United Lincolnshire Hospitals NHS
NHS Trust

Annual Report and Final Accounts 2014/15

Accessibility

This annual report and full accounts will be available at
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Chairman's and Chief Executive's Foreword

In 2014/15, we continued to build on our quality improvement journey.

We had a challenging year but once again we can be proud of our staff. We feel we have made headway across a number of areas to move us towards achieving our organisational vision but we also recognise there are areas where much more work is needed.

2014/15 ended on a real high for our patients, staff and partners with the announcement that the Trust had been taken out of special measures following its most recent review by the Care Quality Commission. This was a real boost to staff and patients, and helped to build confidence in the services that we provide.

This decision reflects big strides in improving the safety and quality of our services and the patient experience over the previous 12 months. We recruited more nurses and doctors, and improved clinical practice, which together with hard work had the combined impact of better quality services. This was achieved through our 'Beyond Good' quality improvement programme.

There continued to be significant operational and financial pressures. Like many other Trusts, we are struggling to manage demand and capacity. We will need to find new ways of working to tackle these pressures with limited resources and this will be a core priority for the year ahead.

During 2014/15, we did not meet the standards expected of us for treating or discharging 95% of A&E patients within 4 hours, the national cancer standards, and referral to treatment times (18 weeks from referral to treatment). Improving these are priorities for us as we head into 2015/16.

As an organisation, we achieved our most demanding cost improvement programme to date totalling in excess of £25 million. Despite this, we finished the year with a financial deficit, as we did not generate sufficient income to cover our costs. Work is under way to explore, as part of the Lincolnshire Health and Care programme (LHAC), what we can do differently across Lincolnshire to improve quality whilst also reducing our costs.

Looking ahead to 2015/16, we will finalise plans on acute service configuration, finish our vast estates programme of work, and shift gear in recruiting more staff to the Trust and work hard to retain the great staff we do employ.

We will focus on seven key objectives which are:

- Continuously improve quality provision of safe care, and deliver a positive patient experience
- Create the conditions for our staff to achieve their best

- Recruit the right staff to the right places
- Move towards a clinically led organisation
- Deliver our 2015/16 financial plan
- Improve performance
- Set out our plans for the future

We won't rest on our laurels. We have significant challenges to deliver high quality services in a tight financial environment. We have clear annual and operational plans for each of our sites to achieve this and move further towards achieving our vision.

Jane Lewington, Chief Executive
Ron Buchanan, Chairman

About the Trust - Who we are

United Lincolnshire Hospitals Trust (ULHT), situated in the county of Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 720,000 people.

Our vision is to provide “consistently excellent and safe patient-centred care for the people of Lincolnshire, through highly skilled, committed and compassionate staff working together”.

We provide acute and specialist services to people in Lincolnshire and neighbouring counties. We have an annual income of £433.25 million. Our main contracts are with Lincolnshire East, Lincolnshire West, South Lincolnshire and South West Lincolnshire clinical commissioning groups (CCGs).

ULHT operates out of four main hospitals:

- County Hospital, Louth
- Grantham and District Hospital
- Lincoln County Hospital
- Pilgrim Hospital, Boston

We also provide some outpatient and day case services from John Coupland, Gainsborough; Laundon House, Sleaford; Johnson Community Hospital, Spalding; Riverside House, Spalding; Holbeach Hospital, and Skegness and District General Hospital.

The population we serve

The population of Lincolnshire is estimated to be 724,500. The GP registered population is slightly higher at 732,510. The population is projected to rise to 838,200 by 2033. This projected rate of increase is above the national rate of growth.

Lincolnshire is the second largest county in the UK and is characterised by dispersed centres in large towns and the city of Lincoln, and largely rural communities. The means the population density is low.

Transport networks are underdeveloped resulting in transport times of around one hour between our hospital sites increasing the cost and complexity of delivering or receiving services.

In Lincolnshire, there is a declining younger population and a growing older population. Between 2003 and 2013, the population of those aged 65 or over increased to approximately 22 per cent. There are 19,700 people aged 85 or over, an increase of approximately 5,900 in 10 years.

By 2033, all age groups are projected to grow. However, the number of people over 75 years of age is predicted to double between 2012 and 2037.

These factors combine to increase pressure on hospital services, particularly urgent care (chronic obstructive pulmonary disease, diabetes, coronary

heart disease, and elderly frailty) and referrals for cancer treatment.

Life expectancy for both men and women is similar to the England average but varies considerably across the county. Life expectancy is 7 years lower for men and 4.8 years lower for women in the most deprived areas of Lincolnshire than in the least deprived areas.

In 2012, 27.2% of adults were classified as obese, worse than the average for England. The rate of people killed and seriously injured on roads is worse than average.

In its ethnic profile, Lincolnshire is predominately white-British. The non-white population makes up just 2.4% of the population; the national average is 14%. 7.1% of Lincolnshire's population were born outside the UK, which is lower than the UK average (13.8%). Lincoln, Boston and South Holland have the greatest proportion of foreign-born residents, especially from new EU countries. 15.1% of the population of Boston were born outside the UK which is higher than the UK average.

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

The use of hospital services is lower for the migrant population compared to the Lincolnshire population as a whole, with the exception of maternity services.

How we are organised

The Trust Board

The Board is responsible for setting the overall policy and strategy for the organisation and for ensuring the effective implementation of that strategy. It establishes a committee structure 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 who since 2014/15 have been appointed by the NHS Trust Development Authority 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 2014/15 this committee consisted of the Chairman and the non-executive directors.

Board membership for 2014/15 was as follows:

Non-executive directors

Ron Buchanan – Chairman
Interests declared: None
Term of office: March 2014 to March 2016

Penny Owston - Non Executive Director
Interests declared: None
Term of office: April 2010 - April 2016

Geoffrey Hayward – Non Executive Director
Interests declared: Spouse - volunteer for Butterfly Hospice Boston
Term of office: July 2013 – July 2017

Tim Staniland, Non Executive Director
Interests declared: Director, Liberation Ltd
Term of office: March 2011 – March 2017

Dr Paul Grassby, Non Executive Director
Interests declared: University of Lincoln – service level agreement for teacher practitioners and student placements
Term of office: July 2013 –July 2017

Kate Truscott, Non Executive Director
Interests declared: Trustee Children's Links Charity
Term of office: March 2014 - February 2016

Professor Steve Barnett, Non Executive Director
Interests declared: Chairman – SSG Health Partnership; Chairman – Finegreen Associates Ltd; Senior Vice President (UK) Teletracking Technologies Inc; Managing Director Steve Barnett and Associates Ltd; Trustee/ Board Director – Institute of Employment Studies; Visiting Professor – University of West London, Cranfield University and University of Bradford; Spouse is Chief Executive Rotherham NHS Foundation Trust
Term of office: March 2014 – February 2016

Keith Darwin – Associate Non-Executive Director (non-voting member)
Interests declared: Chairman - Investors in Lincoln, Chairman - Lincolnshire Economic Action Partnership; Trustee – St Barnabas Hospice, Governor – University of Lincoln
Term of Office: on-going

Executive directors

Jane Lewington - Chief Executive
Interests declared: Non-executive director of NAVIGO Health and Social Care Community Interest Company

Kevin Turner – Deputy Chief Executive / Director of Performance Improvement
Interests declared: None

Suneil Kapadia – Medical Director
Interests declared: Member of the independent drug monitoring committee for trial with Sanofi-Pasteur

Pauleen Pratt – Acting Chief Nurse
Interests declared: None

Paul Boocock - Director of Estates and Facilities (non-voting member)
Interests declared: None

David Pratt - Director of Finance and Corporate Affairs
Interests declared: Non

Ian Warren – Director of Human Resources and Organisational Development (non-voting member)
Interests declared: None

Michelle Rhodes - Director of Operations (non-voting member)
Interests declared: Sister employed by Park Hospital, Nottingham

Mark Brassington, Acting Director of Performance Improvement (from 1 November) non-voting member
Interests declared: None

Other board members during the year:
One other director served on the Board for part of the year:

Nick Muntz – Associate Non-Executive Director (from 1 April 2014 to 31 August 2014).

Audit Committee membership comprises three non-executive directors, one of whom will have considerable financial expertise. For 2014/15, membership was as follows:

Audit Committee Members
Geoffrey Hayward – Chair
Kate Truscott – from April 2014
Steve Barnett – from April 2014

Staff profile

Our staff are fundamental to our ability to deliver high quality services that will put our patients at the centre of all that we do and provide the best quality care with passion and pride. At the end of 2014/15 the Trust employed 7,496 staff.

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

Table 1: Analysis of ULHT staff by gender

	Headcount			Percentage	
Staff Group	**Female**	**Male**	**Total**	**Female**	**Male**
Additional Professional Scientific and Technical	151	79	230	65.65%	34.35%
Additional Clinical Services (Inc HCSWs)	1107	152	1259	87.93%	12.07%
Administrative and Clerical	1211	212	1423	85.10%	14.90%
Allied Health Professionals	319	84	403	79.16%	20.84%
Estates and Ancillary	625	285	910	68.68%	31.32%
Healthcare Scientists	67	55	122	54.92%	45.08%
Medical and Dental	292	550	842	34.68%	65.32%
Nursing and Midwifery Registered	2149	137	2286	94.01%	5.99%
Students	17	4	21	80.95%	19.05%
Total ULHT Workforce	**5938**	**1558**	**7496**	**79.22%**	**20.78%**

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

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

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

By order of the Board

Chief Executive

Date 2.6.15

Director of Finance and Corporate Affairs

Date 2.6.15

Our vision

Our vision is "to provide consistently excellent and safe patient-centred care for the people of Lincolnshire, through highly skilled, committed and compassionate staff working together".

Our objectives and performance

We have one purpose, one vision, five values, three aims and seven annual objectives.

Our achievements in 2014/15

The past year ended on a real high for our patients, staff and partners with the announcement that the Trust, following its most review by the Care Quality Commission (CQC) in February, had been taken out of special measures.

In April and May 2014, the Trust was inspected by the CQC. On publication of the reports in July 2014, the CQC recommended the Trust remained in special measures for another six months.

Following the publication of the reports, we developed a quality improvement plan. The two outstanding actions from our Keogh action plan were incorporated into our quality improvement plan. This plan defined, at a high level, the continuing quality improvement journey ULHT is making and the improvement goals that the Trust was working towards over 18 months. The plan included all of the "must do" recommendations in the CQC reports and detailed plans were developed for each project/work area. In addition, detailed underlying plans were in place to execute all of the "should do" actions at site level. However, they also included longer-term pieces of work that the Trust is pursuing to improve overall quality and responsiveness across the organisation.

The CQC inspection in February 2015 found significant improvements across all five domains with effective, caring and

well-led rated as 'good' Trust-wide. Out of 79 key questions previously rated 'requires improvement' or 'inadequate', 64 have improved to 'good' with one moving from 'inadequate' to 'requires improvement'. Overall 83% of our ratings are now "good" or "outstanding" – 47% more than last year.

We are very pleased that the CQC recognised the significant improvements and changes we made on the quality of our services. We continue to embed the improvements we have made and will also focus on new key areas of quality improvement that have been highlighted in the CQC report and that we have identified as quality priorities for 2015/16. For example, a review of patient documentation and patient discharges will be new areas of work whilst we will continue to focus on improving the appointment system and patient experience in outpatients.

In addition, we invested in our hospitals to improve the services that we provide but also the environment in which they are delivered. Last year we started the largest capital investment programme in our history. This included investment in new linear accelerator machines for radiotherapy, improvement to outpatients at Lincoln, new beds on our wards, and upgrade of boilers at Grantham to name just a few. Significant capital investment will continue into 2015/16 as we address many of our historical estate issues, which have been made possible through the support of the NHS Trust Development Authority (TDA).

We achieved our stretch savings plan of £25 million. However, we ended the year with £15 million deficit as we did not generate enough income to cover our expenditure. We are working with our NHS and council partners, as part of the Lincolnshire Health and Care programme, to explore what we can do differently across the county to improve quality whilst also reducing our costs.

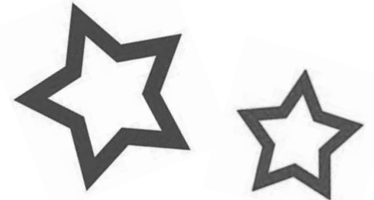
We know we need to improve our performance. We did not meet the standards expected of us for treating or discharging 95% of A&E patients within 4 hours, the national cancer standards, and referral to treatment times (18 weeks from referral to treatment).

Coming out of special measures is a fantastic achievement and is due to our inspirational staff. We cannot underestimate the massive progress we have made as a Trust over the 12 months. However coming out of special measures was not our end goal. We will always aim to deliver the very best care for all our patients. Improving performance, quality and finances are all priorities for us in 2015/16.

Award winning year

In 2014/15, the Trust was nominated and won many national and regional awards.

The infographic below highlights our key awards.



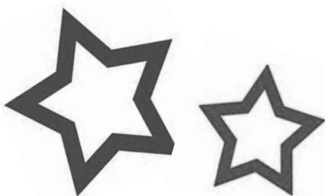
Orthopaedic team at Pilgrim Hospital won the clinical leadership and musculoskeletal care categories of the Patient Safety and Care Awards and the National Patient Safety Awards.

We, along with our partners, were finalists for HSJ Value in Healthcare Award. We all designed a new way of working to support health care professionals in the community to care for patients in their own home or closer to home to keep people out of hospital

One of our community midwives, Karen Swan, won the title of national midwife of the year.

Lincolnshire Heart centre was a runner-up in the Patient Safety and Care Awards

Lincoln County's macular service team was named Macular Society's 'clinical service of the year' following praise from patients.



Overview of our objectives and performance in 2014/15

The Trust set three organisational aims to monitor the delivery of our vision. These are:

1. **Transforming and improving services for our patients**
2. **Meeting the highest expectations of patients**
3. **Developing and supporting our workforce**

2014/15 was both challenging and rewarding. Having started with a challenging financial gap and an ambitious savings plan we are pleased to report we met our deficit and savings plan and delivered many quality improvements, however we didn't meet any of NHS constitutional standards and our income was below what was expected.

For the last 12 months, the Trust focused on delivering our quality improvement plan – beyond good, financial and performance plans.

Last year's key achievements included:

- Taken out of special measures.
- £25 million estates improvement programme started.
- Making big strides in reducing hospital standardised mortality rates (HSMR) rates to 98.4.
- A 100% increase in the number of staff completing their core learning and big increases in appraisals too
- Achieving best diagnostics. performance in the East Midlands meaning patients are seen earlier
- Nominated and won many national and regional awards.
- Improving medicine management and safety.
- The Lincolnshire Heart Centre at Lincoln County exceeded national targets in its first year for carrying out procedures quickly on patients. suffering heart attacks, and has lower mortality rates than national average
- Our hip fracture team at Pilgrim. Hospital are the best in the country for speed of access to surgery for the second year running.
- Continuing to reduce the incidence of pressure ulcers from 1.2% to 0.5% - compared with the national rate of 4 to 6%.
- Listening into Action (LiA), a unique piece of workforce engagement work which has involved hundreds of colleagues working together and coming up with ideas on how to improve services.
- Reducing the number of consultant vacancies from 102 to 58.
- Working with St Barnabas Hospice, we launched the "hospice in a hospital" at Grantham Hospital, a new six-bed inpatient unit and the first venture of its kind in the UK.

More detail on our key achievements linked to our organisational aims and objectives are shown over the following section.

Work delivered towards our organisational aims and objectives

1. Transforming and improving services for our patients

Our first strategic aim “transforming and improving services for our patients” is about making them sustainable, affordable and accessible within Lincolnshire and treating patients in the most appropriate care setting. The following examples show how we delivered this aim in 2014/15.

Leading on acute care reconfiguration for Lincolnshire

Last year was a busy year in relation to preparing to design the future for United Lincolnshire Hospitals NHS Trust. Following agreement of the high-level clinical strategy from the Trust Board in April 2014, the medical director formed the Clinical Strategy Implementation Group (CSIG) in July 2014. The group was given the task of developing the detailed clinical strategy for ULHT.

The CSIG consists mainly of clinicians with a small number of managers supporting them. Since July, the group has achieved the following:

- Put in place a clear set of governance arrangements to support development of the clinical strategy.
- Established the first four clinical strategy project teams focussing on emergency care, women and children’s services, breast services and orthopaedic services.
- Aligned the work of the CSIG to that of the Lincolnshire Health and Care programme (LHAC).
- Adopted a collaborative approach with the LHAC programme for the development of planned care.
- Developed in detail a number of strategic and service delivery model options for emergency care and women and children’s services.

The Lincolnshire Heart Centre leads the way

The Lincolnshire Heart Centre exceeded national targets in its first year for carrying out procedures quickly on patients suffering heart attacks, and had lower mortality rates than the national average.

The Heart Centre is a great asset for the whole of Lincolnshire. When a patient has a heart attack, wherever they live in the county, the patient is transferred to Lincoln County Hospital by ambulance where ambulance staff have direct access to the centre without patients having to go to A&E first.

One of the greatest achievements was the mortality rates for the centre which were much lower than the national average. Our 30 day mortality figure was 5.7%, compared with a national 30 day mortality of 8.1% for all hospitals and 7.9% for dedicated heart attack centres. This means fewer people die in Lincolnshire following a heart attack than elsewhere.

Last year, the service was shortlisted for the National Patient Safety Awards and has been recognised by NICE and the Royal College of Nursing as an example of best practice.

Our hip fracture team at Pilgrim Hospital the best in the country

Our hip fracture team at Pilgrim Hospital was the best in the country for speed of access to surgery for the second year running.

Information published in the 2014 annual report of the National Hip Fracture Database has revealed that compared to 182 hospitals, Pilgrim was top for ensuring that patients are operated on quickly. This has a major impact on patients' ability to make a full recovery. Pilgrim was also the number one hospital in the country for achieving best practice criteria in the National Hip Fracture Database report in 2013.

