated within 18 Wks	95.35%	95.05%	95.15%	94.24%	95.06%	94.64%	95.83%	95.02%	95.31%	95.01%	95.55%	95.06%

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.

The Trust achieved the standard of 90% at the end of the year.



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
% Treated within 18 Wks	93.11%	90.40%	92.03%	91.46%	90.09%	91.81%	89.65%	91.24%	90.67%	90.90%	90.64%	90.03%

Cancer standards

The Trust's progress up to March 2013 against these standards can be seen in the table below;

Measure	**Standard**	**Trust performance** (to March 13)
2 week wait suspected cancer	93%	94.68%
2 week wait symptomatic breast	93%	91.28%
31 day decision to treat to treatment	96%	97.26%
31 day subsequent treatment: drug	98%	98.12%
31 day subsequent treatment: surgery	94%	95.57%
31 day subsequent treatment: radiotherapy	94%	91.40%
62 day referral to treatment	85%	83.25%
62 day screening	90%	95.63%

Data source and calculations

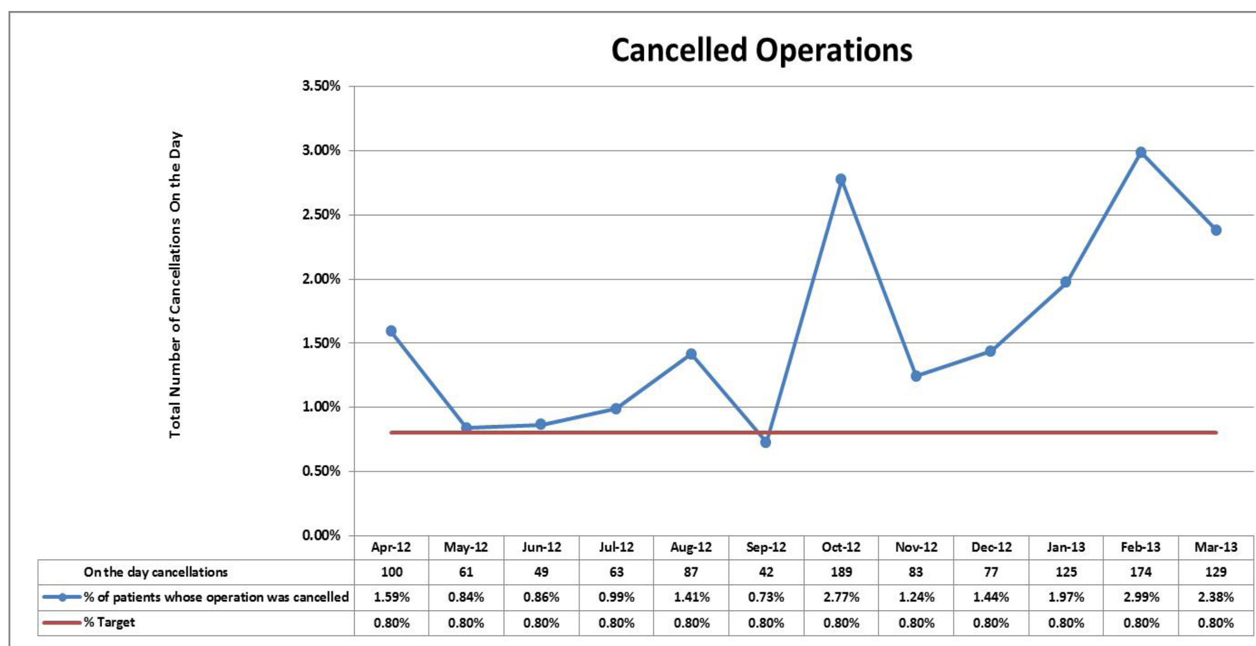
The data to calculate performance against cancer waiting times is taken from the Trust's Patient Administration System (PAS) and radiology system. The information is pulled together into a cancer database to track patients on their pathways. The number of breaches is subtracted from the total number 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 standard for the short notice cancellation of operations for 2012/13 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. This standard was not achieved due principally to the sustained pressures experienced in urgent care demand from October and continuing through the winter period to the end of the financial year. The demand for general and critical care beds during this period was such that, despite the opening of significant numbers of escalation beds there was a severe impact on our ability to maintain routine elective admissions in a planned way.

Number of cancelled operations:

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
100	61	49	68	87	42	189	83	77	124	174	129



Developing an effective organisation

Year-on-year performance analysis: 2012/13 performance

Target Area	11/12	12/13
Delayed transfers of care	2.52%	2.76%
18 weeks to treatment - Admitted	87.58%	90.87%
18 weeks to treatment - Non-Admitted	94.37%	95.10%
MRSA	4	6
C.Diff	74	76
Chest pain 2 week wait	100%	100%
Cancer 2 Week Wait	95.2%	94.6%
31 Day Cancer	93.8%	97.2%
62 Day Cancer	80.5%	83.8%
Diagnostics Waits	1.92%	0.96%
Cancelled operations	1.16%	1.59%
Fractured neck of femur	-	74.34%
A&E Wait	92.86%	95.17%
VTE Assessment	-	90.67%

Revolutionising the care of hip fracture patients at Pilgrim hospital

Hip fracture patients are receiving fast, specialist care following a project run at Pilgrim Hospital in Boston.

Over the past year, teams at Pilgrim have revolutionised the care of patients by improving assessment, the speed at which patients are taken to theatre for surgery and after care.

This has resulted in the hospital meeting its target to operate on all hip fracture patients within 36 hours of arrival in A&E.

The Pilgrim hip fracture project started in May 2012, following recognition that patients admitted to hospital with hip fractures are often seriously ill, elderly and frail, resulting in poor outcomes.The team looked at how care for these patients could be improved.

Forward look – Overview of Trust strategy 2013/14

The Trust, other local providers and the Lincolnshire Clinical Commission Groups have recognised the need for rapid service redesign. This process had begun, but with the publication of the Francis report, the pace and scale of the change increased. The health economy in Lincolnshire recognises the need for this to ensure the on-going availability of modern and high quality services that are expected by our patients.

Why we need to change

When we look outside of our organisation and consider some of the wider issues we can see a number of forces that will influence the future of our services. We can see that:

Politically:

- Provision of healthcare is becoming increasingly competitive.
- The NHS failure regime is starting to be felt in some parts of the NHS, with hospitals no longer shielded from the effect of financial reality.
- The requirement for service reconfiguration in most areas is now inevitable given the necessary shift towards safe specialisation on the one hand, and delivering some services in local community settings on the other.

Economically:

- The broader economic context and recovery cannot be ignored. The NHS continues to face challenges, such as saving £20billion. The severity and reality of the future financial challenge is understood within a health-economy that is already over-heating. At the simplest level this manifests itself in on-going and challenging CIP and QIPP programmes locally and a continued reduction in tariff payments for hospitals in the future.
- The expansion of competition in the NHS exposes the Trust to further risk as competition may be geared towards less risky, low cost, high economy initiatives, potentially and quickly undermining the viability of our services.
- Quality improvement expectations will mean that, increasingly, quality improvements will be linked to payments to fund our services.

Socially:

- Population change will shift the burden of health provision from acute hospital care to supporting people with chronic conditions in local community settings.
- Our patient's expectations, rightly, continue to grow.
- Variation in urgent care demand across Lincolnshire exists and will continue, alongside the patient's right to choose. This variation needs to be better understood and influenced.
- There is a greater than ever health consciousness with a real focus on quality and safety. The findings of Sir Robert Francis following the events at Mid Staffordshire has rightly brought a sharper focus and increased sensitivity to quality and safety matters. This is likely to be reinforced by the outcomes of the independent reviews into care and treatment into 14 Trusts across the country with high mortality indicators.

Technologically:

- New technologies will become increasingly available, driving pressure on the NHS to enhance its investment in ever developing or specialised intervention, rather than generalist application.
- Telemedicine technologies are now available and utilised in the NHS generally to provide care in or closer to home. This needs to be explored and implemented in Lincolnshire.

Strategic aims and linked ambitions for 2013/14

Recognising these pressures, for 2013/14 we are setting out to meet or exceed the expectation of patients. We will deliver improvements in four strategic areas:

- Meeting the highest expectations of patients for quality and safety
- Transforming services for the future
- Developing our staff
- Making it happen

Central to these four themes are ‘our patients’.

Meeting the highest expectations of patients for quality and safety

- **Ambition 1** - Ensure that our patients are safe - through acting on safety and effectiveness and by a continuous reduction of harmful adverse events and mortality rates
  Ambition 2 - Ensure that our patients have the best possible experience **-** through our structured approach to the patient experience, we aim to ensure excellence at each discrete point of contact throughout the patient’s journey with us
- **Ambition 3 -** Ensure that our treatment is effective and compliant **-** by building strong systems of compliance, monitoring of standards and supporting clinical change, we aim to care for our patients according to the highest clinical standards
- **Ambition 4 -** Become a high reliability organisation **-** through our focus on building capacity for improvement, flagship interventions and education for change, we aim to create a culture of safety, reliability and improvement

Transforming our services for the future

- **Ambition 5** – Integrate care pathways between hospital based specialist secondary care, with community based services, in partnership with other providers, so that patients are always seen in the right care setting
- **Ambition 6** – Ensure that our services are clinically and financially sustainable; ensuring access to those services within Lincolnshire; (locally, within Lincolnshire, where we can)

Developing our staff

- **Ambition 7** – Ensure an engaged, empowered and healthy workforce
- **Ambition 8** – Ensure that staff are appropriately developed and skilled
- **Ambition 9** – Ensure that services are well led

Making it happen 2013/14

- **Ambition 10** – Ensure that our services are finically sustainable by making profits to reinvest in services
- **Ambition 11** – Ensure a ‘fit for purpose’ estate
- **Ambition 12** – Being a well governed organisation which delivers all that is expected of it, and being capable of securing a licence from Monitor, FT or otherwise.

Key Performance Indicators 2013/14

NHS Constitutional Pledges

Referral to treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral- 90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral- 95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral- 92%

Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral- 99%

A&E waits
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department- 95%

Cancer waits- 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP- 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)- 93%

Cancer waits- 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers- 96%
Maximum 31-day wait for subsequent treatment where that treatment might be surgery- 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen- 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy- 94%

Cancer waits- 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer- 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for call cancers- 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)- no operational standard set Category A ambulance calls

Mixed sex accommodation breaches
Minimise breaches

Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.

Additional measures which the NHS Commissioning Board has specified for 2013/14

Referral to treatment waiting times for non-urgent consultant-led treatment
Zero tolerance of over 52 week waits
No urgent operation to be cancelled for a second time

A&E waits
No waits from decision to admit to admission (trolley waits) over 12 hours

Ambulance Handovers
All handovers between ambulance and A&E must take place within 15 minutes are crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

Note: In addition, the Trust is finalising the agreed list of clinical quality indicators for 2013/14 to be added to the overall KPI schedule.

Emergency preparedness, resilience and response (EPRR)

The Trust is required to comply with legislation and standards regarding emergency preparedness and works closely with colleagues in NHS Lincolnshire's public health directorate and other health providers to consider, plan and test the preparedness for the county.

The Trust has a senior manager responsible for emergency preparedness, resilience and response and business continuity which greatly increases the organisation's resilience in times of crisis.

ULHT is also an active member and participant of a multi-agency group reporting to the Lincolnshire Resilience Forum for emergency planning and business continuity, working in partnership with the Joint Emergency Management Service and other category one responders.

There are plans in place to deal with major incidents and specific plans that have been updated and tested this year include a live Chemical, Biological, Radiological and Nuclear exercise and a command post exercise. Site cascade call-out plans are regularly tested and updated.

This year the Trust has been planning to take part in exercise Georgiana in May 2013. The Trust has worked closely with NHS Lincolnshire and partner agencies and updated mass evacuation planning for Pilgrim Hospital, Boston in preparedness for the possibility of east coast flooding, in line with the community risk register for Lincolnshire.

Managing complaints about our services

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. Local managers are also taking steps to improve the quality of the services they provide as issues are identified.

The Trust is committed to achieving a standard of 80% of complaints responded to in an agreed timeframe (the timeframe is agreed with each complainant on an individual basis) and has had a much improved performance over the year, achieving 72%. The Trust undertakes frequent reviews of performance, improved governance and management processes to ensure accountability and ownership of complaints as well supporting 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 2012/13 there were no such incidents reported.

Other data rated incidents for the year are summarised below:

Summary of other personal data related incidents in 2012-13		
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	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	0

Becoming an NHS Foundation Trust

Looking to the future, the Trust has a vision of involving and engaging staff, patients, carers and the public to ensure they play a leading role in how the organisation is run.

