CARING FOR YOU

United Lincolnshire Hospitals NHS
NHS Trust

Annual Report and Final Accounts 2015-16

Accessibility

This annual report and full accounts will be available at www.ulh.nhs.uk

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

Contents

Chief executive and chair's foreword

Welcome to our annual report for 2015/16. We are both relatively new to the Trust starting part way through the year in December and March respectively but we quickly got to know our hospitals and staff. We have been deeply impressed by the commitment of staff to do the best for patients, as well as their dedication to the Trust.

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

As well as reported challenges, we also have much to be proud of. One of our key achievements was meeting the wait for treatment within a maximum of 18 weeks target for the last eight months of the year. This is the best performance in Lincolnshire for many years.

We've made good progress with developing our clinical strategy options. Following extensive staff and clinical engagement, Trust Board, Clinical Executive Committee (CEC) and Clinical Strategy Implementation Group (CSIG) reviewed the draft options in March putting us in a good position for developing a strategic outline case in 2016/17 to inform our own plans and Lincolnshire Health and Care (LHAC).

Despite many vacancies, the quality of our services have been maintained or improved and we have taken forward innovative approaches. The Lincolnshire Heart Centre continues to deliver results above the national average, we carried out the first EVAR (endovascular aneurysm repair) procedure in the county at Pilgrim, the Hospice in a Hospital at Grantham continues to shine and the endoscopy units at Louth and Lincoln received the esteemed JAG status. Many of our staff have won or been nominated for national, regional and ULHT awards and some of our doctors have been awarded professorships.

We also invested in the future of services with a new state of the art linear accelerator (LINAC) at Lincoln, revamped maternity and gynaecology wards at Pilgrim, committed to invest in the neonatal facility at Lincoln, developed an Ambulatory Assessment Care unit at Grantham and started work on dementia friendly wards at Lincoln.

What are our plans for 2016/17? It will be a year of transformation for the Trust. As well as aiming to deliver our plans around quality, performance and finance we need to make improvements to the way we work for our patients and begin to transform our approach to the way we manage the movement of urgent care patients around and out of hospital. We will also look to carry out more elective work and improve how we employ, support, train and develop our workforce. Our plan, whilst realistic is also stretching because this time next year we need to be geared-up to deliver our services in a more sustainable way. More information on our objectives for the year can be found on page 30.

Our foreword to this annual report would not be complete without thanking our dedicated and talented staff. Over 7,000 people work at our hospitals, delivering services to the local community, which continue to be safe, and of high quality despite increasing pressures throughout the NHS. We are immensely proud to lead an organisation with so many hard-working colleagues who provide such important services. Thank you to all our staff for their continuing dedication to delivering high quality care.

We hope that you find this report informative and that it demonstrates to you just how hard we are working to really focus on what matters to our patients.


Jan and Dean

Performance report

Overview

About us

United Lincolnshire Hospitals Trust (ULHT) is one of the biggest acute hospital trusts in England serving a population of around 731,500 people.

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

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

We have an annual income of £440 million. Our main contracts are with Lincolnshire East, Lincolnshire West, South Lincolnshire, and South West Lincolnshire clinical commissioning groups (CCGs).

We provide services from three acute hospitals in Lincolnshire:

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

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health Services NHS Trust or local GP clusters. These include:

- Louth County Hospital
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital, Spalding
- Skegness and District General Hospital.

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

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

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

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

How we are organised

The Trust Board
The Board is responsible for setting the overall policy and strategy for the organisation and for ensuring the effective implementation of that strategy. It establishes a committee structure that supports it in driving the delivery of the principal objectives through a process of risk management, control and assurance.

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

The non-executive directors are independent people, drawn from the local community and appointed by the NHS Trust Development Authority (subsequently called NHS Improvement) on behalf of the Secretary of State for Health.

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

The remuneration of executive and associate directors is determined by a remuneration and terms of service committee. During 2015/16, this committee consisted of the chair and the non-executive directors.

More about our Board, Board members and committees can be found in the governance section on page 32 onwards.

Staff profile
Our staff are fundamental to our ability to deliver high quality services that put our patients at the centre of all that we do and provide the best quality care with passion and pride. At the end of 2015/16, the Trust employed 7,521 staff.

Table 1 on page 5 shows the percentage breakdown of staff groups at the Trust by whole time equivalent. It shows the large majority (79%) of our staff were female.

In terms of the Trust's senior managers, of the 10 executive directors employed in the year 2015/16, 3 were women and 7 were men. All our executive directors are very senior manager bands.

For full analysis of staff numbers, see the accounts note 9.2 (audited).