The average length of stay for patients was also one of the lowest in the country at 12.7 days compared to a national average of 15.3 days.

The project has been a fantastic success in helping to shape the healthcare delivered at the Trust. Most hip fractures are suffered by frail elderly patients, for whom the injury is life-threatening. Therefore the improvements we have made are saving lives.

We have the best diagnostics performance in the East Midlands

The Trust has achieved the 99% standard for all patients waiting for a diagnostic test to be seen less than 6 weeks from referral for the past 7 consecutive months. We plan on mirroring this achievement throughout 2015/16.

Revamping outpatients in Lincoln began

Transforming outpatients is a big priority for the Trust. In 2014, three areas of outpatients at Lincoln were judged inadequate by the CQC. There are more than 3,000 outpatient appointments a week, making it one of the busiest parts of United Lincolnshire Hospitals NHS Trust.

Transforming outpatients isn't about saving money. It's about improving patient experiences and working lives for our staff. We want all patients to have good patient experiences and be well communicated with at each and every interaction with the Trust.

Building work costing more than £580,000 started to help improve Lincoln County Hospital's outpatients department.

The first phase of the revamp was the creation of a central reception area for many of the clinics near the main outpatient entrance.

We also installed self-check-in kiosks. These kiosks help improve accessibility for people with disabilities and also speed up the check in process.

This was followed by improvements to clinical areas including the upgrade of treatment rooms to improve access for disabled patients, particularly people in wheelchairs.

Signs guiding people around the outpatient area were improved along with installation of more effective and efficient lighting.

Work ranged from extra treatment rooms, with all areas having at least one room which is accessible to wheelchair users, to new working practices to reduce disruption for patients.

Reveal LINQ heart monitoring device launched at Lincoln and Grantham

Cardiology departments at Grantham and Lincoln launched a new heart monitoring service.

Patients with suspected heart rhythm problems can now undergo implantation of a Reveal LINQ device locally. The device, which was only launched nationally in 2014, is a heart monitor similar in size to a AAA battery. The device is injected under the skin after a

small incision has been made under local anaesthetic.

The devices are implanted by a senior cardiac physiologist, assisted by the chief physiologist. The LINQ devices are a big step forward for patients with heart rhythm problems, as they take only a few minutes to implant and allow us to monitor the patient's heart 24 hours a day for up to three years.

This new device contains a heart monitor that watches the patient's heart rhythm continuously, picking up any abnormalities. The battery lasts for three years, which means that patients can now get a diagnosis even if their rhythm problems only happen very infrequently.

Cara Mercer is one of only a handful of cardiac physiologists undertaking this procedure in the UK, which gives patients greater continuity of care as she also supervises their follow-up visits.

New heart device fitted for the first time in Lincolnshire

In 2014/15, a new device, using a less intrusive procedure to help monitor a patient's heart, was used for the first time in Lincolnshire.

Joan Smith, became the first patient in Lincolnshire to have the new heart device fitted at Lincoln County Hospital.

Previously, devices required surgical implantation in a procedure that took up to 45-minutes. Patients then had to attend hospital for their device to be monitored. However, the team at the Lincolnshire Heart Centre implanted the first of a new type of device that is 'injected' into the chest wall under local anaesthetic in a procedure that now takes approximately 15-minutes, rather than by surgery.

The new technique performed by a consultant nurse for cardiology, rather than a doctor, has many advantages including less pain and discomfort for the patient, smaller scars and a shorter hospital stay.

These new devices allow the Trust to monitor patients' hearts remotely via the mobile phone network. This is a major advantage in a rural county like Lincolnshire. It will mean less trips to hospital, earlier identification of serious heart rhythm abnormalities. It will also reduce carbon emissions so is also better for the environment.

2. Meeting the highest expectations of patients

Our second strategic aim is "meeting the highest expectations of patients" by delivering consistently safe, effective and reliable care to satisfied patients. The following examples show how we delivered this aim in 2014/15.

Trust removed from special measures

We are delighted that the Trust was taken out of special measures following a CQC re-inspection in February 2015 and a recommendation made by the CQC's Chief Inspector of Hospitals, Mike Richards.

The decision reflects our workforce's dedication and commitment to delivering compassionate and high quality care. It was the hard work, the passion and the resilience of our staff that has led to the Trust being taken out of special measures.

We cannot overstate the massive progress we have made as a Trust over the last 20 months. The CQC have said quite clearly that the Trust has taken 'significant action' since the last inspection in April 2014 and made a 'substantial' number of improvements. Patients can be confident in our staff and in our services.

Although the Trust's overall rating of "requires improvement" remains the same, the detail behind this is very different from 2014 - 83% of our ratings are now "good" or "outstanding" – 47% more than last year.

Two year £25 million estates improvement programme commenced

In 2014/15, we launched a two-year estate development programme with an investment of £25m. In year, £9m was directed towards clinical service developments, £2m in replacement medical equipment, and £0.6m in clinical information systems. Amongst the clinical service developments delivered in 2014/15, of particular note were:

- The start of the linear accelerator replacement programme at Lincoln
- New beds for all our hospitals
- Reconfiguration schemes on the Grantham site including improvements to A&E and the ambulatory care unit
- Reconfiguration schemes on the Pilgrim site including improvements to the mortuary facilities
- Enhancing the digital mammography service
- Full conversion of the x ray equipment at Lincoln to digital technology
- Refurbishment and modernisation of the Lincoln endoscopy service

Trust focus on quality led to lowest mortality figures since 2006/07

The Trust's mortality rate fell to the lowest rate for eight years as staff continued to implement across-the-board improvements in patient care.

Data on mortality rates, known as HSMR, showed that the 2013/14 score for the trust was 98.4, down from 109 in the previous year and better than the national average.

The figure was the lowest since 2006/07 when the score was 106.

There's no single factor that led to the reduction, it is due to widespread improvements to quality of patient care and fostering a safety culture at our hospitals.

Continuing to reduce incidences of pressure ulcers

Staff across Lincolnshire's hospitals continued our commitment to reduce pressure ulcers.

In 2013/14 significant improvements to recognise the signs of and reduce pressure ulcers were made. Staff

undertook specific training and we introduced a new adult patient assessment booklet and a bookmark to educate patients and their carers on the causes and ways to reduce pressure ulcers.

As a result, in 2014/15, the Trust reduced the incidence of pressure ulcers by nearly 40% to 0.5%, compared with the national rate of 4-6%. The increase in nursing staff at the Trust over the previous 18 months has also helped to further improve both care and patient experience.

Launch of the "hospice in a hospital" at Grantham Hospital

Working with St Barnabas Hospice, we launched the "hospice in a hospital" at Grantham Hospital in September 2014 - the first venture of its kind in the UK..

The six-bed inpatient unit welcomes an estimated 160 people from south west Lincolnshire each year who will benefit from the homely environment that has been created on their doorstep.

It will save them and their family and friends a 60-mile round journey to what is currently the charity's only existing inpatient unit at Nettleham Road, Lincoln.

Its opening came at the same time as latest population figures revealed that south west Lincolnshire had one of the fastest-growing populations the UK, with GPs reporting an increase in the number of their patients suffering from cancer, heart and lung disease and dementia

Bowel cancer surgery at Pilgrim

Last year, Mr Zakir Mohamed and Mr Milind Rao, consultant colorectal surgeons at Pilgrim, carried out an innovative procedure for bowel cancer at Pilgrim Hospital for the first time in this region.

A team of surgeons used the novel "single port" technology for reversal of Hartmann's procedure. Hartmann's is a complex surgical procedure to remove part of the large intestine and create a stoma, often used in emergency surgery and for advanced cancers. Due to the complexity of this procedure, 60% of these patients do not get the colostomy reversed. A single port surgery is a minimally invasive approach that leaves only a small scar, as it is carried out through one entry point aiding early recovery. This minimally invasive procedure really helps to transform the health of patients.

The single port approach in this case means that the patient does not need any incision apart from the cut around the stoma. This is pushing the boundaries of minimally invasive surgery. The benefits of this minimally invasive approach are less post-operative pain, early return to normal life activities, and a better cosmetic outcome. This is the first single port Hartmann's reversal in Lincolnshire.

Space age technology saves Lincoln man's hip

In 2014, one of the Trust's surgeons carried out innovative surgery using space age material to save a patient's hip replacement.

Over the years the plastic component in patient Mr Coultman's primary hip replacement had worn away and he required a redo surgery in 2010. Ever since, he has had a number of admissions to A&E and orthopaedic wards with ongoing hip problems.

Orthopaedic surgeon Mr Antapur decided to redo Mr Coltman's hip using trabecular metal. Trabecular metal™ is made out of pure Tantalum and is also used by NASA to build space shuttles and jet engines. Its porous nature ensures that it mimics the characteristics of human bone. In fact it is hailed as the 'next best thing' to natural bone. Mr Antapur is one of the few surgeons in the country to use this new technique.

Within a week of being referred to Mr Antapur, Mr Coltman underwent a five hour complex redo hip surgery. The aim was to naturally fuse the bone and metal over time to give Mr Coltman as natural a hip as possible.

Within three months Mr Coltman was back on his feet and felt like a new man.

Burton ward £180,000 dementia redevelopment

We know that hospitals can be particularly distressing for people with dementia and they often need extra care and support. That is why we made simple changes to the environment on our ward to make a big difference to our patients with dementia.

A complex needs ward at Lincoln was revamped to provide a better environment for patients with dementia.

Burton ward at Lincoln County Hospital underwent a £180,000 redevelopment to reduce patients anxiety and encourage better independence for people with dementia.

The number of beds per bay was reduced from six to four to provide patients who are prone to wandering with more space to walk around independently. Hand rails and bay doors are brightly coloured to help patients to find their way around the ward and relocate their bed easily. All bays have dementia friendly clocks, which not only tell the time but tell the patient whether it is morning, afternoon or night.

All bathroom and toilet doors have extra-large picture signs on them, to allow patients to identify them easily. We replaced all showers in the en suite bathrooms with walk in wet rooms to make it easier for patients with reduced mobility to shower. Any doors that aren’t for patients to access are painted the same colour as the walls so that they fade away.

Sounds, including those from buzzers, phones and nurse call systems, are kept to a minimum so not to distress patients with dementia who might not understand where the noise is coming from or what it means.

3. Developing and supporting our workforce

Our third strategic aim was "developing and supporting our workforce" by delivering skilled, compassionate and efficient care to our patients. The following examples show how we delivered this aim in 2014/15.

Big increases in the number of staff completing their core learning and appraisals

In July 2014, the Trust was criticised in a CQC report for low numbers of staff completing their core learning and having an appraisal.

A new appraisals policy and process were implemented, and compliance was managed through monthly performance clinics, all of which helped rates rise from 47% to 76%.

We improved access to core learning, we started a strategic core learning group and core learning plus panel to oversee core learning and induction needs and content. We also increased the number of staff with direct access to core training records.

This action and commitment from staff and managers saw rates of core learning rise from 49% to 79% in-year.

We listened to over 1,500 staff as part of Listening into Action

Our staff engagement method – using the Listening into Action (LiA) methodology continued to have a positive impact on staff and patient care. LiA teams have achieved some great successes.

In 2014/15, the LiA teams focussed on priorities within our quality improvement journey. The key achievements were:

Lincoln

- The outpatient case note team set up a central collection points for case notes to speed up case note recovery.
- A new front door frailty service was launched so frail patients were assessed as soon as they are admitted to A&E.
- An extra 91 volumetric pumps were purchased to meet demand for pump-controlled infusions to ensure medical equipment is in the right place at the right time.

Pilgrim

- The medicines management team introduced drug round in progress tabards.
- Inpatients leaflets were translated into Polish, Greek and Portuguese on AMU.
- The radiology team improved portering efficiency with the introduction of a two-way radio system.

Grantham

- At Grantham the discharge before 10am team doubled the number of morning discharges since August.
- The never events team developed a new WHO safe surgery checklist.
- The enhanced recovery programme reduced the length of stay in hospital following hip and knee surgery.

Improved safer staffing levels

Last year we reduced our consultant vacancies from over 102 to 58. We appointed six locum radiologists to address the significant shortfall in this specialty.

In terms of improving nursing levels, we carried out a formal review of ward establishments, including specialist areas presented to the Trust Board. Board approved the substantive appointment of 39 additional trained nurses and 25 additional health care support workers with a particular focus on accident and emergency, paediatrics and oncology/haematology.

We started a focused recruitment campaign – locally, regionally and

nationally – to boost staffing numbers across all our sites. We also worked with Lincolnshire health partners to encourage former registered nurses to return to practice. We piqued enough interest for the University of Lincoln to run a Lincolnshire return to practice course.

We also closed paediatric beds and neonatal cots to maintain safe staffing levels.

Second annual staff awards celebrate excellence

We held our second annual staff awards ceremony at the Epic Showground in Lincoln in March to thank staff publicly for their hard work, dedication and commitment to providing high quality care for the people in Lincolnshire.

There were 13 award categories in total with members of the public invited to nominate in four of them, including 'Compassion and Respect Towards Others', 'Unsung Heroes', 'Extra Mile Award' and 'Chairman's Fantastic Customer Service'.

Well done to all staff nominated and the winners.

Our performance against national standards in 2014/15

The Trust had a challenging year in 2014/15. We experienced one of the highest sustained periods of demand for hospital beds for emergency patients. This had a knock-on effect on planned elective work. We also introduced a new patient administration system that took time to embed, we faced constrained finances and we had two CQC inspections in less than 12 months.

Last year, the Trust went live with a new patient administration system (PAS), A&E and Business Intelligence suite. As expected with any large and complex project there have been some transitional challenges in areas such patient letters, A&E discharges and coding, 'outcoming', clinic setups, system configuration, staff access and roles, filters, reports, training, etc. These experiences are not unusual and no different to other Trusts that have replaced their PAS systems. The vast majority of the initial challenges are now resolved and the Trust is scaling back the additional staffing put in place during transition. Work is ongoing around optimisation and we are still in the planning phases of the next upgrade.

If we look back over the last year, we have seen some significant improvements. However, it is recognised that further improvements are needed.

Our performance against national targets

Table 2: Trust actual activity against planned for 2014/15

Activity Type	14/15 Plan	14/15 Actual
Day care spells	63,900	60,468
All elective spells	12,351	12,544
Non-elective spells (emergency)	74,231	72,484
New outpatient attendances	226,308	209,738
Subsequent outpatient attendances	462,101	412,861
A&E attendances (Excl. LCHS diverts)	147,109	147,688

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. Unfortunately the Trust did not meet this standard over the course of the year, recording performance of 90.67%.

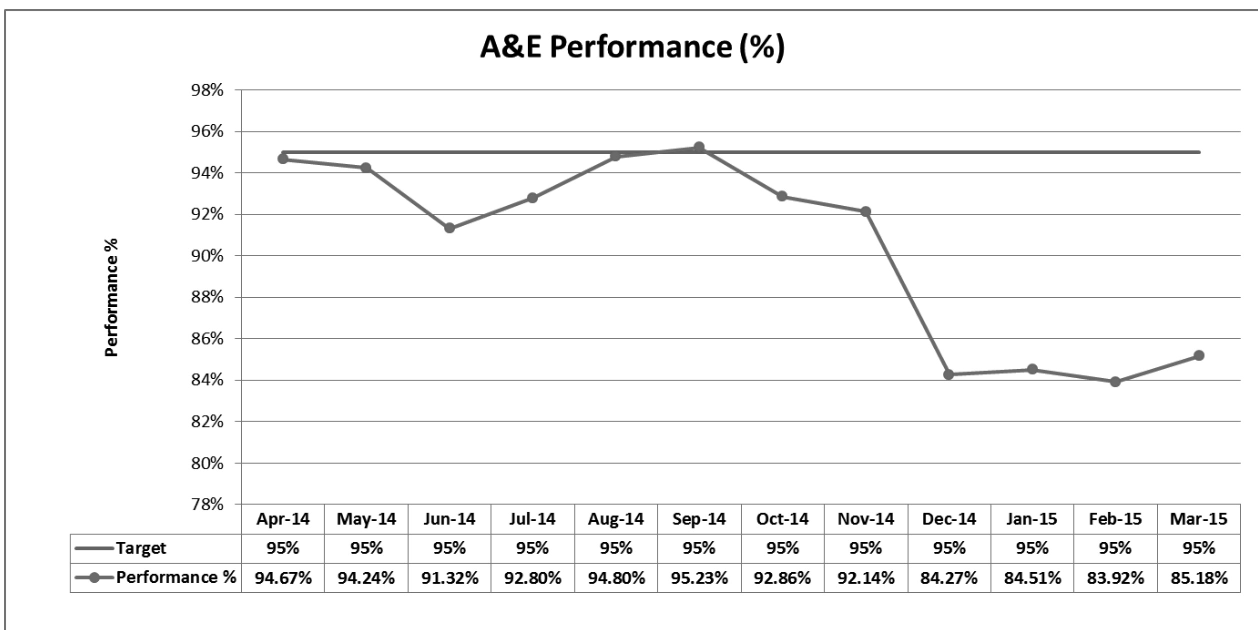
The following table and graph show the Trust's performance against this target.