The Trust is on a journey of improvement built upon its focus on quality and safety and improving the patient experience, and one step on this journey will be achieving Foundation Trust (FT) status.

A Foundation Trust Programme Board and Foundation Trust Operational Group are now up and running, working on putting in place all of the requirements that are needed in order to apply to become an NHS Foundation Trust. A timeline for application is currently being developed.

Work has also begun in the last year on engaging local populations and staff in the work of the organisation. This has involved beginning to gather members, setting up members' focus groups and meetings and starting to spread the FT message through staff meetings and communications.

This work will now continue, and relies upon staff, the public and local interested parties getting involved and signing up as Trust members. Members can choose the level of involvement that they have in the life of the Trust, which can vary from simply receiving updates and commenting when they want, to attending meetings and putting themselves forward for elected roles.

If you are interested in finding out more about the application to become an NHS Foundation Trust, or getting involved as a staff or public member, please log on to www.ulh.nhs.uk or contact the Foundation Trust office on (01522) 572301 or email foundationtrustoffice@ulh.nhs.uk

Sustainability

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

- Saving revenue and delivering major carbon reductions
- By reducing energy consumption and our carbon footprint we save money, enhance and protect our reputation and help everyone in the fight against climate change.
- Utilising no cost and low cost solutions
- Seeking out third party providers who are prepared to deliver capital expenditure, energy solutions, delivering guaranteed savings
- Ensuring that policies and practices in all aspects of the Trust's work reflect this commitment

United Lincolnshire Hospitals NHS Trust is committed to reduce its CO^2 emissions by 30% by 2015. It is expected to save the Trust at least £623,500pa. Considering year on year increases in energy costs and increasing carbon taxes, such as the CRC energy efficiency scheme, the actual savings and avoidance costs could be considerably more.

Planned initiatives range from installing biomass boilers and combined heat and power (CHP) to increased staff awareness and encouragement of sustainable behaviours.

Context

The NHS as a whole is responsible for an average of 18 million tonnes of CO^2 a year. The Trust continues to proactively address its share of the outputs in the clear knowledge that sustainable thinking and substantial savings go hand in hand.

What we've already achieved

Focusing first on engineering improvements, the Trust has installed and is successfully operating a biomass boiler, and 525 kWe gas fired CHP at Pilgrim hospital, reducing site CO^2 emissions by 35% from 11,122 to 7,262 tonnes.

The biomass boiler is fuelled by virgin and recyclable woodchip, sourced from local suppliers whenever possible. Together with the CHP this provides all of the hospital's heat and hot water except during peak periods in winter, when one of two new oil fired boilers provides top up energy supplies.

The Carbon Management Plan, which the Trust first created and adopted in 2009, has now moved onto Grantham and District Hospital. There the Trust is developing the business case for the reconfiguration of energy services using an energy performance contract which is designed to deliver guaranteed savings.

Studies have concluded that by replacing the existing boilers the hospital could reduce its CO^2 emissions by 2,000 tonnes per year. With the potential of producing revenue savings of £117,500 per year after applying some sensitivity analysis to the key variables (ie fuel costs)

Recognition of our work

In the last four years, the Trust has:

- Won the Health Business Award for Sustainable Hospital,
- Received a Highly Commended Award at the CHPQA Awards
- Achieved a commendation and certificate from the Carbon Trust for its ambitious target towards carbon dioxide reduction

Next steps – Key headlines

Transport, building design, waste management and water management have also been included in a comprehensive new approach putting sustainability at the heart of policy.

Capital expenditure

The Trust is striving to achieve a further reduction of 10-15% in energy consumption through various capital expenditure initiatives at both Lincoln and Pilgrim hospitals. Projects will only be presented to the Trust if they can deliver guaranteed savings associated with the capital expenditure investment and demonstrate a cash flow positive position.

Business as usual

The Trust is committed to supporting the NHS Sustainable Development route map. To ensure that sustainability is part of every aspect of our 'business as usual', the Trust's Sustainability Development Management Plan (SDMP) will be monitored and evaluated each year by the Trust Board.

Encouraging sustainable behaviours

Raising awareness among staff of the impact of their behaviour as individuals is a central priority. The Trust is recruiting environmental champions at each site, plans to hold staff training days, as well as incorporating responsible energy use into staff inductions.

Procurement

Carbon management is being embedded as a central element to be considered 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 CO^2 emissions resulting from supplier partnerships, and establishing reporting arrangements to keep track of improvements.

Waste management, reduction and recycling

The Trust is working with its waste contractors to increase the level of recycling to 75%. It is currently re-tendering its clinical, domestic waste and recycling contract to achieve best value for money.

The Trust recycles cardboard and non-confidential paper, shreds confidential papers and recycles the shredded paper. It is also increasingly recycling plastics, aluminium and tin cans, some glass, furniture and scrap metal.

New NHS ‘friends and family’ test to improve patient experience and care

Patients can now have their say about the care and treatment they receive in hospital like never before, following an initiative launched across the NHS.

The new friends and family test ensures that patient experience is at the top of the region’s nursing and management agenda.

Patients admitted to hospitals are now asked a single, simple question to gauge how well their expectations are being met. The question is “How likely is it that you would recommend this services to a friend or family?” using an “extremely likely” to “not at all likely” scale.

Our staff: Information and consultation

The Trust has a wide range of formal and informal mechanisms in place to inform and consult staff and staff side organisations. These include:

- Monthly Executive Partnership Forum with membership from senior management and union representatives from the four hospital sites
- Monthly Site Partnership Forums on the three main sites
- Fortnightly meetings between HR and staff side chairs
- Weekly meetings between site HR leads and site lead representatives
- Agreed communication methods with staff side representatives
- Weekly Newslinc newsletter sent to all staff
- Monthly Team Brief following Trust Board meetings
- Executive roadshows on each site
- Newsletters
- HR news for managers
- Consultation mechanism in place which include staff side representation
- Organisational change policy allows for staff to comment on proposed changes and receive response

Policy in relation to disabled employees

The Trust has a general policy in relation to disabled employees, which is contained within its Single Equality Scheme. The Trust aims to ensure that its recruitment processes, the arrangements for determining who should be offered employment and the terms on which employment is offered should not put disabled people at a disadvantage. Terms of employment and opportunities such as promotion, transfer, training or receipt of benefits should not be refused on the grounds of a person's disability and other formal processes including disciplinary and capability policies have been through Equality Impact Assessments to ensure that disabled employees are not subject to unlawful discrimination.

The Trust's Managing Attendance Policy recognises the organisation's duties as an employer under the Equality Act 2010. It will take the appropriate steps to ensure no member of staff is treated less favourably as a result of their disability, and will make reasonable adjustments to allow disabled employees to carry out their duties.

The Trust has been assessed as meeting the criteria for the Two Ticks scheme and Mindful Employer.

Equality and diversity

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.

The Trust is working to transform its organisational culture by committing to implementing the Equality Delivery System. It will continue to promote equality and challenge discrimination in all service provision, recognising and meeting the needs of the diverse communities it serves.

The organisation is striving to provide an environment in which people want to work and to be a model employer, leading in good employment practice. It is also committed to enabling each member of staff 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 will be addressed in accordance with the Trust's policies and procedures.

Corporate responsibility for the Single Equality Scheme lies with the Chief Executive. The Director of Human Resources is the board champion for equality and diversity. All board members have a responsibility for ensuring that the Single Equality Scheme is implemented and for promoting equality in the Trust's business. Responsibility for delivery rests with the identified lead for each of the outcome areas in the action plan.

Sickness absence data

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 Trust set a target of 3.2% for sickness absence levels for 2012/13, which would have constituted a reduction of 1.75% from the 2011/12 annual rolling absence rate of 4.95%. The actual annual rate for 2012/13 was 5.12%.

Charging for information

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

In common with most public organisations United Lincolnshire Hospitals NHS Trust freely posts information about its 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.

Cataract surgery closer to home for Louth patients

Patients needing cataract surgery are now able to have both their pre-operative assessments and operations closer to home thanks to a new service at Louth hospital.

United Lincolnshire Hospitals NHS Trust has invested £250,000 in eye surgery at County Hospital in Louth.

The investment in new equipment will allow surgeons to carry out cataract operations as well as minor oculoplastic procedures such as ptosis (droopy eyelid) surgery and surgery to correct abnormal eyelid position such as entropion (eyelid rolling in) and ectropion surgery (eyelid rolling out).

The new service means that many patients will no longer have to travel to Lincoln, Boston or Grantham for these procedures, or for the pre-operative assessments that come before them.

Our finances

The outturn for the financial year ending 31 March 2013 showed a small surplus of £0.1 million against the Trust breakeven duty. This excludes technical adjustments in relation to impairments and changes in accounting policy in relation to donated and government granted assets, which when taken into account results in a deficit of £5.2million. The cumulative position against the Trust breakeven duty however remains a deficit of £8.2 million.

Performance against the key financial targets during 2012/13 are summarised in the following table:

Target		2011/12	2012/13
Income and expenditure position against breakeven duty		£0.3 million surplus	£0.1 million surplus
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%
Better Payment Practice code Invoices paid within 30 days (measured by volume)	Trade	86%	89%
	NHS	78%	74%

Trust income

The majority of the income in 2012/13 (£379.1 million or 89.7% 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.

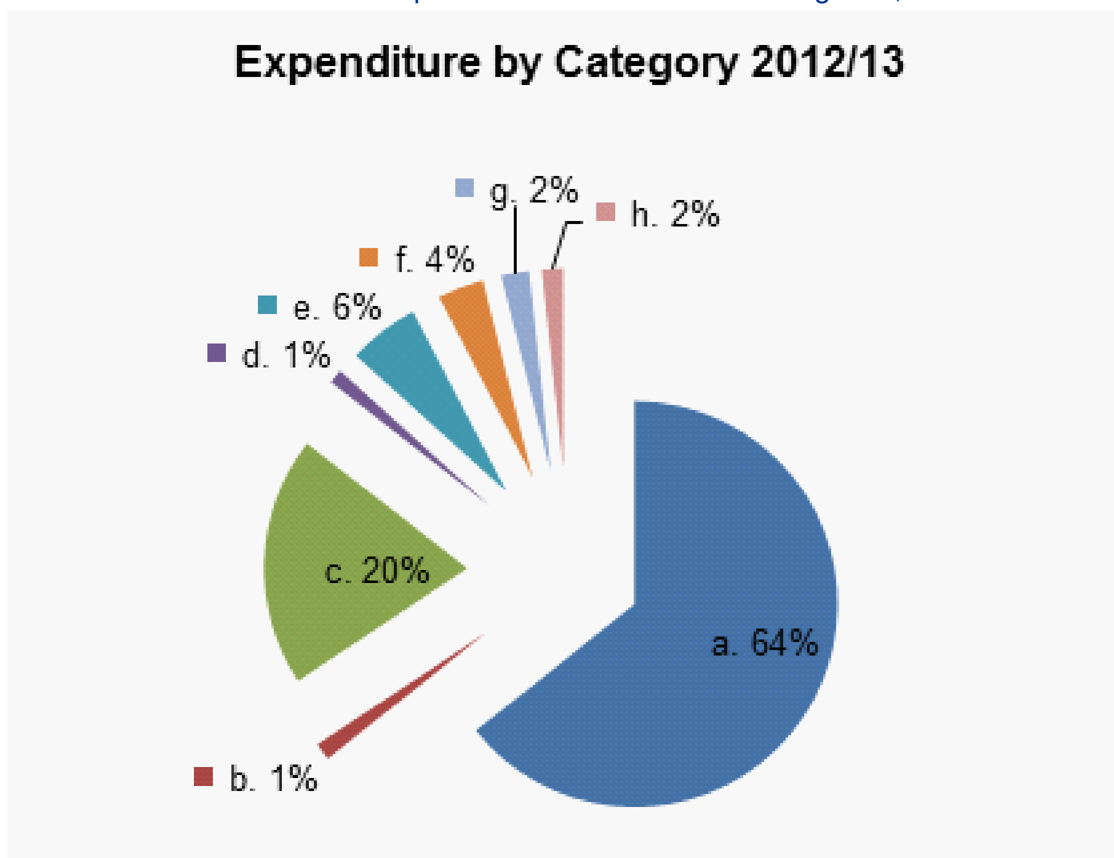
The Trust has, once again, seen or treated more patients than in previous years, and this is reflected in the increased income received during 2012/13.

The Trust earned £19.2 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 64% of the total expenditure.