Table 1: Analysis of ULHT staff by gender

	Headcount			Percentage	
Staff Group	Female	Male	Total	Female	Male
Add prof scientific and technic	152	77	229	66.38%	33.62%
Additional clinical services	1143	153	1296	88.19%	11.81%
Administrative and clerical	1229	240	1469	83.66%	16.34%
Allied health professionals	321	88	409	78.48%	21.52%
Estates and ancillary	610	290	900	67.78%	32.22%
Healthcare scientists	65	54	119	54.62%	45.38%
Medical and dental	290	531	821	35.32%	64.68%
Nursing and midwifery registered	2128	136	2264	93.99%	6.01%
Students	11	3	14	78.57%	21.43%
Total ULHT Workforce	**5949**	**1572**	**7521**	**79.10%**	**20.90%**

Purpose, vision and objectives

We have one purpose, one vision, five values, three aims and in 2015/16 had seven annual objectives.

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

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

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

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

The long-term ambition for the Trust is to develop the potential to become a national, if not international, centre for rural health and care. We will develop our research, develop our staff and education. The aim is to improve patients' access to services locally, improve our quality of services whilst meeting challenging financial balances across the health and care system in Lincolnshire.

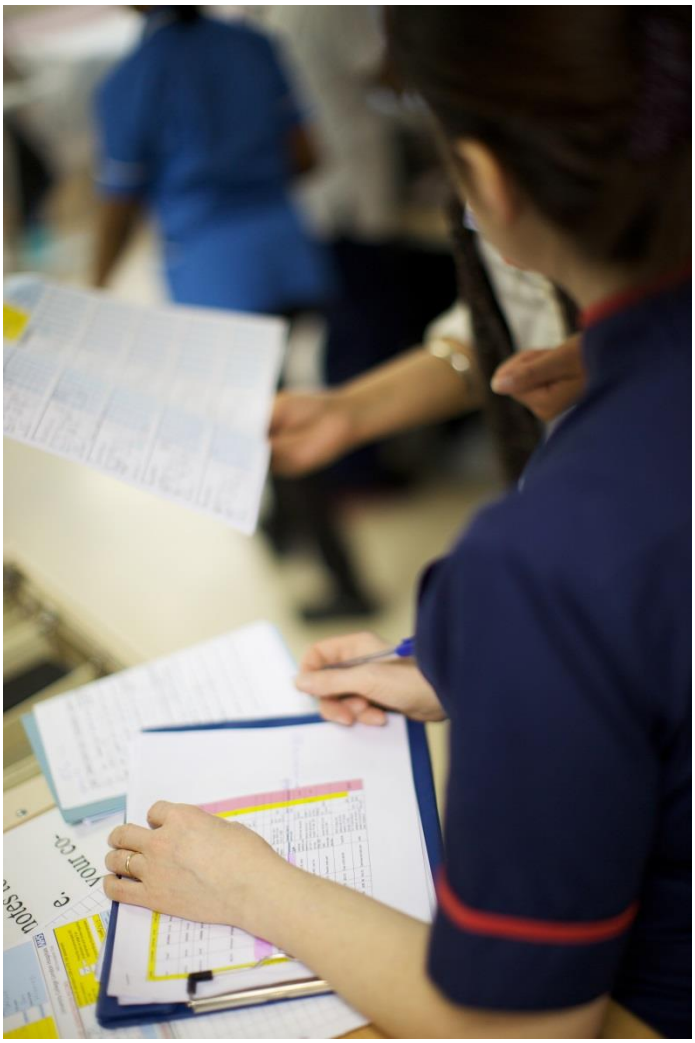
Our objectives and performance

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

Our key risks and issues

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

The Trust is working hard to address these issues, which are causing difficulties across the whole NHS, and will continue to do so in 2016/17. The Trust has a corporate risk register outlining what it perceives its key challenges to be.



We have developed our Integrated Annual Operational Plan for 2016/17 to clearly lay a strong foundation for sustainable improvement over the next five years. We aim to put in place the capability and capacity to deliver Lincolnshire's sustainability and transformation plan (STP) and set out our intent of long term improvement though our medium term plan. We will embrace new technologies and develop a dynamic and fully engaged responsive workforce.

Performance challenges

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

Staffing challenges

We ended the year with 339 nurse vacancies and 124 doctor vacancies. We worked hard to recruit staff locally, nationally and internationally including nurses and doctors from the EU, and despite our turnover rate being low, we have an over reliance on locum and agency staff to get our staff numbers up.