Table 3: A&E attendances and breaches in 2014/15

A&E attendances 2013/14	Attendances	Breaches	Performance
Grantham	31,891	1,716	94.62%
Pilgrim, Boston	53,717	5,438	89.88%
Lincoln County	71,973	7,466	89.63%
ULHT Trust (Incl. LCHS diverts)	156,545	14,601	90.67%

Data source and calculations

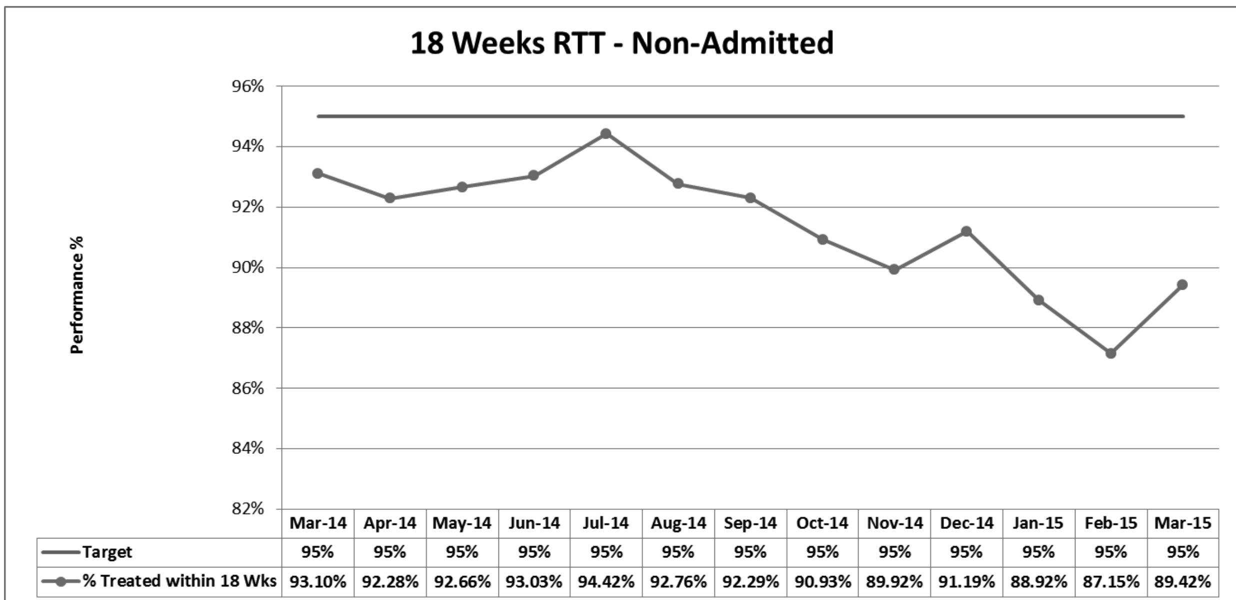
The data to calculate performance against A&E waiting times is taken from the Trust's Patient Administration System (PAS). Every patient is entered into this system with a start time and end time from when they arrive in the A&E Department to when they are seen. If this time is longer than four hours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



18 week referral to treatment - non admitted patients

The 18 week referral to treatment standard (RTT) 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.

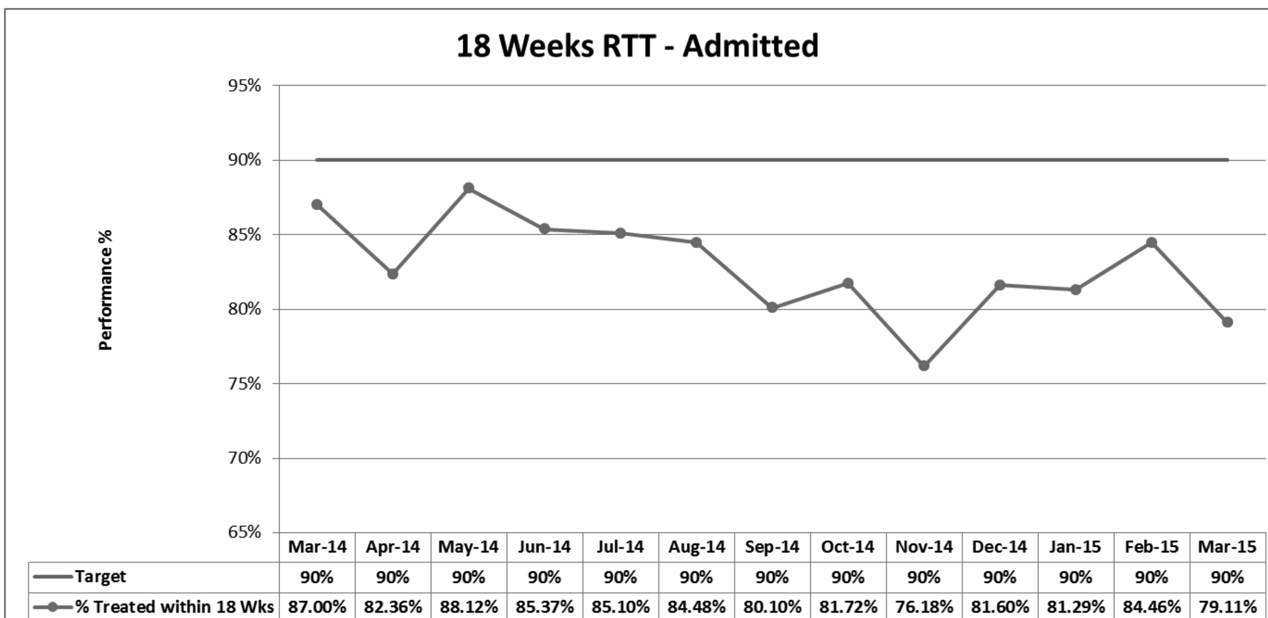
Unfortunately the Trust did not meet the standard of 95% at the end of the year. our performance was 89.42%.



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.

Unfortunately the Trust did not meet the standard of 90% at the end of the year.



Cancer standards

The Trust's performance against these standards can be seen in the table on the following page. The Trust met three of the standards - 31 day subsequent treatment: drug, 31 day subsequent treatment: surgery, and 62 day screening.

Table 4: Performance against cancer standards in 2014/15

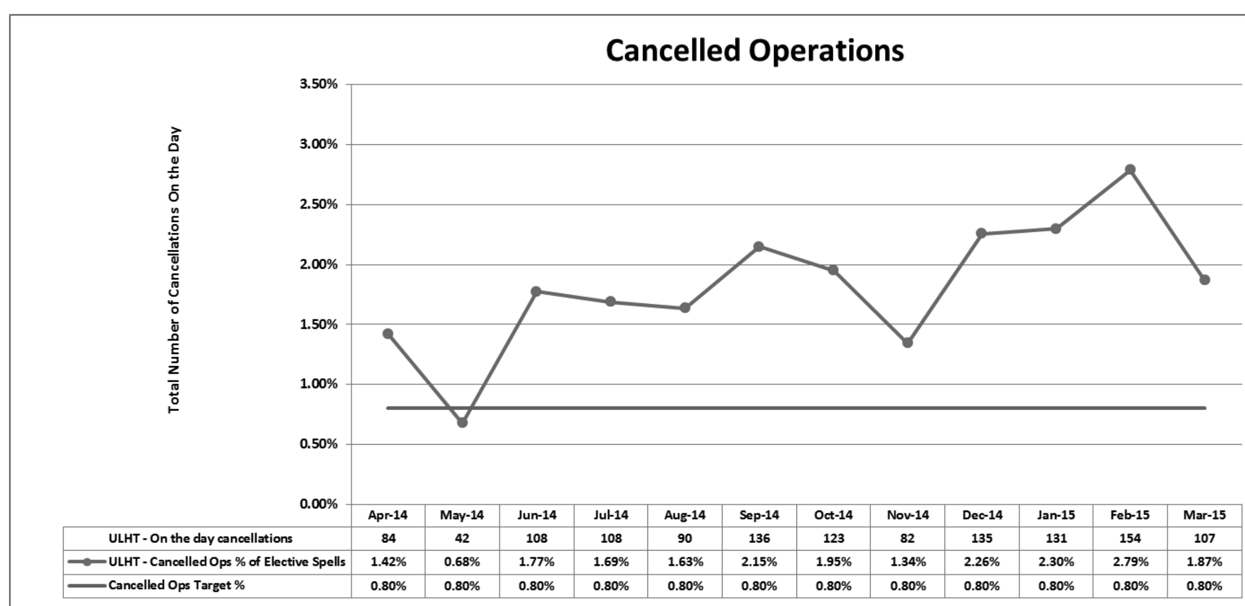
Measure	Standard	Trust Performance
2 week wait suspected cancer	93%	87.64%
2 week wait symptomatic breast	93%	71.11%
31 day decision to treat to treatment	96%	95.91%
31 day subsequent treatment: drug	98%	98.59%
31 day subsequent treatment: surgery	94%	92.86%
31 day subsequent treatment: Radiotherapy	94%	89.21%
62 day referral to treatment	85%	74.42%
62 day screening	90%	92.70%

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 (on the day) for 2014/15 was to achieve a cancellation rate of no higher than 0.8%, and ensuring that patients who receive such a cancellation have their operation within 28 days of their original postponement. Unfortunately due to the continued increase in emergency demand, the availability of ward and critical care beds was not sufficient to ensure all elective patients received their operation on the planned date. This resulted in an annual cancellation rate of 1. 87%.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ULHT - On the day cancellations	84	42	108	108	90	136	123	82	135	131	154	107
ULHT - Cancelled Ops % of Elective Spells	1.42%	0.68%	1.77%	1.69%	1.63%	2.15%	1.95%	1.34%	2.26%	2.30%	2.79%	1.87%
Cancelled Ops Target %	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%

Developing an effective organisation

Table 5: Year-on-year performance analysis: 2014/15 performance

Target Area	2012/13	2013/14	2014/15
Delayed transfers of care	2.76%	2.65%	4.82%
18 weeks to treatment - Admitted	90.87%	90.68%	82.37%
18 weeks to treatment - Non-admitted	95.10%	94.43%	91.13%
MRSA	6	3	1
C.Diff	76	61	65
Cancer 2 week wait	94.60%	93.22%	87.70%
31 day cancer	97.20%	96.90%	95.95%
62 day cancer	83.80%	81.29%	74.36%
Diagnostics Waits	0.96%	0.78%	2.83%
Cancelled operations	1.59%	1.42%	1.81%
Fractured neck of femur	74.34%	78.20%	78.9%
A&E wait	95.17%	94.54%	90.67%
VTE assessment	90.67%	95.96%	n/a

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 that affect their health and wellbeing.

The Trust set a target of 3.5% for sickness absence levels for 2014/15, which would have constituted a reduction of 1.68% from the 2010/11 annual rolling absence rate of 5.18%. The actual annual rate for 2014/15 was 4.79%.

Overall performance over the last four years shows a trend of improvement, despite a slight increase of 0.12% from 4.67% in 2013/14. Further improvement will be a key focus for the Trust.

This still remains one of the lowest reported annual sickness rates for the Trust since the introduction of ESR (electronic staff record) in May 2007.

Forward looking – our priorities in 2015/16

Strategic aims and linked ambitions for 2015/16

To build on the good work of last year, we have seven main objectives for 2015/16. These are:

1. **Continuously improve quality, provision of safe care, and deliver a positive patient experience by:**
   - Reducing avoidable harm
   - Improving friends and family test score
   - If complaints occur, respond more quickly
   - Improving the safety and suitability of our estate
   - Implementing a digitisation strategy for the Trust

2. **Create the conditions for our staff to achieve their best through:**
   - Supporting staff through higher rates of appraisals and core training
   - Achieving a higher level of staff engagement across the trust
   - Implementing our leadership development strategy

3. **Recruit the right staff to the right places by:**
   - Ensuring safe staffing across all clinical areas
   - Recruit, develop and retain staff to ensure all staff have the required skills

4. **Move towards a clinically led organisation:**
   - Implementing our workforce development strategy
   - Define the clinically led model
   - Develop and implement the transition plan

5. **Deliver our 2015/16 financial plan**
   - Achieve our contract value in full
   - Continue to manage expenditure
   - Achieve our planned savings

6. **Improved performance by ensuring**
   - Improvement across the emergency care pathway and performance
   - Improvement in the 18 week RTT pathway and performance
   - Improved cancer pathways and waiting times
   - Reduction in cancelled operations
   - Reduction in short notice clinic cancellations
   - Implement integrated discharge pathway

7. **Set out our plans for the future:**
   - Confirm service models for women and children and emergency care
   - Development of site configurations
   - Develop the reconfiguration business case
   - Develop a future financial strategy for sustainability as part of Lincolnshire Health and Care plans

Our quality priorities

We have made significant improvements to the quality of the care we deliver at all our three hospitals. However, there is still more to do.

We have a revised quality improvement plan. The purpose of this plan is to define, at a high level, the overall continuing quality improvement journey ULHT is making and the improvement goals that the trust will work towards over the next 12 months. The plan includes all of the MUST DO recommendations in the CQC Quality Reports and detailed plans are being developed for each project/work area. In addition detailed underlying plans are in place to execute all of the SHOULD DO actions at site level.

However, the plan is broader than those actions and includes longer-term pieces of work that the trust is pursuing to improve overall quality and responsiveness across the organisation.

The plan outlines the trust's overall ambition to be "beyond good".

During 2014/15, it became clear that some of our patient administration and business processes are both inadequate and insufficient. For some patients, this can result in a poor patient experience. This year, the Trust will embark on a major review of processes alongside the adoption and implementation of a digitisation strategy. This will lead to a fundamental redesign and rewrite of how our administration processes support patient journeys into, through, and out of the hospital including the sharing of relevant information to health and social care partners.

Dementia and frailty care is a national and regional priority. At ULHT we will take forward the actions within our dementia strategy that will raise awareness, provide training across all staff groups, fight stereotypes and ensure we provide the best possible care and support to our patients living with dementia and who are frail and also, importantly to their carer's and family.

Our work around our Trust values and behaviours continues with a clear message that all that we do, and the way that we do it is expected to be undertaken with care and compassion, respect and dignity to our patients, public and our colleagues.

Embedding these values from recruitment to appraisal and proactively seeking feedback from patients and staff will ensure we give care and provide services that our friends and family would wish to use.

Our complaints and patient feedback at times tell us that we could communicate better and our current and continuing work around patient experience, education and training, customer care and our values and behaviours will ensure we identify where and how we need to focus improvements and ensure we make a difference.

Falls prevention remains a high priority on the patient safety agenda and a Trust-wide multi-disciplinary falls group has been reformed. ULHT is part of the *Sign up to Safety Campaign* which again has a

clear focus on the prevention of harm. Safety and quality are discussed regularly with our partners from the wider health economy and we plan to share our learning.

Our acting chief nurse is also leading a review of patient documentation. The duplication of paperwork at the Trust frustrates staff and is also inefficient. This review is a major priority for our staff and will feed into our digitisation strategy.

We are committed to ensuring that we review our nurse staffing requirements in line with the National Quality Board guidance and ensure the Board are sighted on any challenges to safe staffing. We have revised our escalation process; however, consistent staffing remains a challenge as we continue to work hard to fill vacant nursing posts.

We will be working with our health and community partners on a comprehensive programme to improve patient flow around the hospitals and the timely

discharge out of the hospital. This includes better, earlier discharge planning for people with complex needs, improving communications with patients, their families and primary care.

Implementing the Medway PAS and A&E system in 2014/15 was our first step towards a full electronic patient record, which will help us to increase our clinical and operational efficiencies and help us to provide a higher quality and safer service to our patients by having a tightly integrated system. This will deliver more benefits for our patients and staff.

In 2015/16, we will move forward with implementing our 5-year digitalisation strategy which sets out how the Trust will become a more efficient paperlite organisation providing real time and accurate clinical information to the right people, at the right time in the right place. We will make safe digital record-keeping commonplace across our organisation.

Transforming our services

One of the key priorities for the Trust in 2015/16 is to move forwards with the transformation of our services with partners through Lincolnshire Health and Care (LHAC). This will of course involve listening to the views of our patients and our staff.

The one constant in the life of the NHS is that there is always change. It’s the only way the NHS can survive and improve. The whole health system faces many challenges, unfortunately there are very few places where this is more evident than Lincolnshire. Therefore we have to make significant progress with the development of our clinical strategy during 2015/16. The key problems the clinical strategy will address are quality of care and finance.

Our plans will feed into the LHAC public consultation during 2015/16. As an organisation, we have to complete the detailed strategic development for all service specialties, develop our new site configurations and make significant progress in forming the business case to support the required changes. Progress of course will be subject to public consultation. However to survive we must make significant progress within the next

2 years to ensure clinical and financial sustainability.

Over the next few months, our main steps are:

- The Clinical Strategy Implementation Group will present the strategic and service delivery model options for emergency care and women's and children's services through the appropriate programme and organisational governance structures to agree the direction of travel for these two key service areas. Recommendations will be made to the Trust Board.
- The detailed strategic direction and service delivery model options for planned care will continue to develop. Hospital site configuration options will be considered.
- Preparation for the public consultation process will be undertaken as part of the LHAC programme.
- Business plans will be drawn up to support the areas of transformation and change, identifying investment needed which will include implementation and transition costs.

Improving our estate

Effective capital investment is a key enabler to improving the quality and safety of clinical services and last year we embarked on the largest capital investment programme in the Trust's history. In 2015/16, we will be investing over £26.4m in capital schemes. These include clinical service developments, medical equipment replacement, improving our estate, and modernising our information systems including those directly supporting clinical care through Web-V. The Trust is seeking additional borrowing to supplement the current capital plan to help further enhance the quality of our services.

Meeting key performance indicators 2015/16

Meeting the NHS constitutional standards is a key priority for the Trust. By taking focused actions, we can be confident in improving our services towards meeting the NHS constitutional standards for the people of Lincolnshire.

Projected demand

We are assuming a 3.35% growth in overall total activity from the 2014/15 outturn position to the 2015/16 plan, across the organisation.

We have worked closely with commissioners, throughout the contract negotiation process, to agree a view on future demand.

Capacity

It is recognised that the effective flow of patients through our services is reliant on good capacity planning and staffing.

Capacity planning is crucial to ensure sufficient capacity to treat the level of demand on the service. The Trust has undertaken an extensive capacity review for each service as part of agreeing the contracted level of activity with our commissioners.