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



a - Pay (£274.9m)– The Trust's largest cost each year is paying the salary of its 6,100 permanently employed staff (average contracted whole time equivalent) and all the associated costs an employer needs to spend including national insurance and pension contributions. In addition pay costs include charges associated with the use of Agency and bank staff. Pay costs for 2012/13 are set out in detail within Note 10.1 – 10.4 within the Trust Accounts.

Within these notes termination costs (2012/13 - £0.5 million) are identified separately, these incorporate costs associated with compulsory and voluntary redundancy, leavers under the Mutually Agreed Resignation Scheme (MARS), payments in lieu of notice and non-contractual severance payments. The costs under the latter of these were £1,200.

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 (see note 10.5).
The remuneration report sets out details of payments made to Trust Senior Managers along with accrued pension benefits.

The Trust continues to rely heavily upon Medical Agency staff and as a consequence total Agency spend was £15.9 million in 2012/13. Much of this is due to on-going difficulties experienced in the recruitment of medics to permanent positions on all three hospital sites.

The costs of responding to the findings of Care Quality Commission reports are reflected within the continued high pay costs.

Overall pay costs reduced by £0.3 million compared to 2011/12

b- Public Dividend Capital (£5.9m)– 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 (£85.0m)– The cost of patients' medication, dressings, syringes and other medical equipment.

d – Other (£4.9m) – Includes education and training, legal fees, non-pay recharges to other NHS bodies, losses, finance costs and 'other'.

e - Maintenance (£24.3m)– What the Trust spends on gas, electricity, water and telephone bills as well as business rates and minor repairs and maintenance programmes

f - Depreciation (£15.7m)– 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 (£9.6m) – To cover the Trust against fire, theft and clinical liabilities claims.

h - General Supplies & Services (£7.2m) – Includes bedding, linen and catering supplies

Cost Improvement Programme

The national tariff for 2012/13 had an implied efficiency of 4%, other contracts similarly utilised this figure.

The Trust planned to achieve savings of at least £21.7 million as part of the financial plan.

The Trust successfully delivered savings of £14.5 million; this was consistent with delivery in the previous financial year.

Looking forward the Trust faces significant future challenges in the delivery of cost improvements and as a consequence financial breakeven and stability.

Cash flow

The cash balance of £6.0 million on 31 March 2013 meant that the cash and Department of Health external financing limit target for 2012/13 was achieved.

The Trust received in-year cash support from the Department of Health during 2012/13 to improve liquidity. This initially took the form of a short term capital loan and temporary Public Dividend Capital (PDC), but in March 2013, a £6m allocation of permanent PDC was approved and drawn down. A further £6m was also approved for draw-down in April 2013.

It is likely that in future years the Trust will require additional cash support in the form of working capital loans in order to attain the levels of liquidity required by Monitor to support its Foundation Trust application.

During 2012/13 the long term capital loan of £4.3 million taken out the previous year was also converted to PDC.

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 2012/13 due to the low interest rates, returns were limited to £59,000.

Capital

The Trust invested £11.5 million in the capital programme during the year. The table below summarises this by category.

	£ million
Buildings and Estate	5.2
IT Infrastructure	2.2
Medical Equipment	4.0
Other	0.1
Total	11.5

The capital programme was funded through internally generated resources (depreciation and sale of assets) and donated assets of £0.4 million.

The basis of valuation for Trust assets is set out within the notes to the accounts. Land and buildings are however re-valued annually; generally this is undertaken on a modern equivalent basis (ie the cost of re-providing existing service capacity using a modern building / construction techniques). The only exceptions to this are Laundon House, Sleaford (£0.1 million) and Progress Living dwellings at Lincoln, Boston and Grantham (£22.1 million), all of which were valued on an open market basis at 31 March 2013.

During 2012/13 the Louth site and buildings were transferred to Lincolnshire PCT.

Accounting policies

The Trust accounting policies are detailed within Note 1 to the accounts. Standard Accounting Policies are mandated by the Department of Health and the ability of NHS Trusts to deviate from these is limited.

There are no material changes to the Accounting Policies set out in 2011/12. The only issue of note is that the Trust no longer holds the revaluation reserve at site level; instead, this is now recorded in greater detail at the level of individual blocks / buildings. An accounting transfer between the retained earnings and revaluation reserves has supported this change.

The 2012/13 Accounting Policies of the Trust were approved by the Audit Committee under delegated authority from the Trust Board in April 2013.

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 2012/13 against this target is summarised as follows:

	2012-13	
	Number	Value
Percentage of Non-NHS trade invoices paid within target	89%	82%
Percentage of NHS trade invoices paid within target	74%	90%

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

The Trust Accounts for 2012/13 are set out in full following the main body of this report. These have been prepared on a 'Going Concern' basis and 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.

Auditors and audit fee

KPMG LLP are the Trust's appointed external auditor and were paid £132,550 (Exc. VAT) in respect of statutory audit fees for the 2012/13 financial year.

The range of audit services provided by the KPMG included statutory review which incorporated including audit of the Annual Financial and Quality Accounts, value for money assessment and review of the Trust's governance and financial arrangements.

KPMG's review of the 2012/13 Financial Statements resulted in an unqualified opinion. 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. Further copies 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

Boston becomes the hub for vascular surgery

Pilgrim hospital was this year approved to carry out all inpatient vascular surgery for United Lincolnshire Hospitals NHS Trust as the county's specialised vascular centre. This is surgery for conditions of the arteries and veins, such as aneurysms, thrombosis and varicose veins.

Part of the development of the service included major building work to develop a state-of-the-art outpatient and vascular diagnostics laboratory facility.

This new facility includes two outpatient consulting suites, treatments rooms and three diagnostic rooms. All vascular diagnostics can be done in the new facility and the one stop clinics are also being developed.

Remuneration report

Introduction

The Treasury Financial Reporting manual (FReM) requires 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 and its purpose is to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors. Non-executive directors, including the Chairman, are appointed by the NHS Trust Development Authority on behalf of the Secretary of State for Health and are typically appointed for a standard term of four years.

The committee membership during 2012/13 comprised of 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.

During the year, all very senior managers employed on permanent contracts had a six month employer to employee notice period.

Remuneration report disclosure requirement in relation to pay multiples:

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

The banded remuneration of the highest paid director in United Lincolnshire Hospitals NHS Trust in the financial year 2012-13 was £180,000 (2011-12, £185,000). This was 7.63 times (2011-12, 8.16) the median remuneration of the workforce, which was £23,589 (2011-12, £22,676).

In 2012-13, zero (2011-12, zero) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £180,000 to £5,214 (2011-12 £185,000-£5,214).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.”
(Salary has been defined for the purposes of this calculation as basic salary which excludes overtime and enhancements)

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.

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 market valuation factors produced by the Government Actuary's Department (GAD) 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

Name and title	Notes	Term in post		2012/13 Salary (bands of £5,000)	2012/13 Other Remuneration (bands of £5,000)	2012/13 Bonus Payments (bands of £5,000)	2012/13 Benefits in kind (Rounded to the nearest £00)	2011/12 Salary (bands of £5,000)	2011/12 Other Remuneration (bands of £5,000)	2011/12 Bonus Payments (bands of £5,000)	2011/12 Benefits in kind (Rounded to the nearest £00)
		Start	Finish	£000's	£000's	£000's	£00's	£000's	£000's	£000's	£00's
Mr P Richardson - Chair		Jul-09	Ongoing	20 - 25			9	20 - 25			12
Mr T Staniland - Non Executive Director		Mar-07	Ongoing	5 - 10			5	5 - 10			5
Mr K Brown - Non Executive Director		May-08	Ongoing	5 - 10			8	5 - 10			7
Mr N Muntz - Non Executive Director		Jul-09	Ongoing	5 - 10				5 - 10			
Mr K Darwin - Non Executive Director		Jan-10	Ongoing	5 - 10			4	5 - 10			3
Mrs P Owston - Non Executive Director		Apr-10	Ongoing	5 - 10			17	5 - 10			6
Jane Lewington - Chief Executive / Director of Strategy and Performance		Dec-10	Ongoing	150 - 155				135 - 140			
Andrew North - Chief Executive		Aug-10	Nov-11	120 - 125				180 - 185			
Kevin Turner - Director of Finance		Jan-11	Ongoing	135 - 140				135 - 140			
Michelle Rhodes - Director of Service Delivery	1	Oct-10	Ongoing	115 - 120				45 - 50			
Sylvia Knight - Chief Nurse		Jul-04	May-12	15 - 20				100 - 105			
Eiri Jones - Director of Nursing	2	Aug-12	Ongoing								
Tracy Pilcher - Acting Director of Nursing		Jun-12	Jul-12	10 - 15							
Stephen Hewitt - Acting Director of Strategy and Performance		Dec-12	Mar-13	35 - 40							
Ros Edwards - Director of Human Resources		Aug-08	Aug-11					40 - 45			
Jaki Lowe - Interim Director of Human Resources	3	Sep-11	Jan-13								
Ian Warren - Director of Human Resources	4	Feb-13	Mar-13								
David Levy - Medical Director		Apr-11	Ongoing	170 - 175				165 - 170			
Mike Speakman - Director of Estates and Facilities		May-08	Oct-12	55 - 60				95 - 100			
Nigel Myhill - Director of Estates and Facilities	5	Oct-12	Ongoing								

Notes:
1. Michelle Rhodes was seconded as Interim Director of Service Delivery from Nottingham City PCT at a cost of £77,050 in 2011/12 before being appointed substantively in September 2011.
2. Eiri Jones has been seconded from Bedfordshire NHS Trust at a cost of £88,125.
3. Jaki Lowe was employed through a private company at a cost of £133,062 during 2012/13 (2011/12 - £89,768)
4. Ian Warren has been seconded on a part time basis from Lincolnshire Community Health Services NHS Trust (LCHS). The secondment has formed part of a wider cost and resource sharing exercise between the two organisations and United Lincolnshire Hospitals have not been therefore been recharged directly for Ian Warren's costs. Details of Mr Warren's Salary and Pensions Benefits are disclosed in full by LCHS.
5. Nigel Myhill has been seconded on a part time basis from Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG) at a cost of £25,100. Details of Mr Myhill's Salary and Pensions Benefits are disclosed in full by NLAG.

Pension Benefits 2012/13								
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 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	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	£00
Jane Lewington - Chief Executive / Director of Strategy and Performance	2.5 - 5	12.5 - 15	60 - 65	180 - 185	1,264	1,086	121	
Andrew North - Chief Executive	-	-	80 - 85	240 - 245	-	1,562	(1,097)	
Kevin Turner - Director of Finance, Procurement & Informatics	-	-	55 - 60	175 -180	1,121	1,060	6	
Michelle Rhodes - Director of Service Delivery	0 - 2.5	2.5 - 5	25 - 30	85 - 90	470	416	32	
Sylvia Knight - Chief Nurse	-	-	30 - 35	90 - 95	466	435	1	
Eiri Jones - Director of Nursing	2.5 - 5	10 – 12.5	40 - 45	130 - 135	897	730	85	
Tracy Pilcher - Acting Director of Nursing	0 - 2.5	0 - 2.5	25 - 30	75 - 80	404	363	4	
Stephen Hewitt - Acting Director of Strategy and Performance	0 - 2.5	5 - 7.5	30 - 35	100 - 105	665	493	48	
David Levy - Medical Director	-	-	60 - 65	185 - 190	1,205	1,114	32	
Mike Speakman - Director of Estates and Facilities	0 - 2.5	2.5 - 5	25 - 30	80 - 85	415	351	23	

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.

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 market valuation factors produced by the Government Actuary's Department (GAD) for the start and end of the period.

Review of tax arrangements of public sector appointees

Public sector bodies are required to publish details of numbers of individuals engaged within the business who are not paid though the organisation's payroll and who are therefore not subject to tax and national insurance deductions at source.

The tables below present the number of off payroll engagements at United Lincolnshire Hospitals in the format prescribed by the Treasury and Department of Health.

New unit is a boost for hospital breast services

Patients are set for an improved service thanks to a new dedicated breast cancer unit at Grantham and District Hospital.

The new unit brings together all breast care services in one place to provide a single, dedicated breast care unit at the hospital. It includes outpatient clinics, examinations, counselling and prosthetic services.

Members of the public were given the chance to name the new breast unit at the hospital with a competition run in the unit and through the local media.

The staff from the breast unit voted on their favourite from the public suggestions and the name they have chosen is "Emerald Suite".

Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012

	Off payroll engagements - number
No. in place on 31 January 2012	7
Of which:	
No. that have since come onto the Organisation's payroll	0
Of which:	
No. that have since been re-negotiated/ re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have come to an end	0
Total	7

Having reviewed invoice records and identified existing arrangements the Trust is currently seeking to bring individuals onto the Trust payroll or where this is not an option to re-negotiate contracts to satisfy itself that the contractor is accounting in full for tax liabilities.