To help we have a number of actions in place. We are working in partnership with other trusts developing a Lincolnshire attraction strategy to market Lincolnshire and individual organisations to clinical staff countrywide. We will progress working on developing Lincolnshire as a Centre of Rural Health and Care, building our research, development and education footprint through collaboration with regional universities to attract medical recruitment to a centre of excellence through a 'Team Lincolnshire' approach. We are also looking at innovative ways to overcome reliance of registered nurses by employing assistant occupational therapists, physiotherapist and pharmacy technicians on wards.

Financial challenges

Like much of the rest of the NHS, ULHT faces unprecedented financial challenges and has done for a few years now, but 2015/16 was particularly challenging. In some areas such as acute medicine and emergency care, rising demand for services meant the need to use more agency staff and that income-generating elective surgery sometimes had to be cancelled so that emergency patients could be treated instead.

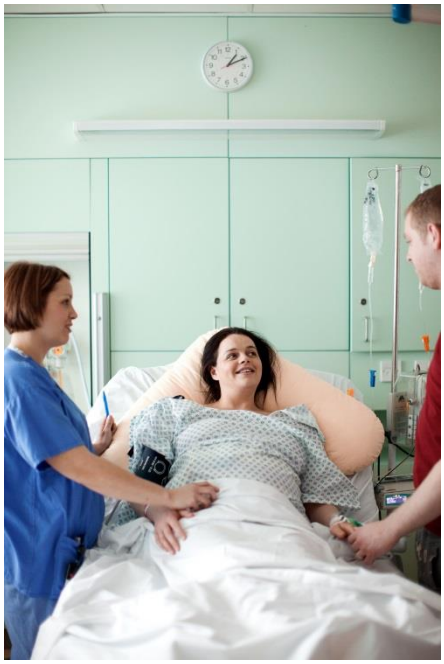
Changes in our healthcare system would still be required even if the current deficit did not exist. Demand for our services will increase, particularly with an ageing population and increased prevalence of long term conditions and co-morbidities. This means we need to explore how health and social care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

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

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

In 2016/17, the challenges will continue, as the Trust is required to make further efficiencies at a time when demand continues to rise.

Population challenges



The population of Lincolnshire is estimated to be 731,500 (ONS, May 2014). Lincolnshire has one of the fastest growing populations in England and it is projected to rise to 838,200 by the year 2033. Greater life expectancy and increased long-term conditions will increase the demand for healthcare. If we stand still we will soon be unable to meet all the needs of increasing numbers of patients.

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

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

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

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

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

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

In the medium to long term, we need to reconfigure our services as part of Lincolnshire Health and Care (LHAC) to deliver sustainable, safe care for the people of Lincolnshire.

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

More information on our risks and how we manage them can be found in our accountability report from page 37.

Review of 2015/16

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

We had seven main objectives for 2015/16 and made great strides in meeting them. Below is a snapshot of some our achievements.

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

One step closer to becoming a digital organisation
Following a successful two month pilot on Johnson Ward at Lincoln, eOBS (electronic clinical observations) roll out started at Pilgrim in February.

Pilgrim was chosen as there are fewer nurses there and this system helps free up clinical time.

We tested various systems with NLAG, our preferred partner, and decided on WebV version 2.3. This will fundamentally change how we work.

Consultants are now able to search for their patients anywhere in the Trust, staff are able to audit in real time whether they are up to date with their observations and food orders will automatically be cancelled when a patient is discharged saving money and reducing waste.

It will be rolled out everywhere from the start of 2016/17 and will continue into 2017.

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

The redevelopment of Stow Ward at Lincoln into an innovative dementia friendly ward started and is due to finish early 2016/17. This new facility will help reduce levels of anxiety for patients.

We modernised the boilers at Grantham hospital as the old steam plant was reaching the end of its life.

We approved a £2.1m investment in upgrading the neonatal unit at Lincoln County Hospital. The investment will see the existing unit ungraded into a state of the art facility housing between 18 and 20 cots. The unit will move down to the revamped first floor of the maternity block whilst work takes place on the 6th floor. It is anticipated that the new unit will be up and running by early 2017.

New maternity ward at Pilgrim
The final pieces of a new state of the art maternity ward at Pilgrim were installed in March.

We've invested £5.2 million in Pilgrim hospital to create a new 22 bed maternity unit alongside a 16 bed gynaecology and post-natal ward to replace the outdated M1 and M2 wards there.

The new £3.7 million modular unit took great skill and effort from facilities staff and Kier, our partners in the scheme.

Most of the work was done off site, including construction of bathrooms with blinds. Almost 26 parts varying in size arrived from the north of Hull and were put together using cranes over a two week period. This helped to save us money and limit disruption to the site.