The Trust has had significant activity challenges in two particular specialities - breast surgery and neurology. A continued increase in demand has been seen within breast services and capacity has been hindered by struggling to recruit radiologists. The neurology service relies on visiting consultants and therefore it is difficult to be flexible with capacity, creating capacity shortfalls. The Trust has addressed these two specific shortfalls as part of the negotiation process with

commissioners and confirmed a level of activity that can be provided by ULHT. We remain committed to providing these services in 2015/16 and through these actions we can be more confident in providing a service that meets the NHS constitutional standards.

A number of other specialities are undergoing service redesign due to the significant pressures faced in 2014/15 and predicted capacity shortfalls in 2015/16. These include dermatology, ophthalmology, pain, trauma and orthopaedics and urology.

How we plan to improve performance

Improving our performance on the national NHS constitutional standards is a priority for ULHT in 2015/16.

We will do this by being an integral member of the System Resilience Group (SRG) which has representatives from all health and care organisations in Lincolnshire. They work together to review pathways for delivering safe and effective care in the county. Our performance is reliant on the whole system's ability in Lincolnshire to manage patient flow, including managing the need for urgent care and ensuring medically fit patients are discharged in a timely way to the appropriate community setting.

A further development in 2015/16 is the re-launch of the Planned Care Board which will take strategic ownership of the delivery and improvement of services linked to 18 week referral to treatment (RTT) and cancer waiting time standards. ULHT is a core member of the board.

The Trust is also committed to ensuring delivery of services that are of high quality, efficient and safe. Therefore, the following improvements will be made:

4 hour emergency access standard

- Embedding the ambulatory care model.
- Ensuring good senior medical and nursing staff availability.
- Establishing out of hours streams at the front door including a frailty unit at Lincoln.
- Revising early escalation procedures
- Increasing focus on internal discharge process and external delays to transition of care.

18 week referral to treatment standard

- Speciality recovery plans in place to meet expected levels of demand
- Service redesign in specialities where problems have been identified with meeting the expected levels of demand.
- Extensive activity modelling and monitoring throughout the year to ensure capacity and demand levels are managed and are transparent.
- Increase levels of support for the operational business units to provide realistic and achievable trajectories and remedial action plans.
- Increase levels of support for clinicians and business managers in identifying issues outside of their control, and facilitating the dialogue with commissioners to rectify issues in a proactive manner
- Ongoing data quality improvement, training and validation.

National cancer waiting times

- Urology, lower GI and breast pressures impacting on 2 week wait.
- Matching contracted breast activity to available capacity to ensure the service provided meets national standards.
- Breast redesign programme underway.
- 62 day pathway focus on lower GI, lung, urology including a focus on capacity planning.
- Increasing radiology staffing and multi-disciplinary team support.
- Increasing level 1 / high dependency unit access.

Emergency planning

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 England (Leicestershire and Lincolnshire) and other local health partners to consider, plan and test resilience and preparedness within the county.

The Trust has a senior manager responsible for EPRR and business continuity and all directors have completed the strategic leadership in a crisis course which enhances the organisation's resilience in times of crisis. ULHT is also an active member and participant of the Local Health Resilience Partnership which reports to the Lincolnshire Resilience Forum; a group that works with Lincolnshire County Council's joint emergency management service and other category one responders.

In 2014/15, the Trust's EPRR core standards assurance process was reviewed and audited by the NHS England operations and delivery directorate who acknowledged that significant progress and standards have been achieved across a broad range of subjects over the last 12 months. The Trust has also been able to provide full assurance to NHS England that plans and procedures are in place to deal with any suspected cases of the widely reported Ebola viral disease.

Plans that deal with major incidents, hospital evacuations, exposure to hazardous materials and visiting VIPs have been produced this year. Business continuity plans were tested for real during the Trust's migration from the patient administrative system to the new MEDWAY electronic patient records system.

The Trust took part in a significant pan-Trust exercise in June 2015. Teams from Public Health England delivered the exercise using the Emergo Training System; a pedagogic simulation tool that is focused on the medical chain of responding to major incidents and accidents. Completion of this exercise satisfied the NHS Core Standards requirement which is to test major incident plans through a live or simulated exercise every three years. The one-day exercise involved up to 150 members of staff representing all three major hospital sites.

Managing patient complaints

The Trust developed a new complaints and concerns pathway during 2013/2014 following a detailed review. In partnership with patient representatives, ex-complainants and stakeholders, the new complaints process called See it My Way was developed. See it My Way embraces the Parliamentary and Health Services Ombudsman's principles for remedy, putting the patient/complainant at the heart of our decision.

Now each complainant receives a phone call from a senior member of staff to discuss their complaint offering apologies and taking remedial action, if possible, at the first contact. In addition to a senior lead being assigned to each complaint a case manager is identified who will determine an appropriate remedy for the patient and where this is not possible, explore the option of financial recompense for any injustice or hardship as a result of maladministration or poor service.

At the beginning of the complaints process the complainant is provided with a letter and leaflet, providing details of those involved in the investigation, contact names and numbers and information about what happens next. A timescale is also agreed with the complainant during the contact from the identified senior lead. The See it My Way documentation includes an investigation grid that is shared with the complainant and details each concern, the findings following investigation and what has been learnt and what action has been taken from the complaint being raised. Together with this explanation a response letter from an executive director will offer apologies when there has been maladministration or poor service.

Remedy is determined on an individual basis and recorded on a database which is used for internal and external reporting. The type of remedy; apology, explanation, remedial action or financial compensation will depend on the case and what the patient feels would resolve their complaint. Where financial remedy is awarded, the amounts are proportionate and fair to the injustice or hardship and in line with those that have suffered similar injustice or hardship. Where there are lessons learnt/actions taken from a complaint this information is inputted on to a change register and monitored through the Trust's governance procedures.

Serious incidents which require investigation (SIRI) - 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 2014/15 there were no such incidents reported.

Other data rated incidents for the year are summarised below:

Summary of other personal data related incidents in 2014-15		
Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	0

Membership

The Trust membership has been active in many areas of our hospitals over the past 12 months, particularly carrying out patient representative activities and as part of consultation on work programmes.

We now have 1,166 members, of whom 228 are staff. The focus for 2014/15 was not around membership recruitment, but around training and utilising existing members to ensure they could contribute constructively to the Trust activities.

There are now 70 members who have been fully trained and DBS checked to carry out patient representative activities and that number is increasing.

Over the last year, members have participated in ward assurance visits to review the safety and quality of care across all of our hospital sites, worked on PLACE assessment teams to assess the quality of the environment, taken part in the Trust's review of the complaints handling process and sat on many of our boards and committees as patient representatives.

In addition, our Locality Forums at Lincoln, Boston, Grantham and Louth have had good attendance levels from our wider membership and have involved members in discussions and consultation around issues including our emerging clinical strategy, quality strategy and performance.

Sustainability report

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

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

We are committed to reduce our CO^2 emissions at least in line with NHS guidelines. Between 2009 and 2015, we reduced our carbon footprint by 13% against the national target of 10%. By investing in our infrastructure and implementing initiatives ranging from installing new gas and biomass boilers and combined heat and power to increasing staff awareness by encouraging and embedding sustainable behaviours in the organisation, the Trust seeks to continue to be among leading NHS trusts for its environmental and sustainability track record.

Context

The carbon footprint for the NHS in England has risen to 21 million tonnes per year. This is larger than some medium sized countries and has increased by three million tonnes since the previous footprint was calculated. This is primarily due to the growth in NHS services but also because, in line with latest conventions, we now include other greenhouse gases in our calculations, rather than just carbon dioxide. This is expressed as CO^2 equivalent or CO^2e.

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 installed and is successfully operating combined heat and power plant at both of its major acute sites in Lincoln and Boston. In addition at the Pilgrim Hospital Boston, the combined heat and power plant works in combination with a new gas and biomass boiler installation, reducing the site CO^2 emissions by 35%.

The biomass boiler is fuelled by virgin woodchip, sourced from local suppliers whenever possible. Together with the combined heat and power, this provides the hospital's base load for heat and hot water, during periods of high demand a new gas boiler provides top up energy supplies.

The installation of the gas boiler provides the site with greater fuel diversification, further reductions in CO2 emissions and additional revenue savings.

The Trust continues to develop the reconfiguration of energy services at Grantham and District Hospital. This project, as well as replacing time expired plant and critical infrastructure services, will reduce the energy consumption of the site by up to 25%. Studies have concluded that by replacing the existing boilers and upgrading the lighting and heating infrastructure, the hospital could reduce its CO^2 emissions by 2,000 tonnes per year. With the potential of producing

net revenue savings of circa £100,000 per year.

Recognition of our work

In the last five years, the Trust has:

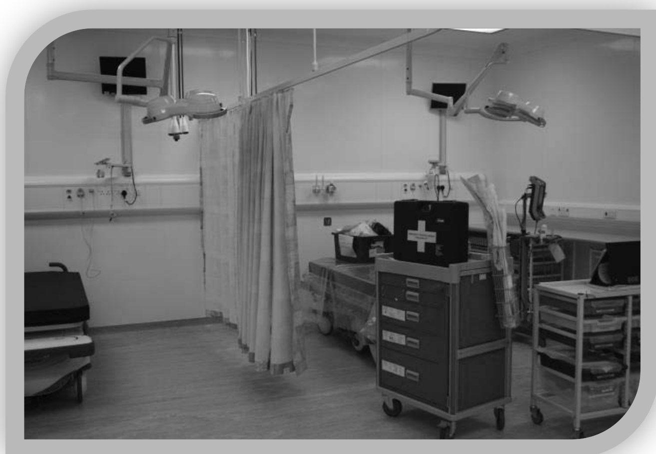
- Won the Health Business Award for Sustainable Hospital.
- Received a Highly Commended Award at the CHPQA Awards.
- Achieved a commendation and certificate from the Carbon Trust for its ambitious target towards carbon dioxide reduction.
- 6 years after the commissioning of the biomass boiler installation at Pilgrim Hospital, other NHS Trusts still see the installation as a leading example of sustainable development and continue to contact and visit the site to learn from our experiences.

Next steps – key headlines

In the summer of 2015, the Trust Board was presented with a "Sustainable Development Management Plan" (SDMP) for approval.

Capital expenditure

The Trust is striving to achieve a further reduction of 10-15% in energy consumption through various capital expenditure initiatives across all of its hospital sites. 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 is replacing its carbon management plan (approved by the Trust Board in 2009) with a "sustainable development management plan" (SDMP). This will focus upon sustainable behaviours, transport, building design, waste management and water management in a comprehensive new approach putting sustainability at the heart of Trust policy. This SDMP is the document which will outline the Trust's commitment to ensuring that sustainable development becomes central to the way we do things in every aspect of our organisation.

Progress against the targets and actions outlined in the plan will be monitored and evaluated each year by the Trust Board.

Our staff

Employee consultation and communication

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 hospital sites.
- Monthly Site Partnership Forums on the three main sites.
- Site Medical Advisory Committees.
- Trustwide Medical Staff Negotiating Forum.
- Site Junior Doctor Forum, including representation from LETB.
- Fortnightly meetings between HR and staff side chairs (trade unions).
- Weekly round-up newsletter/ communications sent to all staff.
- Monthly team brief meetings/CEO updates.
- Lincolnshire Wire – quarterly staff magazine.
- Newsletters.
- HR news for managers.
- Consultation mechanism in place which include staff side representation.
- Organisational change policy allows for staff to comments on proposed changes.
- Listening into Action (LiA).
- Team Lincoln/Pilgrim/Grantham staff engagement meetings each month which are led by staff.
- Medical Staff Engagement Forum.
- Podcasts/video messaging from CEO.
- Senior leadership forum.

These methods of communication are also used to ensure that staff are made aware of any factors affecting the Trust and at service level, including individual and team achievement and/or performance.

The executive directors and non-executive directors routinely conduct ‘Back to Floor Visits’ which enable executive and junior staff to mix in a less formal setting.

Policy in relation to disabled employees

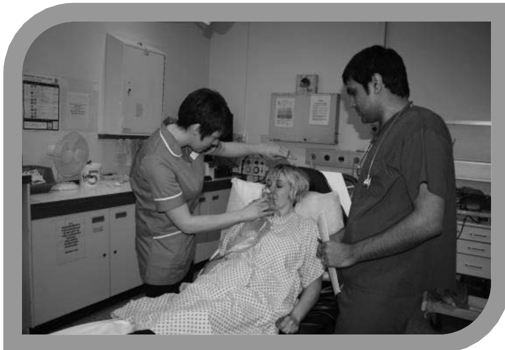
The Trust has a general policy in relation to disabled employees, which is contained within its Single Equality Scheme.

Our objective is that all Trust policies will be subject to an Equality Impact Assessment (EIA), which is a tool for identifying the potential impact of policies, services and functions on an organisation’s employees, patients, carers and other stakeholders. It can help staff provide and deliver excellent services by making sure that these reflect the needs of the community. They will also help to improve policies, strategies, procedures, projects, reviews and organisational change for the whole community.

By carrying out EIAs, we are ensuring that the services we provide do not discriminate and promote equality. In doing EIAs equality is placed at the centre of policy development and review, as well as service delivery.

The Trust’s managing sickness absence policy and associated policies recognise the Trust’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 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 or withheld on the grounds of a person's disability and other formal processes including disciplinary and capability policies have been through EIA to ensure that disabled employees are not subject to unlawful discrimination.



Equality and diversity

United Lincolnshire Hospitals NHS Trust is fully committed to creating an organisational culture of valuing each other and equality.

Everyone has a right to enjoy their work and to be appreciated in the workplace and when using our services. This includes things like taking action to reduce the effects of inequalities and adjusting the way we do things so that everyone is treated with dignity and respect.

We recognise 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.

We are committed to transforming our organisational culture by actively committing to implementing the Trust Single Equality Scheme and other policies such as the dignity in care and the dignity at work policies. The Trust will continue to promote equality and challenge discrimination in all service provision, recognising and meeting the needs of the diverse communities we serve.

The Trust is striving to provide an environment in which people want to work and to be a model employer leading in good employment practice. We are 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 would be addressed in accordance with the Trust's policies and procedures.

The Trust has a number of key policies that support the equality and diversity agenda e.g. transgender policy and interpretation and translation policy.

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

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

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

Corporate responsibility for the Single Equality Scheme lies with the Director of HR and Organisation Development. 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 and action/monitored at sites.

Charging for information

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

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

The Trust therefore ensures compliance with guidance on setting charges for information as set out within HM Treasury's Managing Public Money publication (July 2013).

Statement of the chief executive's responsibilities as the accountable officer of the Trust

The chief executive of the NHS Trust Development Authority (TDA) has designated that the chief executive should be the accountable officer to the Trust. the relevant responsibilities of accountable officers are set out in the accountable officers memorandum issued by the Department of Health. These include ensuring that:

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

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

Jane Lewington, Chief Executive

The Trust's annual governance statement for 2014/15 is within the annual accounts.

Financial review

Introduction

Our financial results for the year ending 31 March 2015 were mixed. We met our plan on forecast deficit and savings, but our income fell. This is against the backdrop of a tightening of the public purse but with an expectation of an increase in the quality and safety of the care provided by United Lincolnshire Hospitals NHS Trust. We continue to focus on maintaining quality while ensuring delivery of a big savings target. With a bigger deficit forecast for 2015/16, our focus seems unlikely to change over the next few years and the challenge will remain in maintaining high quality services and reducing our deficit in a managed way.

A full set of accounts is shown in section B/accounts.

Overview

We have an annual income of £433.25 million. The majority of our income comes from delivering patient care as per our main contracts with local commissioners - Lincolnshire East, Lincolnshire West, South Lincolnshire and South West Lincolnshire clinical commissioning groups (CCGs).

The Trust received £19.5 million to support education, training and research. The majority of this income was received from Health Education England and was provided as reimbursement for training of undergraduate doctors, junior doctors, nurses and technical staff.

Financial targets

We finished the year with a financial deficit of £15.278 million, as we did not generate sufficient income to cover our costs. However, our deficit was lower than planned due to additional TDA funding for meeting our original deficit plan of £25 million.

We have delivered savings of £25.850 million, which was slightly above our target.

Our income was lower than expected and fell during winter months. It was £9.468 million below our plan.

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 64.7% of the total expenditure.

The Trust Accounts for 2013/14 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 £122,550 (exc. VAT) in respect of statutory audit fees for the 2014/15 financial year. The range of statutory audit services provided by KPMG included audit of the annual financial statements, value for money assessment and review of the Trust's governance and financial arrangements. KPMG's statutory review of the 2014/15 financial statements resulted in an unqualified opinion.

An additional payment of £54,000 (exc. VAT) was also made, this related to work commissioned to develop an activity model for the Trust.

The Trust's internal audit services during 2014/15 were provided through TIAA Ltd.

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

The Trust accounts for 2014/15 are set out in full as an appendix within this annual report.

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

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 2014/15 was £181,800 (2013/14: £181,800). This was 8.03 times (2013/14: 7.94) the median remuneration of the workforce, which was £22,636 (2013/14: £22,903).

In 2014-15, zero (2013/14: zero) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £181,800 to £5,214 (2013/14: £181,800 - £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.

Exit packages

Notes 10.4 - 10.5 within the 2014/15 financial statements provide details about payments on termination of employment which were agreed in 2014/15.

These disclosures are required to strengthen accountability in the light of public and parliamentary concern about the incidence and cost of these payments.

There were no 'special non-contractual payments' made and similarly none of the payments related to senior managers.

"Off-payroll engagements"

Following the review of tax arrangements of public sector appointees published by the chief secretary to the Treasury on 23 May 2012, departments and their arm's length bodies must report arrangements whereby senior and/or highly paid individuals are paid through their own companies rather than the organisation's payroll. They are therefore responsible for their own tax and national insurance arrangements and not subject to tax and national insurance deductions at source.

The tables below present the number of 'off-payroll' engagements at United Lincolnshire Hospitals NHS Trust during 2014/15, in the format prescribed by the Treasury and Department of Health.