Table 2: For all new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months

	Off payroll engagements - number
No. of new engagements	0
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
Total	0

Financial statements for the year ended 2012/13

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FOREWORD TO THE ACCOUNTS

Financial Review - year ended 31 March 2013

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

Financial Target	Actual Performance		
	2012/13		2011/12
To break even on income and expenditure, taking one year with another. (Target excludes technical adjustments for impairment following revaluation and the impact of changes in accounting policy relating to Donated / Govt Granted Assets)	**(5,207)**	**Surplus / (Deficit)**	(7,060)
	5,192	**Impairments**	6873
	(139)	**Other adjustments**	507
	124	**Reported Performance**	320
	(8,083)	**Cumulative position against breakeven duty surplus / (deficit)**	(8,207)
To achieve a capital cost absorption rate of between 3% and 4%	**3.5%**		3.5%
To operate within an External Financing Limit set by the Department of Health	**£0.96m**	**Undershoot**	£3.37m
To operate within a Capital Resource Limit set by the Department of Health	**£0.49m**	**Underspent**	£1.32m
To pay 95% of creditor invoices within 30 days (by number of invoices)	**89%**	**Trade**	86%
	74%	**NHS**	78%

Pen Anderson
Acting Director of Finance
June 2013

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

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

Signed Chief Executive

Date 6th June 2013

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and 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 judgments 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 accountng records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

6th June 2013 Chief Executive

6th June 2013 Acting Finance Director

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, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the organisation is administered prudently and economically and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the Accountable Officer Memorandum which sets out my responsibilities of propriety and regulation of expenditure, and for putting in place effective management systems which safeguard public funds and allow for the keeping of proper accounts.

The Trust 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 Midlands and East) being responsible for the performance management of NHS Lincolnshire, who hold the Trust to account through the contract. The Trust reports through NHS Midlands and East and the Department of Health on performance against national objectives.

The governance framework of the organisation

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 governance and system of internal control of the organisations is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,

- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

Trust Board and Committee Structure

The Trust Board meets on a monthly basis and consists of a Chairman, 5 voting Executive Directors, including the Chief Executive and 5 Non Executive Directors. The Director of Operations, Director of Facilities, Director of Human Resources and Head of Governance also attend the Board meetings. The Board focusses on strategic issues, whilst also receiving assurances in relation to the organisational performance. The Trust is continuing to progress its application for Foundation Trust status, and as part of this process has completed a self assessment against the Board Governance Assurance Framework. This process has identified areas where the Boards effectiveness could be further developed.

The Board is compliant with the Corporate Governance Code.

Supporting Committee Structures

To support the Trust Board in carrying out its duties effectively, committees reporting to the Board are formally established. The remit of these committees was reviewed during the year to ensure robust governance and assurance. Each committee receives reports as outlined within their terms of reference and work programme, and provides an exception report to the Trust Board after each meeting.

The key sub committees for governance and assurance are as follows:

Audit Committee - delegated to approve the annual accounts on behalf of the board and provide assurance in relation to , Internal and external audit, counterfraud and security management, financial reporting, integrated governance, risk management and internal control, and the annual governance statement.

Governance Committee – to provide assurance that robust governance and risk management arrangements are in place within the Trust and that they are working effectively. This is achieved through consideration of the risk management arrangements and risk management report, scrutiny of the Board Assurance Framework and the key organisational risks. Exception reports from the Health and Safety Committee, Information Governance Committee and Quality and Safety Committee are considered by the Governance Committee.

Both Audit and Governance Committees have produced highlight reports following each meeting to report to the Trust Board. Covering those areas where assurance has been sought, received, and where further action to gain assurance was required.

Meeting	Attendance rate for voting members
Trust Board	76%
Audit Committee	80%
Governance Committee	67%

In addition the Board is supported by the Remuneration Committee, Charitable Funds Committee, Estates Committee and Foundation Trust Programme Board.

Risk assessment

Overall responsibility for risk management rests with all members of the Board. The Medical Director 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 Trust Board level. The Trust operates and maintains an 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 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 organisation also has the Quality and Safety Committee and a sharing lessons learned framework. These functions facilitate the dissemination of good practice across the organisation, through the Board Governance Committee and other forums. 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. The sharing lessons learned forum considers learning reports and ensures that lessons to be learned are shared across the organisation.

Trust Major Risks during 2012/13

During 2012/13 the Trust took a range of actions to continuously scrutinise and assure against the major risks facing the Trust.

- Challenges to achievement of full compliance with CQC outcomes across all sites.

- Not delivering the financial plan and challenging cost improvement programme and meet the financial pressures faced across the NHS.
- Reliability in providing accessible services with minimal waits to meet minimum national standards

- Overcoming barriers to achieve improved effectiveness and efficiencies through service transformation.

- Meeting the Clostridium Difficile trajectory target.
- The need to fully comply with the Health and Safety Executive for the management of violence and aggression

and manual handling training.

· Further to significant improvement required to reduce the HSMR for the Trust.

During 2012/13 the Trust has recorded one incident related to an unauthorised breach of patient information that has been investigated and action taken to reduce the risk of recurrence, United Lincolnshire Hospitals NHS Trust has 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 reviewed during the year the assurances provided that risks were being mitigated. Information risk management is reviewed and monitored by the Trust Information Governance Committee which meets monthly and reports directly to the Governance Committee.

The risk and control framework

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

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 Trust Board, along with the relevant equality impact assessment.

During 2012/13 the Trust has continued its work to create strong governance arrangements, suitable for its application for Foundation Trust status. Specifically:

- An established and experienced senior management structure

- A robust information governance framework in place
- A review of Standing orders, Standing Financial Instructions and Scheme of Delegation.

- NHSLA accreditation
- Compliance with NHS Protect directives.

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

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

The 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 co-ordinated and effective risk mitigation in achieving the Trust's objectives. This enables the Board to discharge its responsibilities for governance and understand the balance of clinical, operational and financial risk.

Throughout 2012/13, the Board has identified and monitored against key objectives within its Board Assurance Framework. 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.

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

The Trust continues to put in place an adequately resourced plan of work for the Local Counter Fraud Specialist which includes proactive deterrence and prevention of fraud work

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The overall Head of Internal Audit Opinion gave significant assurance, although some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk. 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.

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 Internal Audit reviews undertaken during 2012/13 led to the Head of Internal Audit providing a significant assurance opinion on the system of internal control in the Trust. In reaching this opinion the review assessed

- the design and operation of the assurance framework and supporting processes and the status or preparedness of the organisation with respect to risk management, control and review processes that it had in place for 2012/13.

- The range of individual opinions arising from risk based audit assignments

The Trust has produced a Quality Account, and has taken steps to assure itself of the accuracy of this document by referencing Information Services within the organisation, the Quality and Safety Committee and Internal and External audit processes.

Significant Issues

During the year the Trust identified the following significant control issues

During 2012/13 the CQC visited Lincoln County Hospital in both April and October/November 2012. At the visit in April they reviewed outcome 9 (management of medicines) and judged it to be non-compliant. At the visit in October / November 8 out of the 9 outcomes reviewed were judged to be compliant. This included outcome 9. The current position at the end of March 2013 is that Lincoln County Hospital is compliant with 15 regulations/outcomes. There is still a minor impact relating to the following regulations/outcomes.

- Regulation 22/Outcome 13 Staffing

A Remedial action plan to address this impact on patients is being implemented.

During 2012/13 the CQC visited Pilgrim Hospital in both May and December 2012. At the visit in May they reviewed outcome 9 (management of medicines) and judged it to be non-compliant.. At the visit in December 8 out of the 10 outcomes reviewed were judged to be compliant. This included outcome 9. The position at the end of March 2013 is that Pilgrim Hospital is compliant with 14 regulations/outcomes. There is still a minor impact relating to the following regulations/outcomes.

- Regulation 9/Outcome 4 Care and welfare of people who use services

- Regulation 22/Outcome 13 Staffing

Remedial action plans to address these concerns are being implemented.

In August 2012, the CQC visited County Hospital, Louth as part of a national targeted dignity and nutrition inspection programme. The CQC reviewed 5 outcomes and they were all judged to be compliant. The position at the end of March 2013 is that County Hospital Louth is compliant with all 16 regulations/outcomes.

In February 2013 the CQC visited Grantham Hospital and although the report is yet to be published, 4 out of the 6 outcomes reviewed were judged to be compliant. The position at the end of March 2013 is that Grantham Hospital is compliant with 14 regulations/outcomes.. There are minor impacts relating to the following regulations/outcomes.

- Regulation 17/Outcome 1 Respecting and involving people who use services
- Regulation 22/Outcome 13 Staffing
- Regulation 23/Outcome 14 Supporting Workers

Remedial action plans to address these concerns are being implemented.

The Trust has not participated in any special reviews by the CQC during 2012/13.

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

Accountable Officer : **Chief Executive**

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

We have audited the financial statements of United Lincolnshire Hospitals NHS Trust ('the Trust') for the year ended 31 March on pages 15 to 57. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Board of Directors of United Lincolnshire Hospitals NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has bene undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors and auditor

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

Scope of the audit of financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatments or inconsistencies we comsider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of United Lincolnshire Hospitals NHS Trust as at 31 March 2013 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:
- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the director's report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:
- in our opinion, the Governance Statement does not reflect compliance with the Department of Health's requirements; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

We are considering whether to make a referral to the Secretary of State under section 19 of the Audit Commission Act 1998 on the grounds that the Trust has breached its cumulative statutory breakeven duty.

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

Trust's responsibilities

The Trust is responsbile for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to renew regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in November 2012, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2013.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial resilience we identified that:

- Following a deficit of £13.9 million in 2010/11, the Trust agreed an informal recovery plan with the Strategic Health Authority. The recovery plan indicated a return to break even by 2015/16. The Trust made small surpluses in 2011/12 and 2012/13 and is projecting a deficit in 2013/14 of £17m. The Trust's draft financial plan for 2013/14 indicates that the Trust will now not return to cumulative breakeven until 2016/17. The Trust is in discussions with the NHS Trust Development Authority to develop a new formal recovery plan.

In considering the Trust's arrangements for challenging how it secures economy, efficiency and effectiveness we identified that:

- Issues arising from aspects of the quality of service have impacted on the Trust's financial position. The Trust incurred £7.3m of fines in 2012/13 for breaching the C.Difficile target and other contractual Key Performance Indicators. The Trust will also need to fund additional nursing posts in 2013/14 in order to increase staffing levels in response to a Care Quality Commission report published in March 2013.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commisison in November 2012, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that in all significant respects United Lincolnshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013.

Certificate

We cannot issue an audit certificate until we have completed the work necessary to provide assurance over the Trust's annual quality accounts and have finalised our considerations in respect of maknig a referral to the Secretary of State under section 19 of the Audit Commission Act 1998. Completion of our limited assurance work on the annual quality accounts and our consideration of whether to refer matters to the Secretary of State are not expected to give rise to any issues which will have an impact on the statutory financial statements or on our use of resources conclusion.

Neil Bellamy for and on behalf on KPMG LLP, Statutory Auditor
Chartered Accountants
1 Waterloo Way
Leicester
LE1 6LP

6 June 2013

Statement of Comprehensive Income for year ended 31 March 2013

	NOTE	**2012-13** **£000**	2011-12 £000
Gross employee benefits	10.1	**(274,802)**	(275,143)
Other costs	8	**(146,790)**	(133,605)
Revenue from patient care activities	5	**382,688**	373,380
Other Operating revenue	6	**40,114**	34,595
Operating surplus/(deficit)		**1,210**	(773)
Investment revenue	12	**59**	56
Other gains and (losses)	13	**(372)**	(445)
Finance costs	14	**(207)**	(170)
Surplus/(deficit) for the financial year		**690**	(1,332)
Public dividend capital dividends payable		**(5,897)**	(5,728)
Retained surplus/(deficit) for the year		**(5,207)**	(7,060)

Other Comprehensive Income	**2012-13** **£000**	2011-12 £000
Impairments and reversals	**728**	34
Net gain/(loss) on revaluation of property, plant & equipment	**6,415**	3,907
Total comprehensive income for the year*	**1,936**	(3,119)

* This sums the rows above and the surplus / (deficit) for the year before adjustments for PDC dividend.

Financial performance for the year

Retained surplus/(deficit) for the year	**(5,207)**	(7,060)
Impairments	**5,192**	6,873
Adjustments in respect of donated asset/gov't grant reserve elimination	**139**	507
Adjusted retained surplus/(deficit)	**124**	320

Since the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10 the reported financial performance of NHS Trusts has been adjusted in line with HM Treasury guidance. The following are therefore excluded from measured performance in order to maintain comparability year on year:

a) an impairment charge is not considered part of the organisation's operating position.
b) the impact of changes in accounting policy relating to donated asset and Government Grant Reserves are discounted.