Table 6: For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than six months

	Number
Number of existing engagements as of 31 March 2015	14
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between 1 and 2 years at the time of reporting	1
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	2
for 4 or more years at the time of reporting	6

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

In relation to those engagements listed above, two relate to individuals carrying out a full time role. The remainder relate to individuals providing services to the Trust on a part time/infrequent basis but where the arrangement has been in place for over six months and the daily rate exceeds £220.
Each arrangement is assessed using the HMRC Employment Status Indicator Tool and all new off-payroll engagement contracts are issued with clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations.

Following a comprehensive review of this area in 2013/14, HMRC Inspectors identified no compliance issues. In addition, the Trust is currently in discussions with HMRC to determine whether six of those listed above are correctly classified as reportable 'off-payroll' engagements.

Table 7: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than six months

	Number
Number of new engagements, or those that reached six months in duration between 1 April 2014 and 31 March 2015	3
Number of new engagements which include contractual clauses giving ULHT the right to request assurance in relation to income tax and national insurance obligations	3
Number for whom assurance has been requested	3
Of which:	
Assurance has been received	1
Assurance has not been received	2
Engagements terminated as a result of assurance not being received	0

Table 8: Off payroll engagements with individual board members

	Number
Number of off payroll engagements of board, and/or senior officers with significant financial responsibility, during the year	1
Number of individuals that have been deemed 'board members and/or senior officers with significant financial responsibility" during the year. This figure includes both off payroll and on payroll engagements	10

During 2014/15, the former interim director of nursing was paid ‘off-payroll’ for a period of one month. The circumstances leading to this were deemed exceptional for the following reasons:

1. The Trust was unsuccessful in appointing a substantive director of nursing despite exhaustive efforts to recruit.
2. The director of nursing role was key to delivery of improvements in the Trust following the Keogh inspection in 2013.
3. The period of payment was not expected to be for more than three months
4. The remaining 10 Board members were each engaged and paid via the Trust payroll in 2014/15.

Pension liabilities

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. The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year.

Salaries and allowances

Name and title	Notes	Term in post		Salary	Taxable benefits (total to nearest £100)	All pension-related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total	Salary	Taxable benefits (total to nearest £100)	All pension-related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total
				(bands of £5,000)				(bands of £5,000)	(bands of £5,000)				(bands of £5,000)
		Start	Finish	£000's	£00's	£000's	£00's	£000's	£000's	£00's	£000's	£00's	£000's
Mr R Buchanan - Chair		Mar-14	Ongoing	40 - 45	35		29	50 - 55	0 - 5				0 - 5
Mrs P Owston - Non Executive Director & Acting Chair (Jan - Feb 2014)		Apr-10	Ongoing	5 - 10	24		9	5 - 10	5 - 10	30		13	10 - 15
Mr P Richardson - Chair		Jul-09	Dec-13						15 - 20	46		42	25 - 30
Mr T Staniland - Non Executive Director		Mar-07	Ongoing	5 - 10	11		9	5 - 10	5 - 10	12		5	5 - 10
Mr K Brown - Non Executive Director		May-08	Sep-13						0 - 5	4		4	0 - 5
Mr N Muntz - Non Executive Director		Jul-09	Aug-14	0 - 5				0 - 5	0 - 5				0 - 5
Mr G Hayward - Non Executive Director		Jul-13	Ongoing	5 - 10	16		13	5 - 10	0 - 5	7		6	5 - 10
Mr P Grasby - Non Executive Director		Jul-13	Ongoing	5 - 10	11		3	5 - 10	0 - 5				0 - 5
Prof S Barnett - Non Executive Director		Mar-14	Ongoing	5 - 10	16		15	5 - 10	0 - 5				0 - 5
Mrs K Truscott - Non Executive Director		Mar-14	Ongoing	5 - 10	19		7	5 - 10	0 - 5				0 - 5
Mr K Darwin - Associate Non Executive Director		Jan-10	Ongoing	0 - 5	9		9	0 - 5	5 - 10	12		15	5 - 10
Jane Lewington - Chief Executive (Director of Strategy & Performance prior to Dec 12)		Dec-10	Ongoing	175 - 180	13			180 - 185	175 - 180	15	242.5 - 245		425 - 430
Kevin Turner - Director of Strategy & Performance (Director of Finance prior to Apr 13)		Jan-11	Ongoing	140 - 145	13			140 - 145	140 - 145	6	'5 - 7.5		145 - 150
Mark Brassington - Acting Director of Performance Improvement	4	Nov-14	Ongoing	40 - 45	5	27.5 - 30		70 - 75					
Stephen Hewitt - Acting Director of Strategy and Performance		Dec-12	Apr-13						5 - 10		2.5 - 5		10 - 15
David Pratt - Director of Finance & Corporate Affairs		Oct-13	Ongoing	135 - 140	28	72.5 - 75		215 - 220	55 - 60		25 - 27.5		80 - 85
Pen Andersen - Acting Director of Finance & Corporate Affairs		Apr-13	Oct-13						55 - 60	5	85 - 87.5		140 - 145
Michelle Rhodes - Director of Service Delivery		Oct-10	Ongoing	115 - 120	25			120 - 125	115 - 120	21	10 - 12.5		130 - 135

Eiri Jones - Director of Nursing	1	Aug-12	Apr-14					55 - 60	3	52.5 - 55	110 - 115
Pauline Pratt - Acting Director of Nursing		May-14	Ongoing	105 - 110	33	277.5 - 280	385 - 390				
Sunil Kapedia - Medical Director		Jul-13	Ongoing	180 - 185	108	90 - 92.5	280 - 285	125 - 130	39	140 - 142.5	270 - 275
Ian Warren - Director of Human Resources	2	Feb-13	Ongoing	110 - 115	9	22.5 - 25	135 - 140	60 - 65		52.5 - 55	115 - 120
Paul Boocock - Director of Estates and Facilities		Oct-13	Ongoing	85 - 90	22	25 - 27.5	115 - 120	40 - 45	10	42.5 - 45	85 - 90
Nigel Myhill - Director of Estates and Facilities	3	Oct-12	May-13								

Notes:

1. Eiri Jones was initially seconded from Bedfordshire NHS Trust in 2013 /14 at a cost of £43,128 before being appointed substantively in August 2013. Retirement was taken in December 2013 before returning to the Director of Nursing role on a part time basis in February 2014. Payments of £19,500 were thereafter made through a private limited company in 2013/14 and ££10,500 in 2014/15.
2. Ian Warren was initially seconded on a part time basis from Lincolnshire Community Health Services NHS Trust (LCHS) before being appointed to the Director of Human Resources post on a permanent full time basis in October 2013. The secondment initially formed part of a wider cost and resource sharing exercise between the two organisations and United Lincolnshire Hospitals were not recharged directly for Ian Warren's costs until August 2013. Costs recharged thereafter in 2013/14 totalled £19,181. Details of Mr Warren's Salary and Pensions Benefits prior to appointment were disclosed in full by LCHS.
3. Nigel Myhill was seconded on a part time basis from Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG) at a cost of £9,400 in 2013/14. Details of Mr Myhill's Salary and Pension's benefits were disclosed in full by NLAG.
4. Mark Brassington has been seconded from Nottingham University Hospitals NHS Trust in 2014/15 at a cost of £58,887.

Definitions:

Salary

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

Taxable benefits

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

Benefits in kind

These relate to tax paid by the Trust for home to base travel on behalf of Non Executive Directors.

Pension related benefits in kind

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

No performance related pay or bonus payments have been made in 2013/14 or 2014/15.

Pension benefits 2014/15

Name and title	Notes	Real increase in pension at age 60 (bands of £2,500)	Real increase / (decrease) in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	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	£000's
Jane Lewington - Chief Executive	1						1,574		
Kevin Turner - Director of Strategy & Performance		0 - 2.5	0 - 2.5	60 - 65	185 - 190	1,269	1,200	37	
Mark Brassington - Acting Director of Performance Improvement	0 2.5	2.5 - 5	15 - 20	55 - 60	257	197	22	0 - 2.5	
David Pratt - Director of Finance & Corporate Affairs		2.5 - 5	10 - 12.5	30 - 35	90 - 95	512	420	81	
Michelle Rhodes - Director of Service Delivery		0 - 2.5	0 - 2.5	30 - 35	95 - 100	552	512	26	
Eiri Jones - Director of Nursing	3								
Pauline Pratt - Acting Director of Nursing		12.5 - 15	37.5 - 40	40 - 45	125 - 130	739	469	236	
Sunil Kapedia - Medical Director		5 - 7.5	15 - 17.5	75 - 80	235 - 240	1,640	1,451	149	
Ian Warren - Director of Human Resources	4	0 - 2.5	-	10 - 15	-	134	104	27	
Paul Boocock - Director of Estates and Facilities		0 - 2.5	5 - 7.5	25 - 30	85 - 90	446	397	38	

Notes:
1. Jane Lewington was not a member of the NHS Pension scheme in 2014/15 and as such the NHS Pensions Agency do not provide a Cash Equivalent Transfer Value
2. Mark Brassington is seconded from Nottingham University Hospitals NHS Trust
3. Eiri Jones retired on 31 January 2014 and was in receipt of her pension from this date. She returned to Trust employment until April 2014 working through a Limited Company but no further pension benefits were accrued.
4. Ian Warren is a member of the NHS Pension Scheme under the 2008 section rules. Under this section no automatic lump sum is payable.

Cash Equivalent Transfer Values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

United Lincolnshire Hospitals NHS Trust

Financial Statements for the

Year ended

31st March 2015

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FOREWORD TO THE ACCOUNTS

Financial Review - year ended 31 March 2015

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**		
	2014-15		2013-14
To break even on income and expenditure, taking one year with another. (Target excludes technical adjustments for impairment following revaluation and the impact of changes in accounting policy relating to Donated / Government Granted Assets)	**(15,278)**	**Surplus / (Deficit)**	(26,160)
	899	**Impairments**	327
	(827)	**IFRIC 12 adjustments**	16
	45	**Other adjustments**	4
	(15,161)	**Reported Performance**	(25,813)
	(49,057)	**Cumulative position against breakeven duty surplus / (deficit)**	(33,896)
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	**£0.04m**	**Undershoot**	£0.35m
To operate within a Capital Resource Limit set by the Department of Health	**£0.26m**	**Underspent**	£0.65m
To pay 95% of creditor invoices within 30 days (by number of invoices)	**87%**	**Trade**	85%
	84%	**NHS**	77%

David Pratt
Director of Finance and Corporate Affairs
June 2015

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

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

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

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

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

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

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

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

Signed **Jane Lewington** **Chief Executive**

Date: **2nd June 2015**

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

By order of the Board

Signed **Jane Lewington** **Chief Executive**

Signed **David Pratt** **Finance Director**

Date: **2nd June 2015**

Annual Governance Statement 2014/15

Scope of responsibility

As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives whilst safeguarding public funds and the organisation's assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the organisation is administered prudently and economically and that resources are applied efficiently and effectively. I 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 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. It therefore provides reasonable rather than absolute assurance of effectiveness. The governance and system of internal control of the organisations is based on an ongoing process designed to:

• identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
• evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2015 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 6 Non-Executive Directors. The Director of Operations, Director of Estates and Facilities, Acting Director of Performance Improvement and the Director of Human Resources and Organisational Development also attend the Board meetings. The Board focusses on strategic issues, whilst also receiving assurances in relation to the Trust performance on quality, the NHS constitutional commitments and finance. The Board membership has been stable for the last 12 month period.

The Board completed a self-assessment against the criteria in the Board Governance Assurance Framework in 2014. The purpose of this was to provide assurance of the effectiveness of Board governance. This was done by measuring current status and practice against various leading indicators of effective board governance. The framework was divided in to four sections, Board composition and commitment, Board evaluation, development and learning, Board insight and foresight and Board engagement and involvement. An independent review was then completed in late 2014 which included assessment of Board members and how the board operates. A plan was formulated based on the output of these reviews. The plan includes:

• A board development schedule which has been put in place to engage the Board in strategic and future facing issues for the Trust as well to undertake detailed reviews into key aspects of the Trust's annual plan
• A succession planning process to provide a more consistent flow of Board and senior management talent
• Establishing locality forums to engage our Trust members and local stakeholders. The Locality Forums are chaired by a Non -Executive member of the Board
• Patient listening clinics which the Non-Executive Directors hold and all Board members participate in a programme of Board visits to front line areas.

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

In managing the affairs of the Trust, the Trust Board is committed to the highest standards of integrity, ethics and professionalism in all areas. As part of this commitment the Board supports the highest standards of corporate governance within the statutory framework. The Trust has in place a corporate governance framework which includes standing orders and standing financial instructions and a scheme of delegation.

The Trust Board subscribes to the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles.

Supporting Committee Structures

To support the Trust Board in carrying out its duties effectively, committees reporting to the Board are formally established. A fundamental review of the committee structure was completed in 2013/14 to deliver robust governance and assurance and this has continued to be embedded during 2014/15. Each Assurance Committee of the Board has its own agreed sub structures and the Assurance Committees receive reports as outlined within their terms of reference and work programme, Each Committee provides an Assurance and Exception report to each meeting of the Trust Board. The Assurance Committee structure reflects the key strategic themes within the Trust's Annual Plan.

The key committees for governance and assurance are as follows:

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

Quality Governance Assurance Committee –provides assurance to the Trust Board that appropriate and effective governance mechanisms are in place for all aspects of Quality Governance and risk, In particular ensuring the strategic objectives and trust ambitions are being delivered ie:
• Ensure Our Patients are Safe
• Ensure that our Patients have the Best Possible Experience
• Ensure that our Treatment is Effective and Compliant
• Be A High Reliability Organisation

Finance, Performance and Investment Assurance Committee – responsible for monitoring delivery of performance and financial plans, providing appropriate assurances and/or raising concerns to the Board. Coverage includes but is not limited to the financial plan agreed with the NHS Trust Development Authority (NTDA), performance standards within the NHS Constitution and the Trust's capital programme and estate management function. The key related strategic objectives are:

• Ensure that services are Financially Viable, ie: delivery of agreed CIPs
• Ensure a Fit for Purpose estate
• Be A Well Governed Organisation.

Service Transformation Assurance Committee - responsible for overseeing progress against Service Transformation objectives and providing appropriate assurances to the Board. In particular ensuring the strategic objectives and trust ambitions are being delivered ie:
• Ensure that our services are clinically and financially sustainable; ensuring access to services locally within Lincolnshire where we can

Workforce and Organisational Development Assurance Committee - provides the Board with assurance concerning all aspects of workforce and organisational development relating In particular ensuring the strategic objectives and trust ambitions are being delivered ie:

• Ensure an engaged, empowered and healthy workforce
• Ensure that staff are appropriately developed and skilled
• Ensure that services are well led
• To assure the Board, that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of excellent quality health and social care services
• To assure the Board that strategic workforce and OD risks and issues that may jeopardise the Trust's ability to deliver its objectives are being managed in a controlled and timely way.

Clinical Executive Committee - leads the clinical and operational service delivery across the Trust and advises the Board on clinical and organisational strategy.

The Assurance Committee reports to the Board include those areas where assurance has been sought, received, and where further action to gain assurance was required and what that action is.

Capacity to handle risk

Overall responsibility for risk management rests with all members of the Board. The Director of Human Resources and Organisational Development has overall Executive level responsibility for the risk management strategy and processes within the organisation. The Director of Finance has specific responsibility for financial risks within the Trust, whilst the Medical Director holds specific responsibility for the management of clinical risks. 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 and policies and procedures that identify the levels of accountability and responsibility for all staff within the organisation.

The Trusts Risk Management Strategy and Policy and Procedures define the types of risks that may impact the Trust and the overall Trust approach to risk assessment. The strategic risks are captured in the Board Assurance Framework and form the basis of the Board's risk management agenda, supported by the Business Unit Risk Registers. Operational risks are captured within the Business Unit; Specialty and Committee structures as appropriate to the level of risk identified.

Risks are identified in the Trust by managers and the management of those risks is determined by the risk rating. The risk rating, defined in the Trust's Risk Management Policy and Procedures, is derived from evaluating the likelihood and severity of an occurrence that may impact on the Trusts objectives.

A review of the risks recorded in the Trust's Risk Register over the last year saw the number of extant risks reduced considerably and the risk rating of the remaining risks holds a lower aggregated value. This review has seen certain categories of risk reduced eg health and safety; though the reputational risk arising from ongoing Health and Safety Executive prosecutions and notices remains high. The risk profile shows high risk ratings in the Women's and Children's Business Unit.

The major corporate risks to the Trust relate to its finances, ongoing relationships with regulatory bodies, namely Health and Safety Executive and staffing levels (the appropriate levels of competency and experience). The major clinical risks relate to the management of care relating to the incident of falls; infections and medicine administration errors.

This is in addition to targeted improvement work during the year arising from successive reviews by the Keogh Review team and the Care Quality Commission to mitigate individual risks identified in 2013/2014 and the CQC revisit in March 2014.

Emergent risks are identified from a variety of sources within ULHT: learning from adverse events; the Quality Performance Improvement Committee; the Integrated Performance Report, various Dashboards; Quality Impact Assessments and Internal Review Audits. During 2014/2015 these emergent risks relate to the shortage of sufficient trained staff particularly in nursing and some therapy services. Horizon scanning for emerging risks in the short to medium term (1-5 years) is carried out by the relevant Directors and the Risk Manager. A core element of this will be risk emerging from the transformation in health and social care and its impact upon the Trust's risk profile and strategic objectives.

The Trust reported two data security breaches to the Information Commissioner's Office (ICO) in 2014/2015; one related to patient records being left unsecured in a car park whilst another related to the transfer of personal and sensitive date to a personal computer via a data stick. The latter was also reported to the police. The ICO was content with our investigations into these breaches and the Trust remains compliant with the IG toolkit.

Quality Governance is managed through the monthly Quality Governance Committee, chaired by a non-executive director. This committee takes reports from all supporting key quality committees, including Patient Safety/Clinical Effectiveness, Patient Experience and Quality Performance and Improvement Committee. A detailed annual programme of work and reporting supports this committee, which itself reports directly to Trust Board. The committee also supervises the production of the annual Quality Account and manages, through the Patient Safety and Clinical Effectiveness Committee, Serious Incidents and resulting actions, Never Events and related actions. Further committees, including Information Governance, CQC Compliance Assurance and Health and Safety address regulatory compliance and operational management, and form part of the annual work programme.

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.

The Trust's Risk Management Policy and Procedures are in place and encourage staff to report adverse incidents and near misses in order to minimise risk and take action to prevent recurrence. The Trust's Incident Reporting system has been upgraded to facilitate easier reporting. The policy and procedures underpin the Trust's Risk Management Strategy.

The structure of the Trust's Risk Register has recently been upgraded to capture strategic, operational and local risks. This gives managers at all levels the facility to identify, manage and escalate (where necessary) 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.

Increased reporting of incidents and a culture of learning lessons from adverse incidents helps mitigate against their re-occurrence and acts as a deterrent. Robust reviews of adverse incidents, near misses and recorded risks through the governance committees and specialty governance meetings provides visibility of on-going concerns at all levels.

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

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

Specialised risk management training is provided to staff who have been identified as 'Risk Handlers' to enable them to aggregate risks across their Business Unit or Specialty and consider the impact upon the Trust's strategic objectives.

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

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

The Audit Committee assess the overall adequacy of the Assurance Framework on behalf of the Accountable Officer and the Board and advises the Board in relation to the systems, processes and controls in place for 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 2014/15, 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. In addition, each Assurance Committee reviews at every meeting the parts of the Board Assurance Framework relevant to their terms of reference and then reports to the following Trust Board meeting in an Assurance Report. 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 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 of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the organisation that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report and other performance information available to me. I have been advised on my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Assurance Committees and plans to address weaknesses and ensure continuous improvement of the system are in place.

The Assurance Framework and the Risk report provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed.

The Audit Committee receives and monitors the Assurance Framework and relevant internal audit reports. It monitors and performance manages the action plans to address the recommendations from audits which have identified weaknesses in internal control. It reviews the annual report and accounts including the Trust wide governance arrangements as described. The Chair of the Audit Committee has recent and relevant financial experience and members provide rigorous challenge on reports received by the committee and ensure the application of sound accounting policies and practices.

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 reasonable assurance.

The Internal Audit reviews undertaken during 2014/15 led to the Head of Internal Audit providing a reasonable 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
• The range of individual opinions arising from risk based audit assignments

The preparation of the Quality Account has been informed by scrutiny of guidance. All data incorporated in to the Quality Account is from established sources subject to routine and regular audit of data quality. The comments from Healthwatch, the Lincolnshire Health Overview and Scrutiny Committee and the Clinical Commissioning Groups provide external assurance of the effectiveness of internal controls.

The Trust has engaged its External Auditor to provide an external assurance audit of the quality report which will be reported to the Audit Committee and Quality Governance Assurance Committee.

The Trust is committed to continuous improvement of its risk management and assurance systems and processes to ensure improved effectiveness and efficiency.

My review is also informed by:
• Opinion and reports from Internal Audit (TIAA) based on a risk based audit plan approved by the Audit Committee
• Opinion and reports from External Audit (KPMG)
• Compliance with CQC essential standards of safety and quality and CQC reports on visits and inspections
• An Information Governance Toolkit Assessment
• Results of national patient and staff surveys
• Monitoring of patient experience and complaints
• External visits and inspections
• Clinical audit reports.

Significant Issues

During the year the Trust identified the following issues.

Following a CQC re-visit in February 2015 a recommendation was made that the Trust was removed from special measures and the CQC recognised that significant improvement had been made since their previous inspection in 2014. However the visit identified that there were still some essential standards of quality and care that were not being met and required improvement. Out of a possible 113 ratings the Trust achieved 95 ‘good’ or ‘outstanding’ ratings, 16 ‘requires improvement’ and 2 ‘inadequate ratings’. The areas where the Trust still needs to take action are recruiting staff to vacancies in some services, managing and monitoring governance systems at Louth and reviewing the Trust wide system for patient appointments.

Improvement plans to take account of the CQC findings in conjunction with wider quality improvement plans have been put in place which include
• Formation of recruitment and retention group chaired by Director of Human Resources
• Agreement of an Outpatients demand and capacity management plan
• Review of governance arrangements at Louth
• Increased safeguarding and DOLS training

The Trust reported a financial deficit of £15.2m for the 2014/15 year. Whilst this was a significant improvement on the £25.4m deficit in 2013/14 and the Trust’s cost improvement target was exceeded in year, the duty to break event was not met. The Trust is reviewing its financial strategy and aims to return to financial balance at the earliest realistic point.

The Trust failed to deliver the key NHS constitutional standards for:

• A&E 4 hour wait - internally efforts have focussed on:
– ensuring good senior medical and nursing staff availability
– establishing out of hours streams at the front door including the frailty unit at Lincoln
– revised early escalation procedures.

• Planned care and referral to treatment (RTT) - we have carried out a significant programme of validation, data cleansing and capacity planning to improve the current position and reduce waiting times. The Trust assures itself of the quality and accuracy of elective waiting time data through specific training for staff, the use of electronic solutions to improve accuracy, validation processes linked to the new systems and inclusion in the internal and external audit work programmes. The risks associated with elective waiting times and specifically those attached to the new Patient Administration System (PAS) have been reviewed and assurance sought at the Finance Performance and Investment Assurance Committee throughout the year.

• Cancer pathways - the national NHS Intensive Support Team demand and capacity tool is being utilised to identify the required capacity as part of an approach to improvement in this area.

• Infection control - in common with many trusts, we continue to have isolated incidents of Clostridium difficile. In 2014/15 the Trust’s final number was 64 against a ceiling of 62. Work continues to embed and enhance infection prevention and control practice across the organisation with performance improving significantly in the last six months of the year.

• Cancelled operations – these have been in excess of the threshold throughout the year. Action plans are in place for all specialties where improvement is required.

The Trust is working with the TDA to agree an improvement trajectory to achieve compliance with the national priorities set out in the NHS TDA Accountability Framework 2014/15.

During the year 2013/14, HSMR showed a significant reduction when compared to previous years. Early indications during the year 2014/15 have shown a rise of overall trust HSMR. It is important to bear in mind that HSMR is affected by many factors not directly related to clinical care. Despite monthly and seasonal variation, crude mortality does not show a significant increase. A number of actions are being undertaken to ensure we remain focused on reducing mortality as well as reviewing the factors that influence HSMR data.

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 : Mrs Jane Lewington, 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 for the year ended 31 March 2015 on pages 16 to 60. 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 been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2015 and of the Trust's expenditure and income for the year then ended; and

- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to 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 Strategic Report and 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 NHS Trust Development Authority guidance;
- 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.

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

Respective responsibilities of the Trust and auditor

The Trust is responsible 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 review regularly the adequacy and effectiveness of these arrangements.

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 of 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 October 2014, 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 2015.

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 adverse conclusion

The Trust reported a deficit in 2013/14 of £26.2 million. It improved on this position in 2014/15, recording a deficit of £15.4m, the planned figure agreed with the NHS Trust Development Authority (TDA). The Trust's 2014/15 five year forward plan sought the delivery of a deficit of £17m for 2015/16 with reductions to allow in-year break-even in 2017/18. Following income reductions and a revised Cost Improvement Programme not included in the 2014/15 forward plan, the Trust is currently projecting a £40 million deficit for 2015/16 and has forecast an equivalent cash support requirement for the year. The projected deficit is a significant increase on the 2014/15 forward plan and as such puts at risk the date for return to break even.

The Trust is in the process of producing a medium term recovery plan to be agreed with the TDA and which will seek to address this financial uncertainty. The challenges faced are significant. The Trust is working with local health economy partners and the TDA in developing a whole health economy solution encompassing the Trust's clinical strategy and wider reconfiguration. Until this work is completed and begun to be implemented there remains an element of uncertainty over the Trust's future financial position.

Adverse conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, the matters reported in the basis for adverse conclusion paragraph above prevent us from being satisfied that, in all material respects, United Lincolnshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of United Lincolnshire Hospitals NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Neil Bellamy, Director
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St Nicholas House
31 Park Row
Nottingham
NG1 6FQ

04 June 2015

Statement of Comprehensive Income for year ended 31 March 2015

	NOTE	**2014-15 £000s**	2013-14 £000s
Gross employee benefits	10.1	**(290,059)**	(291,718)
Other operating costs	8	**(151,993)**	(154,075)
Revenue from patient care activities	5	**395,007**	388,000
Other operating revenue	6	**38,243**	37,524
Operating deficit		**(8,802)**	(20,269)
Investment revenue	12	**45**	44
Other gains	13	**11**	35
Finance costs	14	**(84)**	(103)
Deficit for the financial year		**(8,830)**	(20,293)
Public dividend capital dividends payable		**(6,448)**	(5,867)
Retained deficit for the year		**(15,278)**	(26,160)

Other Comprehensive Income

	2014-15 £000s	2013-14 £000s
Impairments and reversals taken to the revaluation reserve	**519**	3,271
Net gain on revaluation of property, plant and equipment	**5,466**	7,536
Total comprehensive net income / (expenditure) for the year	**(9,293)**	(15,353)

Financial performance for the year

	2014-15	2013-14
Retained deficit for the year	**(15,278)**	(26,160)
IFRIC 12 adjustment (including IFRIC 12 impairments)	**(827)**	16
Impairments (excluding IFRIC 12 impairments)	**899**	327
Adjustments in respect of donated / government grant asset reserve elimination	**45**	4
Adjusted retained deficit	**(15,161)**	(25,813)

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

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

The notes on pages 20 to 60 form part of this account.

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**218,723**	**(79,301)**	**54,014**	**190**	**193,626**
Changes in taxpayers' equity for 2014-15					
Retained deficit for the year	0	(15,278)	0		**(15,278)**
Net gain on revaluation of property, plant, equipment			5,466		**5,466**
Impairments and reversals			519		**519**
Transfers between reserves		1,938	(1,938)	0	**0**
New temporary and permanent PDC received - cash	38,001				**38,001**
New temporary and permanent PDC repaid in year	(14,000)				**(14,000)**
Other movements	0	1	0	0	**1**
Net recognised revenue/(expense) for the year	**24,001**	**(13,339)**	**4,047**	**0**	**14,709**
Balance at 31 March 2015	**242,724**	**(92,640)**	**58,061**	**190**	**208,335**

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
Balance at 1 April 2013	**188,040**	**(56,894)**	**46,961**	**190**	**178,297**
Changes in taxpayers' equity for the year ended 31 March 2014					
Retained deficit for the year	0	(26,160)	0	0	(26,160)
Net gain on revaluation of property, plant, equipment	0	0	7,536	0	7,536
Impairments and reversals	0	0	3,271	0	3,271
Transfers between reserves	0	3,754	(3,754)	0	0
New temporary and permanent PDC received - cash	44,683	0	0	0	44,683
New temporary and permanent PDC repaid in year	(14,000)	0	0	0	(14,000)
Other movements	0	(1)	0	0	(1)
Net recognised revenue/(expense) for the year	**30,683**	**(22,407)**	**7,053**	**0**	**15,329**
Balance at 31 March 2014	**218,723**	**(79,301)**	**54,014**	**190**	**193,626**

Statement of Cash Flows for the Year ended 31 March 2015

	NOTE	**2014-15 £000s**	2013-14 £000s
Cash Flows from Operating Activities			
Operating deficit		**(8,802)**	(20,269)
Depreciation and amortisation		**10,508**	9,708
Impairments and reversals		**(2)**	327
Donated Assets received credited to revenue but non-cash		**(304)**	(329)
Interest paid		**(35)**	(40)
Dividend paid		**(6,679)**	(5,824)
(Increase)/Decrease in Inventories		**(283)**	(786)
(Increase)/Decrease in Trade and Other Receivables		**2,028**	(5,189)
(Increase)/Decrease in Other Current Assets		**6**	1
Increase/(Decrease) in Trade and Other Payables		**1,290**	(2,177)
(Increase)/Decrease in Other Current Liabilities		**(503)**	(503)
Provisions utilised		**(1,288)**	(1,190)
Increase/(Decrease) in movement in non cash provisions		**(384)**	2,550
Net Cash Outflow from Operating Activities		**(4,448)**	(23,721)
Cash Flows from Investing Activities			
Interest Received		**46**	43
Payments for Property, Plant and Equipment		**(17,715)**	(11,117)
Payments for Intangible Assets		**(2,177)**	(799)
Proceeds of disposal of assets held for sale (PPE)		**55**	52
Net Cash Outflow from Investing Activities		**(19,791)**	(11,821)
Net Cash Outflow before Financing		**(24,239)**	(35,542)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**38,001**	44,683
Gross Temporary and Permanent PDC Repaid		**(14,000)**	(14,000)
Other Loans Received		**474**	0
Other Loans Repaid		**(60)**	0
Capital Element of Payments in Respect of Finance Leases		**(149)**	(134)
Net Cash Inflow from Financing Activities		**24,266**	30,549
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**27**	(4,993)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**983**	5,976
Cash and Cash Equivalents (and Bank Overdraft) at Year End	**26**	**1,010**	983

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.1.1 Financial Position

Although the position against the breakeven duty in 2014-15 is a £15.2 million deficit and therefore represents an uncertainty in relation to achieving the statutory break even duty in the future, the accounts have been prepared on the basis that the Trust is a going concern.

Key judgements in this decision are set out below:

- The Trust has defined income streams in place for the next 12 months.

- The National Trust Development Authority (NTDA) has in place an escalation and support process for Trusts in financial deficit to access cash.

- The NTDA has provided a letter of support confirming that cash will be made available to this Trust to meet current liabilities. This letter makes explicit reference to the NTDA view that with this guarantee of support the Financial Statements should be prepared on a going concern basis.

- The Trust along with other Lincolnshire NHS and Social Care organisations is undertaking a review of service delivery across the health economy. This review under the title ‘Lincolnshire Health and Care’ (LHAC), offers a decision making forum, to assess the county wide strategic provision of services across all health and social care bodies. In turn this offers the potential for large scale service reconfiguration and rationalisation and therefore reduced costs through improved efficiency and a reduction in duplication.

- Taking account of its own emerging clinical strategy and the inter-relationship with LHAC, the Trust is developing a revised medium term financial strategy to move towards financial sustainability in the next five years. In addition to clinical service re-configuration, this strategy will encompass continued year-on-year efficiency gains, maximising income opportunities and approaches to assessing and challenging whether the national tariff is reflective of the costs of services provided in a large rural county such as Lincolnshire.

- The Trust is planning for an in-year savings or cost improvement programme (CIP) of £19.0m in 2015-16. This is higher than the nationally set requirement and was designed to maintain the Trust’s underlying deficit at £25m, in line with 2013-14 out-turn and the 2014-15 initial plan. In practice, the Trust's final plan for 2015-16 has had to be adjusted to a £40.3m deficit, as a result, principally, of reduced funding from NHS sources.

- Regardless of the income and expenditure position, service provision is expected to continue and is evidenced within various Trust and National publications, therefore in accordance with the Government Financial Reporting Manual (FReM) interpretation of IFRIC 1 in a public sector context;
For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

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 Charitable Funds

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

1.4 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.

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

1.4.1 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.

Completed activity under Payment by results is billed one month in arrears. Any disputed activity must then be queried and that query resolved within 2 months. The Trust has assumed that all invoiced activity recorded as income as at 31 March 2015, will be paid in full.

1.4.2 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.

An annual revaluation of Trust Property, Plant and Equipment is conducted by DTZ Debenham Tie Leung Ltd (DTZ). As part of this revaluation process the Trust reviews the remaining useful life of its buildings in accordance with advice received from 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 £196.5m and is detailed in note 15.1.

Note 10.6, Pension Costs, details 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 2015.

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 a bed as at 31 March 2015, the estimated income from partially completed spells was £5.5m (31 March 2014: £4.6m). Similarly income received for the period of antenatal care has been deferred where this provision has not been completed, this totalled £2.1m (31 March 2014: £1.8m).

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

Note 35 details the Provisions recognised by the Trust at 31 March 2015. These include legal actions against the Trust in relation to employers and public Liability claims as well as employment, commercial and 'regulatory' litigation. The outcome of each individual case is uncertain and will only be determined through future legal proceedings. Key sources of information in determining the appropriate provision to recognise are reports from the NHS Litigation Authority and Trust solicitor detailing ongoing claims against the Trust and which provide an assessment of the probable outcome and costs. Total provisions recognised at 31 March 2015 were £4.8m.

Note 36, Contingent Liabilities, utilises 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 £1.35m at 31 March 2015.

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 using data extracted from the Ascribe stock system for drugs (£38.0m).

The Trust entered into a contract with a third party in 2006 in which they provide accommodation to Trust employees. As part of the contract a minimum occupancy level was guaranteed. Costs of under-occupancy are met by the Trust. Future under-occupancy charges have been estimated for the relevant properties based upon trends over the preceding 6, 12 and 24 months (after excluding any identified short term fluctuations) ending February 2015. The assets associated with this 'onerous' contract are impaired based upon this assessment.

Outstanding pay liabilities included within Note 28, trade and other payables incorporate estimates for:

- Annual Leave - based upon average pay rates for 2014-15 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 2015 - based upon actual payments for a 'similar' accounting period.

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

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from NHS commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the end of the reporting period multiplied by 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 NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

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

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS 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 Trust 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.

1.7 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.

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

1.8 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

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 following 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.

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

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.

1.9 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 £5,000.

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.

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

1.10 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). 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.

1.11 Donated assets

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.

1.12 Government grants

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.

1.13 Other Reserves

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

1.14 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.

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

1.15 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.

1.16 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.

1.17 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.

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

1.18 Private Finance Initiative (PFI) transactions

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

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

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

The liability is amortised over the lifetime of the asset in accordance with the service concession arrangement.