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

PDC dividend: balance receivable/(payable) at 31 March 2013	**(119)**
PDC dividend: balance receivable/(payable) at 1 April 2012	**(145)**

The notes on pages 19 to 57 form part of this account.

Statement of Financial Position as at 31 March 2013

	NOTE	31 March 2013 £000s	31 March 2012 £000s
Non-current assets:			
Property, plant and equipment	15	**203,798**	205,160
Intangible assets	16	**1,262**	1,306
Trade and other receivables	22.1	**1,795**	1,994
Total non-current assets		**206,855**	208,460
Current assets:			
Inventories	21	**6,669**	6,335
Trade and other receivables	22.1	**17,967**	15,076
Other current assets	25	**7**	84
Cash and cash equivalents	26	**5,976**	2,156
Total current assets		**30,619**	23,651
Non-current assets held for sale	27	**0**	355
Total current assets		**30,619**	24,006
Total assets		**237,474**	232,466
Current liabilities			
Trade and other payables	28	**(36,942)**	(29,866)
Other liabilities	29	**(503)**	(503)
Provisions	35	**(2,493)**	(5,112)
Borrowings	30	**(134)**	(121)
Working capital loan from Department	30	**0**	(3,000)
Capital loan from Department	30	**0**	(216)
Total current liabilities		**(40,072)**	(38,818)
Non-current assets plus/less net current assets/liabilities		**197,402**	193,648
Non-current liabilities			
Other Liabilities	29	**(16,100)**	(16,604)
Provisions	35	**(2,512)**	(2,367)
Borrowings	30	**(493)**	(627)
Capital loan from Department	30	**0**	(3,976)
Total non-current liabilities		**(19,105)**	(23,574)
Total Assets Employed:		**178,297**	170,074
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**188,040**	181,753
Retained earnings		**(56,894)**	(38,842)
Revaluation reserve	15	**46,961**	26,973
Other reserves		**190**	190
Total Taxpayers' Equity:		**178,297**	170,074

The notes on pages 19 to 57 form part of this account.

The financial statements on pages 15 to 57 were approved by the Board on 6th June 2013 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2013

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2012	**181,753**	**(38,842)**	**26,973**	**190**	**170,074**
Changes in taxpayers' equity for 2012-13					
Retained surplus/(deficit) for the year	0	(5,207)	0	0	**(5,207)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	6,415	0	**6,415**
Impairments and reversals	0	0	728	0	**728**
Transfers between reserves	0	(12,845)	12,845	0	**0**
Reclassification Adjustments					
New PDC Received	15,287	0	0	0	**15,287**
PDC Repaid In Year	(9,000)	0	0	0	**(9,000)**
Net recognised revenue/(expense) for the year	**6,287**	**(18,052)**	**19,988**	**0**	**8,223**
Balance at 31 March 2013	**188,040**	**(56,894)**	**46,961**	**190**	**178,297**
Balance at 1 April 2011	**181,753**	**(35,897)**	**27,147**	**190**	**173,193**
Changes in taxpayers' equity for the year ended 31 March 2012					
Retained surplus/(deficit) for the year	0	(7,060)	0	0	(7,060)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	3,907	0	3,907
Impairments and reversals	0	0	34	0	34
Transfers between reserves	0	4,115	(4,115)	0	0
Reclassification Adjustments					
Net recognised revenue/(expense) for the year	0	(2,945)	(174)	0	(3,119)
Balance at 31 March 2012	**181,753**	**(38,842)**	**26,973**	**190**	**170,074**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2013

	NOTE	**2012-13 £000s**	2011-12 £000s
Cash Flows from Operating Activities			
Operating Surplus/Deficit		**1,210**	(773)
Depreciation and Amortisation		**10,565**	11,478
Impairments and Reversals		**5,192**	6,873
Donated Assets received credited to revenue but non-cash		**(358)**	(151)
Interest Paid		**(135)**	(101)
Dividend (Paid) / Refunded		**(5,923)**	(5,635)
(Increase)/Decrease in Inventories		**(381)**	(117)
(Increase)/Decrease in Trade and Other Receivables		**(2,692)**	(3,794)
(Increase)/Decrease in Other Current Assets		**77**	585
Increase/(Decrease) in Trade and Other Payables		**8,381**	(8,585)
Increase/(Decrease) in Other Current Liabilities		**(504)**	(529)
Provisions Utilised		**(1,213)**	(2,965)
Increase/(Decrease) in Provisions		**(1,333)**	2,380
Net Cash Inflow/(Outflow) from Operating Activities		**12,886**	(1,334)
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**60**	55
(Payments) for Property, Plant and Equipment		**(12,348)**	(14,887)
(Payments) for Intangible Assets		**(164)**	(455)
Proceeds of disposal of assets held for sale (PPE)		**4,412**	1,829
Net Cash Inflow/(Outflow) from Investing Activities		**(8,040)**	(13,458)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		**4,846**	(14,792)
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		**15,287**	0
Public Dividend Capital Repaid		**(9,000)**	0
Loans received from DH - New Capital Investment Loans		**0**	4,300
Loans received from DH - New Revenue Support Loans		**0**	3,000
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(4,192)**	(108)
Loans repaid to DH -Revenue Support Loans		**(3,000)**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(121)**	(109)
Net Cash Inflow/(Outflow) from Financing Activities		**(1,026)**	7,083
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**3,820**	(7,709)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**2,156**	9,865
Cash and Cash Equivalents (and Bank Overdraft) at year end	26	**5,976**	2,156

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

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

Revenue derived from Payment by Results can be disputed for a period of up to 3 months from the quarter end, the Trust has assumed that all invoiced activity recorded as income as at 31st March 2013 will be paid in full.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.3.2 Key sources of estimation uncertainty

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

Note 15, an annual revaluation of Trust Property, Plant and Equipment is conducted by DTZ Debenham Tie Leung Ltd. As part of this revaluation process the Trust reviews the remaining useful life of it's buildings in accordance with advice received from DTZ. This estimation of remaining useful life is in accordance with the Royal Institute of Chartered Surveyors (RICS) appraisal and valuation manual. The value of land, buildings and dwellings post revaluation was £181.5m.
Where assets are replaced during a major refurbishment, due to age, obsolescence, operational improvements etc, then the original asset is de-recognised from the balance sheet immediately the refurbishment work commences. As it is not possible to determine the carrying amount of the replaced part, the cost of the replacement is used as an indication of what the replaced part was at the time it was acquired or constructed. The cost of the replacement asset is then capitalised in full. The value derecognised in 2012-13 was £0.3m.

Note 10.5, Pension Costs details out the actuarial assumptions used in calculating the Trust's pension Liabilities.

In order to report within the government guidelines, the value of patient care activity for the year ended 31 March has been estimated based on data available at 1 April 2013.
Income for an inpatient stay can be recognised from the day of admission, but cannot be precisely calculated until the patient is discharged. For patients occupying bed as at 31 March 2013, the estimated income from partially completed spells was £2.9m (year ended 31 March 2012, £2.5m)

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

Note 35, details the Provisions recognised by the Trust at 31 March 2013. These include legal actions against the Trust in relation to Employers and Public Liability Claims as well as employment related claims. The outcome of each individual case is uncertain and will only be determined through future legal proceedings. Key sources of information in determining the appropriate provision to recognise are reports from the NHS Litigation Authority and Trust Solicitors detailing on going claims against the Trust and which provide an assessment of the probable outcome and costs. Provision has also been made for employees who have applied or have contractual entitlement to re-grading / assimilation and would be entitled to arrears. Total provisions recognised at 31st March 2013 were £5.0m.

Note 36, Contingent Liabilities utilise reports from the Trust Solicitors to assess potential outcome and costs. Where the potential for the claim succeeding is less than 50% but considered not to be remote a contingent liability is recorded. These total £0.7m at 31st March 2013.

Statement of Changes in Taxpayer's Equity, the Trust's Asset Register is unable to calculate the amount required to be transferred between the revaluation reserve and retained earnings for the excess of current cost depreciation over historical cost depreciation. The value is therefore estimated on the following basis:

Each asset's closing revaluation reserve balance is divided by it's remaining useful life, with the resultant calculated value being transferred from the revaluation reserve to retained earnings, ensuring that the reserve value for each asset at the end of its life is written down to zero. The amount transferred in 2012-13 between the reserves was £1.1m.

The Trust information systems are unable to accurately identify the figures for 'Inventories recognised as expenses' under Note 21. The Trust has therefore estimated this figure by using the figures from the resus stock system for consumables and the ascribe stock system for drugs. These figures are £0.1m and £25.8m respectively.

The Trust entered into a contract with a third party in 2006 in which they provide accomodation to Trust employees. As part of the contract a minimum occupancy level was guaranteed. Costs of under-occupancy are met by the Trust.Future under-occupancy charges have been estimated for the relevant properties based upon trends over the preceding 12 months ending February 2013. The assets associated with this 'onerous' contract are impaired based upon this assessment.
Note 28, estimates of material outstanding pay liabilities have been made for the following:
Annual Leave - based upon average pay rates for 2012/13 and leave carried forward as assessed through a Trust wide sample
Maternity Leave - based upon actual employees on leave, taking account of NHS contractual entitlements
Overtime and Enhancements relating to March 2013 - based upon actual payments for a 'similar' accounting period

1.4 Revenue

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

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5 Employee Benefits

Short-term employee benefits

Salaries, wages and employment related payments are recognised in the period in which service is received from the employee. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

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

1.6 Other expenses

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment being carried at the folowing amounts:-

Where assets are of low value (less than £1 million), and/or have short useful economic lives (less than 10 years), these are carried at depreciated historic cost as a proxy for current value as this is not considered to be materially different from fair value.

Assets above this threshold are carried at current value with, full professional valuations obtained every five years with interim professional valuations in year three

Assets purchased under a finance lease are held at the net present value of the minimum lease payments discounted using the implicit interest rate.

Equipment surplus to requirements is valued at net recoverable amount.

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

Subsequent expenditure

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

1.8 Intangible assets

Recognition

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

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

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it

- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

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

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

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

“Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury’s budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.”

1.10 Donated assets
Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.11 Government grants
Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.12 Other Reserves

Liabilities transferred to the NHS Litigation Authority on 1st April 2000, have been recorded as 'other reserves'. This reserve is not expected to change.

1.13 Non-current assets held for sale

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

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

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

1.14 Leases

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

The trust as lessee

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

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

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

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

The trust as lessor

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

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

1.15 Inventories

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

1.16 Cash and cash equivalents

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

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

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

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.19 Non-clinical risk pooling

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

1.20 EU Emissions Trading Scheme

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

1.21 Contingencies

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

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

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

1.22 Financial assets

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

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

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

1.23 Financial liabilities

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

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

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.24 Liquidity Risk

The Trust's net operating costs are mainly incurred under legally binding contracts with local Primary Care Trusts (to be replaced by Clinical Commissioning Groups with effect from 1st April 2013), which are financed from resources voted annually by Parliament. Under Payment by Results, the Trust is paid for activity on the basis of nationally set tariffs. For contracted activity, the Trust is paid in 12 monthly instalments throughout the year, which significantly reduces the Trust's liquidity risk. Performance in excess of contracted levels is paid in accordance with the terms of the legally binding contracts.

1.25 Market Risk

Interest Rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk.

Foreign currency risk

The Trust has negligible foreign currency income or expenditure.

Credit risk

The Trust operates primarily within the NHS market and receives the majority of its income form other NHS organisations. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise,however, around how the amounts owed are calculated, particularly due to the complex nature of the Payments by Results regime.

1.26 Value Added Tax

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

1.27 Foreign currencies

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

1.28 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 42 to the accounts.

1.29 Public Dividend Capital (PDC) and PDC dividend

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

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

1.30 Losses and Special Payments

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

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

1.31 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

For 2011-12 and 2012-13 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.32 Associates

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.33 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.34 Research and Development

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation"

2. Pooled budgets

United Lincolnshire Hospitals NHS Trust does not have any pooled budgets.

3. Operating segments

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

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

Revenue from activities (medical treatment of patients) is analysed by customer type in note 5 to the financial statements on page 31. Other operating revenue is analysed in note 6 to the financial statements on page 31 and materially consists of revenues from education, training and research and other revenue.