Other assets contributed by the NHS trust to the operator
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset an equivalent deferred income balance is recognised, representing the future service potential to be received by the Trust through the asset being made available to third party users.

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

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

1.19 Provisions

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

The discount rates applicable are 1.5% (0-5 years), 1.05% (6-10 years) and 2.2% (over 10 years) in real terms (1.3% 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 exceed the economic benefits expected to be received.

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.

1.20 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.

1.21 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.

1.22 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.

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

1.23 Financial assets

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

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

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 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.

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

1.24 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.

1.25 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.

1.26 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.

1.27 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 44 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

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

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

1.29 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).

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

1.30 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 Statement of Comprehensive Income 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.

1.31 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 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

2. Pooled budgets

United Lincolnshire Hospitals NHS Trust does not hold 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, the United Kingdom, and materially form Departments of HM Government in England.

Revenue from activities (medical treatment of patients) is analysed by customer type in note 5 to the financial statements on page 32.
Other operating revenue is analysed in note 6 to the financial statements on page 32 and materially consists of revenues from education, training and research, non patient care services to other bodies, income generation and other revenue.

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

	2014-15		2013-14	
	£000s	**%**	£000s	%
Revenue from whole HM Government	**422,447**	**97.5**	414,439	97.4
Revenue from non HM Government sources	**10,803**	**2.5**	11,085	2.6
Total	**433,250**	**100.0**	425,524	100.0

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	**2014-15 £000s**	2013-14 £000s
Income	4,372	4,109
Full cost	(2,760)	(3,199)
Surplus	**1,612**	910

2014-15 and 2013-14 figures comprise catering and car parking income from the public and staff.

5. Revenue from patient care activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	**98**	35
NHS England	**59,672**	53,375
Clinical Commissioning Groups	**322,563**	331,462
Foundation Trusts	**4**	297
NHS Other (including Public Health England and Prop Co)	**175**	0
Additional income for delivery of healthcare services	**10,000**	0
Non-NHS:		
Local Authorities	**76**	70
Private patients	**533**	626
Overseas patients (non-reciprocal)	**80**	33
Injury costs recovery	**1,368**	1,832
Other	**438**	270
Total Revenue from patient care activities	**395,007**	388,000

6. Other operating revenue

	2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**2,016**	2,178
Education, training and research	**19,458**	18,842
Receipt of donations for capital acquisitions - Charity	**304**	329
Non-patient care services to other bodies	**4,886**	4,867
Income generation	**4,372**	4,191
Rental revenue from finance leases	**177**	178
Rental revenue from operating leases	**579**	648
Other revenue	**6,451**	6,291
Total Other Operating Revenue	**38,243**	37,524
Total operating revenue	**433,250**	425,524

Other revenue in 2014-15 includes non-pay recharges £3.2m and release of deferred income relating to the Progress Housing PFI £0.5m.

7. Overseas Visitors Disclosure

	2014-15 £000	2013-14 £000s
Income recognised during 2014-15 (invoiced amounts and accruals)	**80**	33
Cash payments received in-year (re receivables at 31 March 2014)	**10**	0
Cash payments received in-year (from invoices issued 2014-15)	**42**	21
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**0**	0
Amounts added to provision for impairment of receivables (from invoices issued 2014-15)	**25**	7
Amounts written off in-year (irrespective of year of recognition)	**1**	0

8. Operating expenses

	2014-15 £000s	2013-14 £000s
Trust Chair and Non-executive Directors	**91**	60
Supplies and services - clinical	**95,259**	90,816
Supplies and services - general	**7,131**	10,047
Consultancy services	**257**	659
Establishment	**4,513**	5,409
Transport	**984**	979
Business rates paid to local authorities	**1,774**	1,757
Premises	**15,834**	17,325
Hospitality	**12**	16
Insurance	**37**	35
Legal Fees	**718**	517
Impairments and Reversals of Receivables	**(6)**	211
Inventories write down	**200**	215
Depreciation	**9,523**	9,212
Amortisation	**985**	496
Impairments and reversals of property, plant and equipment	**(2)**	327
Audit fees	**155**	164
Other auditor's remuneration*	**54**	1
Clinical negligence	**11,525**	10,734
Research and development (excluding staff costs)	**0**	0
Education and Training	**1,222**	972
Change in Discount Rate	**128**	137
Other	**1,599**	3,986
Total Operating expenses (excluding employee benefits)	**151,993**	154,075
Employee Benefits		
Employee benefits excluding Board members	**288,677**	290,288
Board members	**1,382**	1,430
Total Employee Benefits	**290,059**	291,718
Total Operating Expenses	**442,052**	445,793

*Other auditors remuneration in 2013-14 relates to assurance work completed.
The payment in 2014-15 relates to the development of an activity model for the Trust.

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.

In 2011-12 the Trust entered into a short term operating lease for land on the Lincoln site. This lease expires in March 2016.

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

The Trust leases various items of medical equipment, these leases expire in the period to December 2016.

The Trust has numerous vehicles leased which expire before February 2020.

9.1 Trust as lessee

	Land	Buildings	Other	2014-15 Total	2013-14
	£000s	£000s	£000s	£000s	£000s
Payments recognised as an expense					
Minimum lease payments				**1,745**	1,779
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**1,745**	1,779
Payable:					
No later than one year	1,347	0	301	**1,648**	1,641
Between one and five years	2,244	0	430	**2,674**	5,031
After five years	0	0	0	**0**	0
Total	**3,591**	**0**	**731**	**4,322**	6,672
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.

	2014-15	2013-14
	£000	£000s
Recognised as revenue		
Rental revenue	427	417
Contingent rents	152	231
Total	**579**	648
Receivable:		
No later than one year	276	352
Between one and five years	816	974
After five years	550	599
Total	**1,642**	1,925

10 Employee benefits and staff numbers

10.1 Employee benefits

	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure 2014-15			
Salaries and wages	**248,392**	208,286	40,106
Social security costs	**17,052**	17,052	0
Employer Contributions to NHS BSA - Pensions Division	**26,029**	26,029	0
Other pension costs	**11**	11	0
Termination benefits	**116**	116	0
Total employee benefits	**291,600**	**251,494**	**40,106**
Employee costs capitalised	**1,541**	379	1,162
Gross Employee Benefits excluding capitalised costs	**290,059**	**251,115**	**38,944**

Employee Benefits - Gross Expenditure 2013-14	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	248,450	207,061	41,389
Social security costs	16,958	16,958	0
Employer Contributions to NHS BSA - Pensions Division	26,286	26,286	0
Other pension costs	8	8	0
Termination benefits	96	96	0
TOTAL - including capitalised costs	291,798	250,409	41,389
Employee costs capitalised	80	80	0
Gross Employee Benefits excluding capitalised costs	291,718	250,329	41,389

'Other pension costs' relate to payments into the National Employment Savings Trust (NEST) defined benefit scheme.
The Pensions Act 2008 introduced a new requirement for employers to automatically enrol all eligible jobholders into a workplace pension scheme that meets certain requirements and provide a minimum employer contribution. Where employees do not meet the eligibility criteria for the NHS Superannuation scheme they are automatically enrolled within NEST.

10.2 Staff Numbers

	2014-15			**2013-14**
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**926**	741	185	944
Administration and estates	**1,106**	1,074	32	1,092
Healthcare assistants and other support staff	**1,951**	1,774	177	1,845
Nursing, midwifery and health visiting staff	**2,138**	2,011	127	2,087
Scientific, therapeutic and technical staff	**735**	708	27	734
TOTAL	**6,856**	**6,308**	**548**	6,702
Of the above - staff engaged on capital projects	**39**	**13**	**26**	2

10.3 Staff Sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	68,232	68,989
Total Staff Years	6,389	6,233
Average working Days Lost	10.68	11.07

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	**15**	13
	£000s	£000s
Total additional pensions liabilities accrued in the year	**774**	809

10.4 Exit Packages agreed in 2014-15

Exit package cost band (including any special payment element)	**2014-15** *Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	2013-14 *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	0	29	29	2	32	34
£10,000-£25,000	1	1	2	2	1	3
£25,001-£50,000	0	0	0	2	1	3
£50,001-£100,000	1	0	1	0	1	1
Total number of exit packages by type (total cost)	**2**	**30**	**32**	6	35	41
Total resource cost (£s)	**115,949**	**102,356**	**218,305**	87,236	218,213	305,449

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.

This disclosure reports the number and value of exit packages agreed 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 Exit packages - Other Departures analysis

	2014-15 Agreements	Total value of agreements	2013-14 Agreements	Total value of agreements
	Number	**£000s**	Number	£000s
Mutually agreed resignations (MARS) contractual costs	0	0	1	9
Contractual payments in lieu of notice	30	102	32	144
Exit payments following Employment Tribunals or court orders	0	0	2	65
Total	**30**	**102**	35	218
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	**0**	**0**	0	0

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

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

10.6 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 formal 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. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, 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 2012.

The Scheme Regulations 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.

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) has been used and replaced 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

	2014-15 Number	2014-15 £000s	2013-14 Number	2013-14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**101,531**	**161,260**	110,717	145,691
Total Non-NHS Trade Invoices Paid Within Target	**88,005**	**134,738**	94,289	116,874
Percentage of NHS Trade Invoices Paid Within Target	**86.68%**	**83.55%**	85.16%	80.22%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,244**	**22,013**	2,051	33,711
Total NHS Trade Invoices Paid Within Target	**2,741**	**16,262**	1,585	26,348
Percentage of NHS Trade Invoices Paid Within Target	**84.49%**	**73.87%**	77.28%	78.16%

The Better Payment Practice Code requires the United Lincolnshire Hospitals NHS 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

	2014-15 £000s	2013-14 £000s
Amounts included in finance costs from claims made under this legislation	**5**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**5**	0

12 Investment Revenue

	2014-15 £000s	2013-14 £000s
Interest revenue		
Bank interest	**45**	44
Total investment revenue	**45**	44

13 Other Gains and Losses

	2014-15 £000s	2013-14 £000s
Loss on disposal of assets other than by sale (PPE)	**(14)**	(17)
Gain on disposal of assets held for sale	**25**	52
Total	**11**	35

14 Finance Costs

	2014-15 £000s	2013-14 £000s
Interest		
Interest on obligations under finance leases	**30**	40
Interest on late payment of commercial debt	**5**	0
Total interest expense	**35**	40
Provisions - unwinding of discount	**49**	63
Total	**84**	103

15.2 Property, plant and equipment prior-year

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2013	9,425	149,932	22,125	2,751	49,687	551	6,352	302	**241,125**
Additions of Assets Under Construction	0	0	0	3,386	0	0	0	0	**3,386**
Additions Purchased	0	1,066	0	0	2,356	217	1,535	0	**5,174**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	237	23	69	0	**329**
Reclassifications	0	1,672	0	(3,561)	921	0	695	0	**(273)**
Reclassifications as Held for Sale and Reversals	0	0	0	0	(2,040)	(12)	0	0	**(2,052)**
Disposals other than for sale	0	0	0	0	(1,400)	0	(602)	0	**(2,002)**
Revaluation	463	2,347	642	0	0	0	0	0	**3,452**
Impairments/negative indexation charged to reserves	0	(157)	0	0	0	0	0	0	**(157)**
Reversal of Impairments charged to reserves	0	3,428	0	0	0	0	0	0	**3,428**
At 31 March 2014	**9,888**	**158,288**	**22,767**	**2,576**	**49,761**	**779**	**8,049**	**302**	**252,410**
Depreciation									
At 1 April 2013	0	0	0	0	32,531	461	4,236	99	**37,327**
Reclassifications as Held for Sale and Reversals	0	0	0	0	(2,040)	(12)	0	0	**(2,052)**
Disposals other than for sale	0	0	0	0	(1,384)	0	(601)	0	**(1,985)**
Revaluation	290	(4,068)	(306)	0	0	0	0	0	**(4,084)**
Impairments/negative indexation charged to operating expenses	0	1,149	0	0	0	0	0	0	**1,149**
Reversal of Impairments charged to operating expenses	(290)	(532)	0	0	0	0	0	0	**(822)**
Charged During the Year	0	3,451	306	0	4,377	42	1,003	33	**9,212**
At 31 March 2014	**0**	**0**	**0**	**0**	**33,484**	**491**	**4,638**	**132**	**38,745**
Net Book Value at 31 March 2014	9,888	158,288	22,767	2,576	16,277	288	3,411	170	**213,665**
Asset financing:									
Owned - Purchased	9,888	157,695	0	2,576	15,005	267	3,340	170	**188,941**
Owned - Donated	0	512	0	0	931	21	71	0	**1,535**
Owned - Government Granted	0	81	0	0	0	0	0	0	**81**
Held on finance lease	0	0	0	0	341	0	0	0	**341**
On-SOFP PFI contracts	0	0	22,767	0	0	0	0	0	**22,767**
Total at 31 March 2014	**9,888**	**158,288**	**22,767**	**2,576**	**16,277**	**288**	**3,411**	**170**	**213,665**

15.3 (cont). Property, plant and equipment

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

Donor description	**£000s**
United Lincolnshire Hospitals NHS Trust Charitable Fund	243
Friends of Lincoln Hospital	7
Novartis UK	54
Total Donated assets received in 2014-15	**304**

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

Valuation
The Trust commissioned a desktop revaluation of land, buildings and dwellings in March 2015. 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 Sleaford, Laundon House site are non-specialised and have therefore been valued at open market value based upon existing use.
Similarly, Progress Housing Accomodation units are valued at open market value based on existing use.

All other items of property, plant and equipment acquired after 1st January 2009 are held at historic cost.

Accounting policies notes 1.4.2 and 1.8 provide further information regarding the method of valuation.
The asset lives for intangibles and plant and equipment are calculated when the asset is initially recognised. The lives for buildings and dwellings are in accordance with the latest valuation report prepared by the external valuer.

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

	Minimum Asset Life	**Maximum Asset Life**
Intangibles		
Software Licences	3	10
Property, Plant and Equipment		
Buildings exc Dwellings	1	86
Dwellings	57	74
Plant and Machinery	3	15
Transport Equipment	5	10
Information Technology	3	10
Fixtures and fittings	5	10

The following table provides details of property valued on an open market valuation basis at 31 March 2015.

	2014-15	2013-14
	£000s	£000s
Land	60	50
Dwellings	23,668	22,767
Buildings	116	116
Total	**23,844**	22,933

The gross value of fully depreciated assets still in use is £19.13m (2013-14 £20.74m).

A number of buildings owned by the Trust are leased out under operating leases to other NHS bodies. The net book value of these assets at 31st March 2015 was £5.4m as set out in the table below:

	£000s
Net book value 31 March 2014	6,414
Correction to opening balance	(1,177)
Restated Net book value 31 March 2014	5,237
Additions 2014-15	33
Disposals 2014-15	0
Depreciation	(111)
Increase in valuation 31 March 2015	199
Reversal of previous impairments	16
Net book value 31 March 2015	**5,374**

16.1 Intangible non-current assets

2014-15	IT - in-house and 3rd party software	Computer Licenses	Total
	£000s	£000s	£000s
At 1 April 2014	**20**	**4,198**	**4,218**
Additions Purchased	0	393	**393**
Reclassifications	0	4,531	**4,531**
At 31 March 2015	**20**	**9,122**	**9,142**
Amortisation			
At 1 April 2014	**19**	**2,361**	**2,380**
Disposals other than by sale	0	0	**0**
Charged during the year	1	984	**985**
At 31 March 2015	**20**	**3,345**	**3,365**
Net Book Value at 31 March 2015	**0**	**5,777**	**5,777**
Asset Financing: Net book value at 31 March 2015 comprises:			
Purchased	0	5,744	**5,744**
Donated	0	33	**33**
Total at 31 March 2015	**0**	**5,777**	**5,777**

Revaluation reserve balance for intangible non-current assets

	£000s	£000s	£000s
At 1 April 2014	0	0	**0**
Movements	0	0	**0**
At 31 March 2015	**0**	**0**	**0**

16.2 Intangible non-current assets prior year

2013-14	**IT - in-house and 3rd party software**	**Computer Licenses**	**Total**
	£000s	**£000s**	**£000s**
Cost or valuation:			
At 1 April 2013	20	3,552	**3,572**
Additions - purchased	0	799	**799**
Reclassifications	0	273	**273**
Disposals other than by sale	0	(426)	**(426)**
At 31 March 2014	**20**	**4,198**	**4,218**
Amortisation			
At 1 April 2013	15	2,295	**2,310**
Disposals other than by sale	0	(426)	**(426)**
Charged during the year	4	492	**496**
At 31 March 2014	**19**	**2,361**	**2,380**
Net book value at 31 March 2014	1	1,837	**1,838**
Net book value at 31 March 2014 comprises:			
Purchased	1	1,798	**1,799**
Donated	0	39	**39**
Total at 31 March 2014	**1**	**1,837**	**1,838**

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 2014-15

	2014-15 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Total charged to Departmental Expenditure Limit (DEL)	**0**
Other	103
Changes in market price	(105)
Total charged to Annually Managed Expenditure (AME)	**(2)**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Other	518
Changes in market price	(1,037)
Total impairments for PPE charged to reserves	**(519)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(2)**
Total impairments for Intangible Assets charged to Reserves	**0**
Total Impairments of Intangibles charged to SoCI	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**(2)**
Overall Total Impairments charged to SOCI	**(2)**

Donated and Government Granted Assets, included above

PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

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

		£000s	£000s
Reversals of previous impairments charged to SOCI in previous years	Lincoln Site Land	(520)	
	Grantham Site Land	(350)	
	Other - buildings	(155)	
			(1,025)
Impairments Charged to SOCI in current year	Radiotherapy new build Lincoln	437	
	Other buildings	483	
			920
			(105)

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

		£000s	£000s
Reversals of previous impairments charged to SOCI in previous years	Progress Housing Onerous Contract net reversal (see below*)	(901)	
			(901)
Impairments Charged to SOCI in current year	Buildings to be demolished / permanently vacated	1,004	
			1,004
			103

*As set out in notes 1.4.2 and 37, the Trust entered into a contract with a third party in 2006 in which accomodation is provided to Trust employees at Lincoln, Boston and Grantham sites. As part of the contract, a minimum occupancy level was guaranteed. Costs of under occupancy are met by the Trust.