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

	Year Ended 31 March '2013 £'000	%	Year ended 31 March '2012 £'000	%
Revenue from whole HM Government	412172	97.5	397738	97.5
Revenue from non HM Government sources	10630	2.5	10237	2.5
TOTAL	422802	100	407975	100

4. Income generation activities

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

Summary Table - aggregate of all schemes	**2012-13**	2011-12
	£000s	£000s
Income	**5,008**	1,954
Full cost	**4,670**	2,324
Surplus/(deficit)	**338**	(370)

2012-13 figures comprise catering and car parking income from the public and staff (2011-12 catering only)

5. Revenue from patient care activities	**2012-13**	2011-12
	£000s	£000s
NHS Trusts	**4**	4
Primary Care Trusts - tariff	**266,404**	274,784
Primary Care Trusts - non-tariff	**108,989**	91,413
Primary Care Trusts - market forces factor	**3,712**	3,892
Local Authorities	**87**	56
Non-NHS:		
Private patients	**847**	1,129
Overseas patients (non-reciprocal)	**55**	50
Injury costs recovery	**2,247**	1,764
Other	**343**	288
Total Revenue from patient care activities	**382,688**	373,380

6. Other operating revenue	2012-13	2011-12
	£000s	£000s
Recoveries in respect of employee benefits	2,641	1,694
Education, training and research	19,210	19,394
Receipt of donations for capital acquisitions - NHS Charity	358	151
Non-patient care services to other bodies	45	239
Income generation	4,116	3,415
Rental revenue from finance leases	86	30
Rental revenue from operating leases	643	602
Other revenue	13,015	9,070
Total Other Operating Revenue	40,114	34,595
Total operating revenue	422,802	407,975

Other revenue is analysed as below		
SLA income	5,548	4,154
Pathlincs	796	910
Release of progress deferred income	479	479
Income re non pay recharges	3,093	0
Other	3,099	3,527
	13,015	9,070

7. Revenue	2012-13	2011-12
	£000	£000
From rendering of services	422,802	407,975
From sale of goods	0	0

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

8. Operating expenses (excluding employee benefits)	2012-13 £000s	2011-12 £000s
Trust Chair and Non-executive Directors	**56**	56
Supplies and services - clinical	**84,923**	71,271
Supplies and services - general	**7,253**	7,208
Consultancy services	**1,138**	1,775
Establishment	**4,636**	3,860
Transport	**1,163**	1,512
Premises	**18,490**	16,815
Impairments and Reversals of Receivables	**63**	176
Inventories write down	**47**	119
Depreciation	**10,068**	10,968
Amortisation	**497**	510
Impairments and reversals of property, plant and equipment	**5,145**	6,873
Audit fees	**156**	262
Clinical negligence	**9,600**	8,949
Education and Training	**1,125**	999
Change in Discount Rate	**112**	0
Other	**2,318**	2,252
Total Operating expenses (excluding employee benefits)	**146,790**	133,605
Employee benefits		
Employee benefits excluding Board members	**273,398**	273,812
Board members	**1,404**	1,331
Total employee benefits	**274,802**	275,143
Total operating expenses	**421,592**	408,748

9. Operating Leases

The majority of the Trust's leasing arrangements are for plant and equipment supplied under normal

commercial terms by non-NHS suppliers. There is no contingent rent associated with the arrangements.

The Trust has entered in 2011-12 into a short term operating lease for land. This lease expires in the period to March 2014
The Trust has entered in 2012-13 into a short term operating lease for buildings. This lease expires in March 2018.

The Trust leases medical equipment, these leases expire in the period to December 2016. The Trust also has numerous vehicles leased which expire over the next 4 years.

9.1 Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2012-13 Total £000s	2011-12 £000s
Payments recognised as an expense					
Minimum lease payments				**588**	538
Total				**588**	538
Payable:					
No later than one year	1,154	0	366	**1,520**	437
Between one and five years	4,427	0	265	**4,692**	389
Total	**5,581**	**0**	**631**	**6,212**	826
Total future sublease payments expected to be received:				0	0

9.2 Trust as lessor

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

	2012-13 £000	2011-12 £000s
Recognised as income		
Rental revenue	**413**	180
Contingent rents	**230**	422
Total	**643**	602
Receivable:		
No later than one year	**386**	510
Between one and five years	**1,325**	1,755
After five years	**476**	658
Total	**2,187**	2,923

10 Employee benefits and staff numbers

10.1 Employee benefits

	2012-13		
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**233,300**	199,285	34,015
Social security costs	**16,933**	16,933	0
Employer Contributions to NHS BSA - Pensions Division	**24,155**	24,155	0
Termination benefits	**520**	520	0
Total employee benefits	**274,908**	240,893	34,015
Less recoveries in respect of employee benefits	**(2,641)**	(2,641)	0
Total -Net Employee Benefits including capitalised costs	**272,267**	238,252	34,015
Employee costs capitalised	**106**	106	0
Gross Employee Benefits excluding capitalised costs	**274,802**	**240,787**	**34,015**

Employee Benefits 2012-13 - income			
Salaries and wages	2,190	2,190	0
Social Security costs	186	186	0
Employer Contributions to NHS BSA - Pensions Division	265	265	0
TOTAL excluding capitalised costs	**2,641**	**2,641**	**0**

	Total £000s	Permanently employed £000s	Other £000s
Gross Employee Benefits & Net expenditure 2011-12			
Salaries and wages	230,924	202,904	28,020
Social security costs	18,130	18,130	0
Employer Contributions to NHS BSA - Pensions Division	24,515	24,515	0
Termination benefits	1,668	1,668	0
TOTAL - including capitalised costs	275,237	247,217	28,020
Less recoveries in respect of employee benefits	(1,694)	(1,694)	0
Total - Net Employee Benefits including capitalised costs	273,543	245,523	28,020
Recognised as			
Employee costs capitalised	94	94	0
Net Employee Benefits excluding capitalised costs	275,143	247,123	28,020

10.2 Staff Numbers

	2012-13			2011-12
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**855**	735	120	864
Administration and estates	**1,144**	1,112	32	1,176
Healthcare assistants and other support staff	**1,694**	1,625	69	1,744
Nursing, midwifery and health visiting staff	**1,982**	1,902	80	1,990
Scientific, therapeutic and technical staff	**720**	684	36	719
Other	**0**	0	0	1
TOTAL	**6,395**	**6,058**	**337**	6,494
Of the above - staff engaged on capital projects	**2**	2	0	2

10.3 Staff Sickness absence and ill health retirements

	2012-13	2011-12
	Number	Number
Total Days Lost	**69,843**	71,429
Total Staff Years	**6,136**	6,295
Average working Days Lost	**11.38**	11.35

* Sickness figures provided are based on calendar year ending 31 December 2012

	2012-13	2011-12
	Number	Number
Number of persons retired early on ill health grounds	**12**	8
	£000s	£000s
Total additional pensions liabilities accrued in the year	**729**	519

10.4 Exit Packages agreed in 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	6	0	6	2	1	3
£10,001-£25,000	4	0	4	0	9	9
£25,001-£50,000	2	1	3	2	6	8
£50,001-£100,000	0	1	1	2	7	9
£100,001 - £150,000	0	0	0	1	2	3
Total number of exit packages by type (total cost	**12**	**2**	**14**	7	25	32
Total resource cost (£000s)	**171**	**108**	**280**	326	1,073	1,399

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. **Exit costs in this note are accounted for in full in the year of departure.** Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

The reported ''other departures agreed'' consist of departures agreed under the Trust's:-

-Voluntary redundancy scheme
-Mutually Agreed Resignation Scheme (MARS)

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

10.5 Pension costs

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability
as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodolgy prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.
The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).
Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2012-13 Number	2012-13 £000s	2011-12 Number	2011-12 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**105,726**	**140,091**	102,181	113,112
Total Non-NHS Trade Invoices Paid Within Target	**93,735**	**114,769**	87,739	91,902
Percentage of NHS Trade Invoices Paid Within Target	**88.66%**	**81.92%**	85.87%	81.25%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,100**	**32,477**	2,302	**41,973**
Total NHS Trade Invoices Paid Within Target	**1,551**	**29,215**	1,805	**36,237**
Percentage of NHS Trade Invoices Paid Within Target	**73.86%**	**89.96%**	78.41%	86.33%

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

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2012-13 £000s	2011-12 £000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

12 Investment Income

	2012-13 £000s	2011-12 £000s
Interest Income		
Bank interest	**59**	56
Subtotal	**59**	56
Total investment income	**59**	56

13 Other Gains and Losses

	2012-13 £000s	2011-12 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(397)**	(368)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	(77)
Gain (Loss) on disposal of assets held for sale	**25**	0
Total	**(372)**	(445)

14 Finance Costs

	2012-13 £000s	2011-12 £000s
Interest		
Interest on loans and overdrafts	**87**	44
Interest on obligations under finance leases	**49**	57
Total interest expense	**136**	101
Provisions - unwinding of discount	**71**	69
Total	**207**	170

15.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2012	**16,187**	**143,539**	**22,045**	**4,068**	**46,056**	**551**	**6,119**	**293**	**238,858**
Additions of Assets Under Construction	0	0	0	7,272	0	0	0	0	**7,272**
Additions Purchased	0	416	0	0	2,469	0	903	9	**3,797**
Additions Donated	0	0	0	0	317	0	0	0	**317**
Reclassifications	0	5,939	0	(8,589)	2,291	0	111	0	**(248)**
Reclassifications as Held for Sale and reversals	355	0	(375)	0	(479)	0	0	0	**(499)**
Disposals other than for sale - cumulative depn adj	(5,228)	(5,930)	(2,609)	0	(967)	0	(781)	0	**(15,515)**
Upward revaluation/positive indexation	3	3,348	3,064	0	0	0	0	0	**6,415**
Impairments/negative indexation	(1,892)	(1,250)	0	0	0	0	0	0	**(3,142)**
Reversal of Impairments	0	3,870	0	0	0	0	0	0	**3,870**
At 31 March 2013	**9,425**	**149,932**	**22,125**	**2,751**	**49,687**	**551**	**6,352**	**302**	**241,125**
Depreciation									
At 1 April 2012	**0**	**0**	**0**	**0**	**29,256**	**405**	**3,972**	**65**	**33,698**
Reclassifications as Held for Sale and reversals	0	0	0	0	(479)	0	0	0	**(479)**
Disposals other than for sale - cumulative depn adj	(1,228)	(5,628)	(2,609)	0	(859)	0	(781)	0	**(11,105)**
Impairments	1,228	1,612	2,347	0	0	0	0	0	**5,187**
Reversal of Impairments	0	0	(42)	0	0	0	0	0	**(42)**
Charged During the Year	0	4,016	304	0	4,613	56	1,045	34	**10,068**
At 31 March 2013	**0**	**0**	**0**	**0**	**32,531**	**461**	**4,236**	**99**	**37,327**
Net Book Value at 31 March 2013	**9,425**	**149,932**	**22,125**	**2,751**	**17,156**	**90**	**2,116**	**203**	**203,798**
Purchased	9,425	149,366	22,125	2,751	16,154	90	2,104	203	**202,218**
Donated	0	490	0	0	1,002	0	12	0	**1,504**
Government Granted	0	76	0	0	0	0	0	0	**76**
Total at 31 March 2013	**9,425**	**149,932**	**22,125**	**2,751**	**17,156**	**90**	**2,116**	**203**	**203,798**
Asset financing:									
Owned	9,425	149,932	0	2,751	16,702	90	2,116	203	**181,219**
Held on finance lease	0	0	22,125	0	454	0	0	0	**22,579**
Total at 31 March 2013	**9,425**	**149,932**	**22,125**	**2,751**	**17,156**	**90**	**2,116**	**203**	**203,798**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	4,757	16,811	5,149	0	244	1	11	0	**26,973**
Movements (see below)	(4,754)	21,990	2,894	0	(130)	(1)	(11)	0	**19,988**
At 31 March 2013	**3**	**38,801**	**8,043**	**0**	**114**	**0**	**0**	**0**	**46,961**