The assets associated with this 'onerous' contract are reviewed and impaired annually as appropriate based upon an assessment of future occupancy levels.

Impairments charged / (reversed) in 2014-15 against this contract were:

Site:	£000s
Lincoln	(381)
Boston	(1,056)
Grantham	536
Total	**(901)**

17 Analysis of impairments and reversals recognised in 2014-15

	Total	Property Plant and Equipment	Intangible Assets
	£000s	£000s	£000s
Impairments and reversals taken to SoCI			
Loss or damage resulting from normal operations	**0**	0	0
Over-specification of assets	**0**	0	0
Abandonment of assets in the course of construction	**0**	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	**0**	0	0
Loss as a result of catastrophe	**0**	0	0
Other	**103**	103	0
Changes in market price	**(105)**	(105)	0
Total charged to Annually Managed Expenditure	**(2)**	**(2)**	**0**
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			0
Total impairments for PPE charged to reserves			**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(2)**	**(2)**	**0**

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

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 2015	31 March 2014
	£000s	£000s
Property, plant and equipment	**6,749**	916
Intangible assets	**0**	1,899
Total	**6,749**	2,815

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	980	0	9,047	0
Balances with Local Authorities	8	0	343	0
Balances with NHS bodies outside the Departmental Group	46	0	0	0
Balances with NHS bodies inside the Departmental Group	14,897	0	4,050	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	5,684	1,345	24,488	15,571
At 31 March 2015	**21,615**	**1,345**	**37,928**	**15,571**
prior period:				
Balances with Other Central Government Bodies	12,626	0	11,419	0
Balances with Local Authorities	68	0	843	0
Balances with NHS bodies outside the Departmental Group	12	0	0	0
Balances with NHS Trusts and FTs	6,373	0	1,599	0
Balances with Public Corporations and Trading Funds	0	0	635	0
Balances with Bodies External to Government	4,539	1,333	18,406	15,942
At 31 March 2014	**23,618**	**1,333**	**32,902**	**15,942**

The prior period figures have been amended to include 'other liabilities' (£16.1m) and 'borrowings' (£0.5m) which were omitted from the 2013-14 published accounts. These are all classified within bodies external to Government.

21 Inventories

	Drugs	Consumables	Work in Progress	Energy	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**3,059**	**4,379**	**0**	**17**	**7,455**	7,455
Additions	37,971	475	0	93	**38,539**	38,446
Inventories recognised as an expense in the period	(37,954)	(4)	0	(98)	**(38,056)**	(37,963)
Write-down of inventories (including losses)	(180)	(20)	0	0	**(200)**	(200)
Balance at 31 March 2015	**2,896**	**4,830**	**0**	**12**	**7,738**	**7,738**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**6,054**	10,337	**0**	0
NHS prepayments and accrued income	**8,774**	8,373	**0**	0
Non-NHS receivables - revenue	**904**	802	**0**	0
Non-NHS receivables - capital	**37**	0	**0**	0
Non-NHS prepayments and accrued income	**3,305**	2,076	**0**	0
PDC Dividend prepaid to DH	**69**			
Provision for the impairment of receivables	**(455)**	(573)	**(313)**	(250)
VAT	**944**	199	**0**	0
Interest receivables	**0**	0	**0**	0
Operating lease receivables	**59**	115	**0**	0
Other receivables	**1,924**	2,289	**1,658**	1,583
Total	**21,615**	23,618	**1,345**	1,333
Total current and non current	**22,960**	24,951		
Included in NHS receivables are prepaid pension contributions:	**0**			

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

Other receivables includes £3.3m (of which £1.7m is non current) 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 2015	31 March 2014
	£000s	£000s
By up to three months	**2,694**	2,851
By three to six months	**531**	1,109
By more than six months	**462**	902
Total	**3,687**	4,862

22.3 Provision for impairment of receivables

	2014-15	2013-14
	£000s	£000s
Balance at 1 April 2014	**(823)**	(654)
Amount written off during the year	**49**	42
Amount recovered during the year	**126**	48
(Increase)/decrease in receivables impaired	**(120)**	(259)
Balance at 31 March 2015	**(768)**	(823)

The provision for impairment of receivables incorporates two elements:

- a specific provision against invoiced receivables where the Trust believes that it is unlikely to receive payment: £149,000 (2013-14 £218,000)

- a general provision of 18.9% (2013-14: 15.8%) against income receivable from the Compensation Recovery Unit (CRU): £619,000 (2013-14 £605,000).

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

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.

25 Other current assets

	31 March 2015 £000s	31 March 2014 £000s
EU Emissions Trading Scheme Allowance	**0**	6
Total	**0**	6

26 Cash and Cash Equivalents

	31 March 2015 £000s	31 March 2014 £000s
Opening balance	**983**	5,976
Net change in year	**27**	(4,993)
Closing balance	**1,010**	983
Made up of		
Cash with Government Banking Service	**1,000**	973
Cash in hand	**10**	10
Cash and cash equivalents as in statement of financial position	**1,010**	983
Cash and cash equivalents as in statement of cash flows	**1,010**	983
Patients' money held by the Trust, not included above	**0**	0

27 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Plant and Machinery	Transport and Equipment	Total
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	3	**3**
Less assets sold in the year	0	0	0	(3)	**(3)**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	**0**
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2015	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2013	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	**0**
Balance at 31 March 2014	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2014	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 was unable to sell this property and the land value was therefore transferred back to property plant and equipment in 2012-13. At the present time the property although remaining vacant and not in use is not being actively marketed.

Equipment sold in 2014-15 related predominantly to various medical equipment items with nil net book value which were sold to external parties at a profit of £24,843.

28 Trade and other payables

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
NHS payables - revenue	**1,765**	1,304	**0**	0
NHS accruals and deferred income	**2,285**	2,719	**0**	0
Non-NHS payables - revenue	**8,928**	5,192	**0**	0
Non-NHS payables - capital	**5,527**	1,693	**0**	0
Non-NHS accruals and deferred income	**9,342**	11,941	**0**	0
Social security costs	**2,754**	2,755	**0**	0
PDC Dividend payable to DH	**0**	162	**0**	0
Tax	**2,631**	2,597	**0**	0
Other	**3,911**	3,887	**0**	0
Total	**37,143**	32,250	**0**	0
Total payables (current and non-current)	**37,143**	32,250		
Included above:				
outstanding Pension Contributions at the year end	**3,624**	3,607		

29 Other liabilities

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
Lease incentives	**24**	24	**728**	752
Other	**479**	479	**14,366**	14,845
Total	**503**	503	**15,094**	15,597
Total other liabilities (current and non-current)	**15,597**	16,100		

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

30 Borrowings

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
Loans from other entities	**118**	0	**296**	0
Finance lease liabilities	**164**	149	**181**	345
Total	**282**	149	**477**	345
Total other liabilities (current and non-current)	**759**	494		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2015		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 Years	0	282	**282**
1 - 2 Years	0	299	**299**
2 - 5 Years	0	178	**178**
Over 5 Years	0	0	**0**
TOTAL	**0**	**759**	**759**

31 Other financial liabilities

The Trust has no 'other' financial liabilities.

32 Deferred revenue

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2014	**2,519**	611	**0**	0
Deferred revenue addition	**2,920**	2,519	**0**	0
Transfer of deferred revenue	**(2,519)**	(611)	**0**	0
Current deferred Income at 31 March 2015	**2,920**	2,519	**0**	0
Total deferred income (current and non-current)	**2,920**	2,519		

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 (Other)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
Within one year	**183**	179	**164**	149
Between one and five years	**188**	372	**181**	345
After five years	**0**	0	**0**	0
Less future finance charges	(26)	(57)		
Minimum Lease Payments / Present value of minimum lease payments	**345**	494	**345**	494
Included in:				
Current borrowings			**164**	149
Non-current borrowings			**181**	345
			345	494

Finance leases as lessee	**31 March 2015 £000s**	31 March 2014 £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 it has granted long leases to other NHS bodies.

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

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

	Gross investments in leases		Present value of minimum lease payments	
Amounts receivable under finance leases (buildings)				
Of minimum lease payments	**31 March 2015 £000s**	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £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		
Gross Investment in Leases / 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

	Gross investments in leases		Present value of minimum lease payments	
Amounts receivable under finance leases (land)				
Of minimum lease payments	**31 March 2015 £000**	31 March 2014 £000	**31 March 2015 £000**	31 March 2014 £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		
Gross Investment in Leases / 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 2015 £000	31 March 2014 £000
The unguaranteed residual value accruing to the Trust	0	0
Accumulated allowance for uncollectible minimum lease payments receivable	0	0

Rental revenue	**31 March 2015**	31 March 2014
Contingent rent	**177**	178
Other	**0**	0
Total rental revenue	**177**	178

35 Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Restructuring	Other	Redundancy
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2014	**6,428**	2,706	2,270	697	615	140
Arising during the year	**1,134**	87	1,032	0	15	0
Utilised during the year	**(1,288)**	(188)	(661)	(100)	(327)	(12)
Reversed unused	**(1,646)**	(15)	(728)	(597)	(259)	(47)
Unwinding of discount	**49**	49	0	0	0	0
Change in discount rate	**128**	128	0	0	0	0
Balance at 31 March 2015	**4,805**	**2,767**	**1,913**	**0**	**44**	**81**
Expected Timing of Cash Flows:						
No Later than One Year	**2,223**	185	1,913	0	44	81
Later than One Year and not later than Five Years	**715**	715	0	0	0	0
Later than Five Years	**1,867**	1,867	0	0	0	0

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

As at 31 March 2015	**109,308**
As at 31 March 2014	91,313

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

The provision for Early Departure Costs (Pensions) has been assessed using average life expectancies and is thus uncertain as to amount and timing of cash flows.

The provision for legal claims relates to third party liability and property expenses claims and claims made against the Trust in relation to employment, commercial and other litigation issues. In addition to the amount provided within the Trust's accounts, details of contingent liabilities and assets relating to these claims are given in note 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.

Other provisions relate to costs associated with potential retirements due to ill health and relocation expenses.

36 Contingencies

	31 March 2015 £000s	31 March 2014 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(3)**	0
Employment Tribunal and other employee related litigation	**(541)**	0
Redundancy	**0**	0
Other	**(806)**	(633)
Net value of contingent liabilities	**(1,350)**	(633)
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

Other' contingent liabilities reported above comprise the potential costs and fines in excess of those provided for within provisions (note 35). Specifically they relate to litigation cases brought by the Health and Safety Executive and a commercial contract dispute.

Similarly 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 is not disclosed as this information could prejudice the position of the Trust in certain cases.

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

37 PFI and LIFT - additional information

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

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

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

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

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

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

In the event that the 85.3% occupancy rate is not achieved, the Trust is invoiced by Progress Housing for the shortfall. An assessment of historic occupancy levels and trends is undertaken annually as a means to estimate the potential future liability. The estimated future value of this liability is offset against the value of the asset.

The Trust has recorded the assets on its balance sheet in accordance with IAS 17, with the corresponding liability being shown as an 'other liability'. This is amortised to the income and expenditure account over 40 years with an end date of 31st March 2046.

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

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	**2014-15 £000s**	2013-14 £000s
Total charge to operating expenses in year - Off SoFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**0**	0
Total	**0**	0
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Total	**0**	0

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2014-15 £000s**	2013-14 £000s
No Later than One Year	**503**	503
Later than One Year, No Later than Five Years	**2,012**	2,013
Later than Five Years	**13,082**	13,584
Subtotal	**15,597**	16,100
Less: Interest Element	**0**	0
Total	**15,597**	16,100

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2014-15 £000s**	2013-14 £000s
No Later than One Year	**503**	503
Later than One Year, No Later than Five Years	**2,012**	2,013
Later than Five Years	**13,082**	13,584
Total	**15,597**	16,100

The present value imputed finance lease obligations for on SOFP PFI contracts due, analysed by when PFI payments are due, was incorrectly reported as nil within the 2013-14 published accounts.

The prior year comparitor values have therefore been restated above.

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

38 Impact of IFRS treatment - current year

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

	2014-15 £000s	2013-14 £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)		
Depreciation charges	**319**	306
Impact on PDC dividend payable	**258**	213
Total IFRS Expenditure (IFRIC12)	**(324)**	519
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(503)**	(503)
Net IFRS change (IFRIC12)	**(827)**	16
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2014-15	**0**	0
UK GAAP capital expenditure 2014-15 (Reversionary Interest)	**0**	0

39 Financial Instruments

39.1 Financial risk management

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

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the 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 Trust Development 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 revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 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 Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

39.2 Financial Assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Receivables - non-NHS	0	1,345	0	**1,345**
Cash at bank and in hand	0	1,010	0	**1,010**
Total at 31 March 2015	**0**	**2,355**	**0**	**2,355**
Receivables - non-NHS	0	1,333	0	1,333
Cash at bank and in hand	0	983	0	983
Total at 31 March 2014	0	2,316	0	2,316

39.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Other borrowings	0	414	**414**
PFI and finance lease obligations	0	15,942	**15,942**
Other financial liabilities	0	4,902	**4,902**
Total at 31 March 2015	**0**	**21,258**	**21,258**
Other borrowings	0	0	0
PFI and finance lease obligations	0	17,097	17,097
Other financial liabilities	0	6,622	6,622
Total at 31 March 2014	0	23,719	23,719

40 Events after the end of the reporting period

There are no events which have occurred between the end of the reporting period and authorisation of the financial statements on 2 June 2015 that require further disclosure.

41 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 (Associate Non Executive Director ULHT) / Trustee - St Barnabas Hospice	21,485	745,019	9,459	202,495
Mr K Darwin (Non Executive Director ULHT) / Governor - University of Lincoln	35,009	295,072	0	7,027
Mr K Darwin (Non Executive Director ULHT) / Chairman - Investors in Lincoln	10,999	0	0	0
Mr N Muntz (Non Executive Director ULHT) / Managing Director Siemens Industrial Turbo Ltd (Lincoln)	878,319	0	116	0
Prof S Barnett (Non Executive Director ULHT) / Chief Operating Officer Rotherham NHS FT (spouse)	120	0	0	0
Mr M Oko (ENT Consultant) / The Snoring Disorders Centre Ltd	1,740,891	0	65,901	0

Non Executive Director Nick Muntz left the Trust in July 2014. During his employment with the Trust he also held the position of Managing Director at Siemens Industrial Turbo Ltd, part of the larger Siemens Group. No contractual relationship exists between the Trust and Siemens Industrial Turbo Ltd.
Mr Muntz was not engaged in any part of the decision making processes affecting the contractual relationship with the wider Siemens Group. The payments made to Siemens in 2014-15 were made to Siemens PLC, Siemens Diagnostics and Siemens Hearing. 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 2014-15 this amounted to £337,000.

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

CCGs
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority
NHS Trust Development Authority
NHS England

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

The Trust has also received donations of £303,556 (2013-14 : £329,401) to fund capital acquisitions from a number of charitable funds, the Corporate Trustee of which is the Trust Board.

42 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	248,954	33
Special payments	346,825	326
Total losses and special payments	595,779	359

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	820,664	218
Special payments	331,559	200
Total losses and special payments	1,152,223	418

In August 2013 there was a fire which caused significant damage to the boiler house and surrounding buildings on the Grantham site. This resulted in losses of £616,000. An insurance claim was submitted in 2013-14; proceeds are expected to be received during 2015-16.

Included within the losses figure are losses resulting from the disposal of out of date stocks. The movement in the number of cases reported from 218 in 2013-14 to 33 in 2014-15 results primarily from a change in counting methodology.

43. 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.

43.1 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**	**2013-14 £000s**	**2014-15 £000s**
Turnover	289,429	294,154	344,309	353,280	391,141	392,202	407,975	422,802	425,524	**433,250**
Retained surplus/(deficit) for the year	(15,043)	(13,761)	12,488	366	(4,002)	(14,177)	(7,060)	(5,207)	(26,160)	**(15,278)**
Adjustments for impairments	0	0	0	4,821	5,284	297	6,873	5,192	327	**(2)**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	507	139	4	**45**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	0	0	0	0	16	**74**
Other agreed adjustments	4,913	15,043	0	0	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**	**(25,813)**	**(15,161)**
Break-even cumulative position	**(14,886)**	**(13,604)**	**(1,116)**	**4,071**	**5,353**	**(8,527)**	**(8,207)**	**(8,083)**	**(33,896)**	**(49,057)**

* 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.

	2005-06 %	**2006-07 %**	**2007-08 %**	**2008-09 %**	**2009-10 %**	**2010-11 %**	**2011-12 %**	**2012-13 %**	**2013-14 %**	**2014-15 %**
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	(6.07)	**(3.50)**
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)	(7.97)	**(11.32)**

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.

43.2 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%.

43.3 External financing

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

		2014-15	2013-14
		£000s	£000s
External financing limit (EFL)		**24,274**	35,953
Cash flow financing	**24,239**		35,542
Unwinding of Discount Adjustment	**0**		63
External financing requirement		**24,239**	35,605
Under spend against EFL		**35**	348

43.4 Capital resource limit

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

	2014-15	2013-14
	£000s	£000s
Gross capital expenditure	**24,030**	9,688
Less: book value of assets disposed of	**(81)**	(17)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(304)**	(329)
Charge against the capital resource limit	**23,645**	9,342
Capital resource limit	**23,907**	9,994
Underspend against the capital resource limit	**262**	652

44 Third party assets

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

	31 March 2015	31 March 2014
	£000s	£000s
Third party assets held by the Trust	**0**	0