15.2 Property, plant and equipment prior-year

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2011	13,676	147,113	20,391	3,790	48,239	551	7,289	1,022	242,071
Additions - purchased	0	413	(29)	10,757	1,263	0	201	113	12,718
Additions - donated	0	0	0	0	133	0	12	0	145
Reclassifications	0	8,248	0	(10,479)	2,193	0	38	0	0
Reclassifications as Held for Sale and reversals	(900)	0	0	0	(631)	0	0	0	(1,531)
Disposals other than by sale	0	(607)	0	0	(5,141)	0	(1,421)	(842)	(8,011)
Revaluation & indexation gains	3,411	9	490	0	0	0	0	0	3,910
Impairments	0	(2,136)	0	0	0	0	0	0	(2,136)
Reversals of impairments	0	2,170	0	0	0	0	0	0	2,170
Cumulative dep netted off cost following revaluation	0	(11,671)	1,193	0	0	0	0	0	(10,478)
At 31 March 2012	16,187	143,539	22,045	4,068	46,056	551	6,119	293	238,858
Depreciation									
At 1 April 2011	0	0	0	0	28,707	338	4,009	627	33,681
Reclassifications as Held for Sale and reversals	0	0	0	0	(618)	0	0	0	(618)
Disposals other than for sale	0	(13)	0	0	(4,674)	0	(1,335)	(706)	(6,728)
Impairments	0	8,539	1,505	0	0	0	0	0	10,044
Reversal of Impairments	0	(193)	(2,978)	0	0	0	0	0	(3,171)
Charged During the Year	0	3,338	280	0	5,841	67	1,298	144	10,968
Cumulative dep netted off cost following revaluation	0	(11,671)	1,193	0	0	0	0	0	(10,478)
At 31 March 2012	0	0	0	0	29,256	405	3,972	65	33,698
Net book value at 31 March 2012	16,187	143,539	22,045	4,068	16,800	146	2,147	228	205,160
Purchased	16,187	142,966	22,045	4,068	15,632	146	2,132	228	203,404
Donated	0	494	0	0	1,168	0	15	0	1,677
Government Granted	0	79	0	0	0	0	0	0	79
Total at 31 March 2012	16,187	143,539	22,045	4,068	16,800	146	2,147	228	205,160
Asset financing:									
Owned	16,187	143,539	383	4,068	16,232	146	2,147	228	182,930
Held on finance lease	0	0	21,662	0	568	0	0	0	22,230
Total at 31 March 2012	16,187	143,539	22,045	4,068	16,800	146	2,147	228	205,160

15.3 Property, plant and equipment

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

Desciption	£'000
United Lincolnshire Hospitals NHS Trust Charitable Fund	358
Total Donated assets received in 2012/13	358

The Trust revalued its land, buildings and dwellings in March 2013. This revaluation was conducted by Mr D. M. Wilson MRICS of
DTZ Debenham Tie Leung Ltd and was based upon depreciated replacement cost using the modern equivalent basis of valuation.
Land and Buildings on the Louth site were valued at open market value in 2011-12 and disposed of in 2012-13.

Land and Buildings on the Sleaford site Laundon House were valued at open market value in 2012-13 and 2011-12.

Accounting policies note 1.7 provides further information regarding the method of valuation.
All other items of property, plant and equipment acquired after 1st January 2009 are held at historic cost.

Other assets acquired prior to the 1st January 2009 are held at a revalued amount. The revaluation was calculated by reference to annual indices published by the Department of Health.

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

	Minimum Asset Life	Maximum Asset Life
Intangibles		
Software Licences	0	6
Property, Plant and Equipment		
Buildings exc Dwellings	8	90
Dwellings	59	76
Plant & Machinery	0	13
Transport Equipment	0	5
Information Technology	0	8
Fixtures & fittings	0	10

The value of land held at open market value is £50,000 (2011-12 £4,000,000).
The value of dwellings at open market value is £22,125,000 (2011-12 £22,037,000)
The value of buildings held at open market value is £116,000 (2011-12 NIL)
The gross value of fully depreciated assets still in use is £7,865,000

The Trust lease a number of buildings which it owns on operating leases, the net book value of the assets at March 2013 was £4.1m
(March 2012 £4.3m).
The Depreciation charged to the statement of comprehensive income in 2012-13 in respect of these assets amounted to £78,000
(2011/12 £72,000). These assets were revalued as at 31 March 2013 resulting in an upward revaluation of £65,000, impairment losses of £297,000 and reversals of previous impairments of £40,000. The net movement was therefore a reduction of £192,000.

16.1 Intangible non-current assets

2012-13	Software internally generated £000's	Software purchased £000's	Total £000's
At 1 April 2012	**20**	**3,154**	**3,174**
Additions - purchased	0	164	**164**
Additions - donated	0	41	**41**
Reclassifications	0	248	**248**
Disposals other than by sale	0	(55)	**(55)**
At 31 March 2013	**20**	**3,552**	**3,572**
Amortisation			
At 1 April 2012	**11**	**1,857**	**1,868**
Disposals other than by sale	0	(55)	**(55)**
Charged during the year	4	493	**497**
At 31 March 2013	**15**	**2,295**	**2,310**
Net Book Value at 31 March 2013	**5**	**1,257**	**1,262**
Net book value at 31 March 2013 comprises:			
Purchased	5	1,217	**1,222**
Donated	0	40	**40**
Total at 31 March 2013	**5**	**1,257**	**1,262**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's
At 1 April 2012	0	0	**0**
Movements	0	0	**0**
At 31 March 2013	**0**	**0**	**0**

16.2 Intangible non-current assets prior year

2011-12	Software internally generated £000s	Software purchased £000s	Total £000s
Cost or valuation:			
At 1 April 2011	20	3,309	3,329
Additions - purchased	0	455	455
Additions - donated	0	6	6
Disposals other than by sale	0	(616)	(616)
At 31 March 2012	20	3,154	3,174
Amortisation			
At 1 April 2011	7	1,890	1,897
Disposals other than by sale	0	(539)	(539)
Charged during the year	4	506	510
At 31 March 2012	11	1,857	1,868
Net book value at 31 March 2012	9	1,297	1,306
Net book value at 31 March 2012 comprises:			
Purchased	9	1,291	1,300
Donated	0	6	6
Total at 31 March 2012	9	1,297	1,306

16.3 Intangible non-current assets

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

17 Analysis of impairments and reversals recognised in 2012-13	**2012-13 Total £000s**
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	2,305
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**2,305**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	2,840
Total charged to Annually Managed Expenditure	**2,840**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Loss or damage resulting from normal operations	0
Over Specification of Assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	(728)
Total impairments for PPE charged to reserves	**(728)**
Total Impairments of Property, Plant and Equipment	**4,417**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Intangible Assets impairments and reversals charged to the Revaluation Reserve	
Loss or damage resulting from normal operations	**0**
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total impairments for Intangible assets charged to reserves	**0**
Total Impairments of intangibles	**0**

17 Analysis of impairments and reversals recognised in 2012-13

	2012-13 Total £000s
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale	**0**
Inventories - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	47
Changes in market price	0
Total charged to Annually Managed Expenditure	**47**
Total impairments of Inventories	**47**
Total Impairments charged to Revaluation Reserve *	**(728)**
Total Impairments charged to SoCI - DEL	**2,305**
Total Impairments charged to SoCI - AME **	**2,887**
Overall Total Impairments	**4,464**
Of which:	
Impairment on revaluation to “modern equivalent asset” basis	0
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	6
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
* Comprises:	
Impairments 2012-13	3,142
Less reversal previous impairments	(3,870)
	(728)
** Comprises:	
Impairments 2012-13	5,234
Less reversal previous impairments	(42)
	5,192

As set out in note 1.3.2 the Trust entered into a contract with a third party in 2006 in which they provide accomodation to Trust employees. As part of the contract a minimum occupancy level was guaranteed. Costs of under-occupancy are met by the Trust.
The assets associated with this ‘onerous’ contract are reviewed and impaired annually as appropriate based upon an assessment of future occupancy levels.

The impairment charged / (reversed) in 2012/13 against this onerous contract were:	£’000
Boston	2,031
Lincoln	316
Grantham	(42)
	2,305

18 Investment property

The Trust holds no investment properties.

19 Commitments

19.1 Capital commitments

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

	31 March 2013 £000s	31 March 2012 £000s
Property, plant and equipment	**1,135**	2,819
Intangible assets	**2**	0
Total	**1,137**	2,819

19.2 Other financial commitments

The Trust has not entered into non-cancellable contracts.

20 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	9,913	0	13,141	0
Balances with Local Authorities	3	0	66	0
Balances with NHS bodies outside the Departmental Group	46	0	0	0
Balances with NHS Trusts and Foundation Trusts	3,249	0	798	0
Balances with bodies external to government	4,756	1,795	22,937	0
At 31 March 2013	**17,967**	**1,795**	**36,942**	**0**
prior period:				
Balances with other Central Government Bodies	7,566	0	5,440	0
Balances with Local Authorities	0	0	104	0
Balances with NHS Trusts and Foundation Trusts	2,699	0	1,711	0
Balances with bodies external to government	4,811	1,994	22,611	0
At 31 March 2012	**15,076**	**1,994**	**29,866**	**0**

21 Inventories

	Drugs £000s	Consumables £000s	Energy £000s	Work in progress £000s	Total £000s
Balance at 1 April 2012	2,121	4,191	23	0	**6,335**
Additions	26,044	243	18	0	**26,305**
Inventories recognised as an expense in the period	(25,814)	(99)	(11)	0	**(25,924)**
Write-down of inventories (including losses)	(33)	(14)	0	0	**(47)**
Balance at 31 March 2013	2,318	4,321	30	0	**6,669**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
NHS receivables - revenue	**12,340**	9,507	**0**	0
NHS prepayments and accrued income	**3**	4	**0**	0
Non-NHS receivables - revenue	**1,241**	738	**0**	0
Non-NHS prepayments and accrued income	**1,935**	2,195	**0**	0
Provision for the impairment of receivables	**(395)**	(453)	**(259)**	(234)
VAT	**498**	615	**0**	0
Operating lease receivables	**114**	93	**0**	0
Other receivables	**2,231**	2,377	**2,054**	2,228
Total	**17,967**	15,076	**1,795**	1,994
Total current and non current	**19,762**	17,070		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Other receivables includes £4.24m relating to the injury cost recovery scheme administered by the Department of Work and Pensions

22.2 Receivables past their due date but not impaired

	31 March 2013 £000s	31 March 2012 £000s
By up to three months	**1,217**	856
By three to six months	**928**	409
By more than six months	**265**	902
Total	**2,410**	2,167

22.3 Provision for impairment of receivables

	2012-13 £000s	2011-12 £000s
Balance at 1 April 2012	**(687)**	(577)
Amount written off during the year	**96**	66
Amount recovered during the year	**172**	22
(Increase)/decrease in receivables impaired	**(235)**	(198)
Balance at 31 March 2013	**(654)**	(687)

Provisions for the impairments of receivables are based on specific issues where the Trust believes that it is unlikely to receive payment for outstanding invoices. General provisions are not made.

23 NHS LIFT investments

The Trust has no NHS LIFT investments.

24.1 Other Financial Assets - Current

The Trust has no current Other Financial Assets.

24.2 Other Financial Assets - Non Current

The Trust has no non current Other Financial Assets.

24.3 Other Financial Assets - Non Current - Capital Analysis

The Trust has no non current Other Financial Assets.

25 Other current assets	31 March 2013 £000s	31 March 2012 £000s
EU Emissions Trading Scheme Allowance	**7**	84
Total	**7**	84

26 Cash and Cash Equivalents	31 March 2013 £000s	31 March 2012 £000s
Opening balance	**2,156**	9,865
Net change in year	**3,820**	(7,709)
Closing balance	**5,976**	2,156
Made up of		
Cash with Government Banking Service	5,967	2,148
Cash in hand	9	8
Cash and cash equivalents as in statement of financial position	**5,976**	2,156
Cash and cash equivalents as in statement of cash flows	**5,976**	2,156
Patients' money held by the Trust, not included above	0	1

27 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Plant and Machinery	Total
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	355	0	0	0	**355**
Plus assets classified as held for sale in the year	0	0	375	0	**375**
Less assets sold in the year	0	0	(375)	0	**(375)**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(355)	0	0	0	**(355)**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2011	355	0	0	0	**355**
Plus assets classified as held for sale in the year	900	0	0	13	**913**
Less assets sold in the year	(900)	0	0	(13)	**(913)**
Balance at 31 March 2012	**355**	**0**	**0**	**0**	**355**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0

In 2009/10 the Trust classified land at Welland previously used as Hospital buildings as 'held for sale'.

The Trust has been unable to sell this property and is not actively marketing at the current time, the land value has therefore been transferred back to PPE in 2012/13.

The dwellings sold in year related to 4 houses at Louth which were sold to external parties with a profit of £15,000.

28 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Interest payable	**0**	19	**0**	0
NHS payables - revenue	**2,382**	3,004	**0**	0
NHS payables - capital	**1**	0	**0**	0
NHS accruals and deferred income	**284**	78	**0**	0
Non-NHS payables - revenue	**8,356**	7,300	**0**	0
Non-NHS payables - capital	**82**	1,361	**0**	0
Non_NHS accruals and deferred income	**16,590**	17,748	**0**	0
Social security costs	**2,744**	87	**0**	0
Tax	**2,948**	1	**0**	0
Other	**3,555**	268	**0**	0
Total	**36,942**	29,866	**0**	0
Total payables (current and non-current)	**36,942**	**29,866**		

Included above:		
to Buy Out the Liability for Early Retirements Over 5 Years	0	0
number of Cases Involved (number)	0	0
outstanding Pension Contributions at the year end	3,289	4

29 Other liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Lease incentives	**24**	24	**776**	801
Other	**479**	479	**15,324**	15,803
Total	**503**	503	**16,100**	16,604
Total other liabilities (current and non-current)	**16,603**	**17,107**		

The Trust entered into an agreement with Progress Housing in 2006, whereby the Trust transferred ownership of a number of staff accomodation flats to Progress, who agreed to refurbish the flats and build additional units. The Trust does not make any payments to Progress Housing, as they receive income from Employees who pay for accomodation. Due to the nature of the Transaction, the Trust has recorded the Assets on its balance sheet in accordance with IAS 17, with the corresponding liability being shown as an other liability. This Other liability is amortised to the income and expenditure account to offset the depreciation.

30 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Loans from Department of Health	**0**	3,216	**0**	3,976
Finance lease liabilities	**134**	121	**493**	627
Total	**134**	**3,337**	**493**	**4,603**
Total other liabilities (current and non-current)	**627**	**7,940**		

Loans - repayment of principal falling due in:

	31 March 2013		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 years	0	134	**134**
1 - 2 Years	0	134	**134**
2 - 5 Years	0	359	**359**
TOTAL	**0**	**627**	**627**

31 Other financial liabilities

The Trust has no other Financial Liabilities.

32 Deferred income

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2012	**768**	1,774	**0**	0
Deferred income addition	**611**	768	**0**	0
Transfer of deferred income	**(768)**	(1,774)	**0**	0
Current deferred Income at 31 March 2013	**611**	768	**0**	0
Total deferred income (current and non-current)	**611**	768		

33 Finance lease obligations as lessee

The Trust entered into a finance lease with Dalkia Utility Services PLC in 2002 for the provision of a combined heat and power system. Dalkia also manage and maintain the equipment during the term of the lease which is 15 years.
The Unitary charge increases by reference to RPI. Gas prices vary by reference to gas commodity indices.

The legal title to the equipment transfers to the Trust at the end of the lease term.

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum lease**	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**0**	0
Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
			0	0

Amounts payable under finance leases (Land)	**Minimum lease payments**		**Present value of minimum lease**	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**0**	0
Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
			0	0

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum lease**	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000s	£000s	**£000s**	£000s
Within one year	**174**	170	**134**	121
Between one and five years	**550**	724	**493**	627
Less future finance charges	**(97)**	(146)	**0**	0
Present value of minimum lease payments	**627**	748	**627**	748
Included in:				
Current borrowings			**134**	121
Non-current borrowings			**493**	627
			627	748

	31 March 2013	31 March 2012
Finance leases as lessee	**£000s**	£000s
Future Sublease Payments Expected to be received	**0**	0
Contingent Rents Recognised as an Expense	**0**	0

34 Finance lease receivables as lessor

The Trust owns 3 properties where they have granted long leases to other NHS bodies.

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

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

Amounts receivable under finance leases (buildings)	**Gross investments in leases**		**Present value of minimum lease**	
Of minimum lease payments	**31 March 2013 £000s**	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**0**	0
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectible lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	**0**	**0**	0
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Amounts receivable under finance leases (land)				
Of minimum lease payments	**31 March 2013 £000**	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**0**	0
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectable lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	0	**0**	0
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Amounts receivable under finance leases (Other)				
Of minimum lease payments	**31 March 2013 £000**	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**0**	0
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectable lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	0	**0**	0
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

	31 March 2013 £000	31 March 2012 £000
The unguaranteed residual value accruing to the Trust	**0**	0
Accumulated allowance for uncollectible minimum lease payments receivable	**0**	0

Rental Income	**31 March 2013**	31 March 2012
Contingent rent	**86**	30
Other	**0**	0
Total rental income	**86**	30
Finance lease commitments	**0**	0

35 Provisions

	Total	Comprising: Pensions to Former Directors	Pensions Relating to Other Staff	Legal Claims	Restructuring	Continuing Care	Other
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	**7,479**	0	2,544	625	2,423	0	1,887
Arising During the Year	**1,382**	0	164	518	410	0	290
Utilised During the Year	**(1,213)**	0	(191)	(287)	(246)	0	(489)
Reversed Unused	**(2,826)**	0	0	(175)	(1,428)	0	(1,223)
Unwinding of Discount	**71**	0	71	0	0	0	0
Change in Discount Rate	**112**	0	112	0	0	0	0
Balance at 31 March 2013	**5,005**	**0**	**2,700**	**681**	**1,159**	**0**	**465**
Expected Timing of Cash Flows:							
No Later than One Year	**2,493**	0	188	681	1,159	0	465
Later than One Year and not later than Five Years	**708**	0	708	0	0	0	0
Later than Five Years	**1,804**	0	1,804	0	0	0	0

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

As at 31 March 2013	91,033
As at 31 March 2012	77,940

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

The provision for Pensions relating to other staff has been assessed using average life expectancies, and is thus uncertain as to amount and timing of cash flows.

The provision for other legal claims relates to third party liability and property expenses claims, and claims made against the Trust in relation to Employment issues. In addition to the amount provided within the Trust's accounts, details of contingent liabilities and assets relating to these claims are given in note 36. The Trust's legal advisors have assessed each claim and a provision has been made, based upon the expected outcome of the claim, the related probability and the expected settlement date.

The restucturing provision supports the review of management and business unit structures and potential associated exit costs.

Other provisions (£0.5m) relate principally to the following:
- Costs associated with potential obligations under the NHS Consultant Contract (£0.20m)
- Provision for costs associated with emissions under the Carbon Reduction Scheme (£0.22m)

36 Contingencies

	31 March 2013	31 March 2012
	£000s	£000s
Contingent liabilities		
Other	**(2,041)**	(400)
Net Value of Contingent Liabilities	**(2,041)**	(400)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

The contingent liability reported above comprises three elements:

- Employment related legal claims (£0.7m)

A provision for legal claims brought against the Trust in relation to Employment issues has been disclosed at Note 35. This provision is assessed based upon the most likely outcome. The contingent liability reported within this note takes account of the potential liability in the event the Trust assessment is underestimated. The specific breakdown of contingent liabilities has not been disclosed as this information could prejudice the position of the Trust in certain cases.

- Contractual disputes (£0.8m)

The Trust is involved in a long running contractual dispute for which a reasonable estimate has been provided and accounted for within trade payables. The Trust believes the value provided will be sufficient to settle the claim in full, however a contingent liability has been recorded for the disputed amount.

- Potential fines / prosecutions (£0.5m)

The Trust is facing a legal action brought by the Health and Safety Executive relating to an incident in 2012. The Trust believes it has a robust defence but there remains and element of uncertainty while the prosection continues.

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

37 Financial Instruments

37.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with primary care trusts and the way those primary care trusts are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament . The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
37.2 Financial Assets				
Receivables - non-NHS	0	1,795	0	**1,795**
Cash at bank and in hand	0	5,976	0	**5,976**
Total at 31 March 2013	**0**	**7,771**	**0**	**7,771**
Receivables - non-NHS	0	1,994	0	1,994
Cash at bank and in hand	0	2,156	0	2,156
Total at 31 March 2012	0	4,150	0	4,150

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
37.3 Financial Liabilities			
PFI & finance lease obligations	0	627	**627**
Other financial liabilities	0	7,080	**7,080**
Total at 31 March 2013	**0**	**7,707**	**7,707**
Other borrowings	0	7,192	7,192
PFI & finance lease obligations	0	748	748
Other financial liabilities	0	6,622	6,622
Total at 31 March 2012	0	14,562	14,562

	£000
38 Events after the end of the reporting period There are no events that require disclosing after the reporting period. The financial statements were authorised for issue on 6th June 2013 by the Chief Executive.	0

39 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Mr K Darwin (Non Executive Director ULHT) / Trustee St Barnabus Hospice	66,750	241,547	0	46,287
Mr K Darwin (Non Executive Director ULHT) / Governor University of Lincoln	19,200	59,393	0	2,275
Mr K Darwin (Non Executive Director ULHT) / Chairman Investors in Lincoln	20,017	0	0	0
Mr N Muntz (Non Executive Director ULHT) / Managing Director Siemens Industrial Turbo Ltd Lincoln	243,252	0	109	0
Mrs J Lowe (Interim Director ULHT) / Director Interchange HR Ltd	149,624	120	0	0
Mr M Oko (ENT Consultant) / The Snoring Disorders Centre Ltd	1,266,628	0	0	0

Non Executive Director Nick Muntz is Managing Director of Siemens Industrial Turbo Ltd, part of the larger Siemens Group. No contractual relationship exists between the Trust and Siemens Industrial Turbo Ltd. Mr Muntz has not been engaged in any part of the decision making processes affecting the contractual relationship with the wider Siemens Group. The payments made to Siemens in 2012/13 were made to Siemens PLC, Siemens Energy and Siemens Health. No payments were made to Siemens Industrial Turbo Ltd.

The Trust employs a number of consultants who in addition to their NHS duties derive varying levels of income from their work at the Trust's private patient unit. In 2012/13 this amounted to £409,000.

Ian Warren (Interim Director of Human Resources) is also Human Resources Director for Lincolnshire Community Health Services NHS Trust.
Nigel Myhill (Interim Director of Facilities) is also Director of Facilites for Northern Lincolnshire and Goole Hospitals NHS Trust.

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

Strategic Health Authorities
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority
Primary Care Trusts
NHS Blood and Transport

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the Department of Work and Pensions, HM Revenue and Customs, the National Insurance Fund, NHS Pension Scheme and City of Lincoln, Boston and North and South Kesteven Local Authorities and Lincolnshire County Council.

The Trust has also received revenue and capital payments amounting to £1.008m (2011/12 - £1.419m) from a number of charitable funds, certain of the trustees for which are also members of the Trust board. The audited accounts of the Funds Held on Trust are included in this annual report and accounts.

40 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	**135,202**	**211**
Special payments	**300,542**	**215**
Total losses and special payments	**435,744**	**426**

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	339,115	233
Special payments	306,732	274
Total losses and special payments	645,847	507

Details of cases individually over £250,000

There were no individual cases exceeding £250,000.

41. Financial performance targets

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

41.1 Breakeven performance	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s
Turnover	289,429	294,154	344,309	353,280	391,141	392,202	407,975	**422,802**
Retained surplus/(deficit) for the year	(15,043)	(13,761)	12,488	366	(4,002)	(14,177)	(7,060)	**(5,207)**
Adjustment for:								
Timing/non-cash impacting distortions:								
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	**0**
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	**0**
Adjustments for Impairments	0	0	0	4,821	5,284	297	6,873	**5,192**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	507	**139**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	0	0	0	**0**
Adsorption Accounting Adjustment	0	0	0	0	0	0	0	**0**
Other agreed adjustments	4,913	15,043	0	0	0	0	0	**0**
Break-even in-year position	**(10,130)**	**1,282**	**12,488**	**5,187**	**1,282**	**(13,880)**	**320**	**124**
Break-even cumulative position	**(14,886)**	**(13,604)**	**(1,116)**	**4,071**	**5,353**	**(8,527)**	**(8,207)**	**(8,083)**

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

The Trust has not achieved the statutory three year breakeven duty. A recovery plan is to be agreed with the Trust Development Authority.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %
Materiality test (I.e. is it equal to or less than 0.5%):								
Break-even in-year position as a percentage of turnover	-3.50	0.44	3.63	1.47	0.33	-3.54	0.08	**0.03**
Break-even cumulative position as a percentage of turnover	-5.14	-4.62	-0.32	1.15	1.37	-2.17	-2.01	**-1.91**

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

41.2 Capital cost absorption rate

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

41.3 External financing

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

		2012-13	2011-12
	£000s	£000s	£000s
External financing limit		(3,884)	18,159
Cash flow financing	(4,846)		14,792
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		(4,846)	14,792
Undershoot/(overshoot)		962	3,367

41.4 Capital resource limit

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

	2012-13	2011-12
	£000s	£000s
Gross capital expenditure	11,591	13,324
Less: book value of assets disposed of	(4,785)	(2,267)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(358)	(151)
Charge against the capital resource limit	6,448	10,906
Capital resource limit	6,940	12,221
(Over)/underspend against the capital resource limit	492	1,315

42 Third party assets

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

	31 March	31 March
	£000s	£000s
Third party assets held by the Trust	0	1