The new, modern unit will be an extension to the main hospital. It will provide a welcoming and comfortable environment for patients, visitors and staff. This is great news for our patients and our staff. It will open in summer 2016.

Lincoln County hospital treats first patients with state-of-the-art radiotherapy
The first cancer patients were treated using new state-of-the-art radiotherapy in June 2015.

A new linear accelerator (LINAC) started work at Lincoln County Hospital to deliver radiotherapy to patients with cancer, it works by delivering high energy x-rays to the patient's tumour.

The new machine is part of an ULHT £6.7 million investment to replace all three linear accelerators at Lincoln hospital by 2017 and to improve the environment in which treatment is delivered.

The new LINAC uses the most modern technology to provide radiotherapy treatment to patients with tumours to any part or organ in the body. Treatment on the new machines is also more targeted and precise in destroying the cancer cells while sparing the surrounding healthy tissue.

This new equipment was accompanied by a refurbishment of the department to provide easier access for patients and a more comfortable environment.

£1 million boost for x-ray services in Lincolnshire hospitals
Following a £900,000 investment, Lincolnshire patients now benefit from faster and more effective treatment following a major investment in equipment.

The Trust upgraded its x-ray departments at Lincoln County Hospital and John Coupland Hospital, Gainsborough with both units providing fully digital x-ray images and radiography.

This improved the experience of patients, helped doctors to provide much faster diagnoses and health professionals to access the information at the touch of a button.

Direct digital radiography is faster than the alternative film, with images produced in seconds. The quality of the images is better which increases the accuracy of diagnoses and the amount of radiation received by a patient is reduced.

Nurse shines on tackling pressure ulcers

Trust nurse consultant in tissue viability, Mark Collier, was invited to present a session on reducing avoidable heel pressure ulcers at the National Eliminating Heel Pressure Ulcers Conference in London. In February, he also won Pressure Care Nurse of the Year at the British Journal of Nursing awards.

This is brilliant recognition for Mark and the wider Trust on the extensive work carried out throughout the Trust's hospitals over the past few years to significantly reduce the number of pressure ulcers patients experience to some of the lowest rates in the country.

Over the past two years, the Trust has reduced the incidence of pressure ulcers by nearly 40% to 0.5%, compared with the national rate of 4-6%. The Trust has also reduced the incidence of heel pressure ulcers specifically down from over 20% to 6% within orthopaedics.

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

New surgery in the county

The first Lincolnshire patient was treated within the county using a new technique for a potentially life-threatening condition.

A 71 year old patient suffered an AAA (abdominal aortic aneurysm that forms when the main artery weakens and expands) and underwent surgery to strengthen the artery wall, preventing it from rupturing.

He was the first patient to be treated within the county using a technique that involves small incisions being made and a stent put in through the artery to strengthen the wall. AAAs are most common in men aged 65 and over and they can rupture suddenly, leading to death.

Previously patients had to travel to hospitals outside of the county to have the AAA repaired using keyhole surgery.

This operation was carried out by ULHT vascular surgeons Nityanand Arya and Peter Lee Chong and interventional radiologist Dr Guerino Centini, alongside two consultants from Leicester University Hospitals NHS Trust who are working in partnership with ULHT to develop the service. It's one of the first partnerships between two NHS trusts and is being upheld as an example to other trusts.

New A&E service for Grantham and District Hospital

A major new emergency service, officially opened at Grantham and District Hospital by NHS England CEO Simon Stevens, is providing faster, better care for patients who are well enough to be seen and discharged on the same day.

The new Assessment and Ambulatory Care (AAC) unit provides urgent, same day treatment for patients, so that they don't have to be admitted to hospital if there is no requirement for this.

Patients with certain symptoms who arrive via A&E or are sent by their GP are now fast tracked for assessment and appropriate tests by the acute medical team, enabling them to be treated quickly and sent home.

This provides a more positive experience for patients and frees up hospital beds for those who really need them. The service will also play a significant role in reducing the workload in A&E, particularly in the busier winter months.

The new unit at Grantham was created through a joint investment by United Lincolnshire Hospitals NHS and the South West Lincolnshire CCG.

National recognition for our endoscopy units
Louth and Lincoln endoscopy units were recognised nationally for the high standards of care they provide.

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

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

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

New website
In February 2016, the Trust launched a new website to give patients and members of the public better access to information about their local hospitals.

The new website was developed with the input of staff, patients and public groups across the county and is more patient focussed and user friendly than the previous site.

It provides information for patients on what to do in an emergency as well as how to contact a ward or cancel an appointment in Lincolnshire's main acute hospitals. The new site also makes it easier for patients and visitors to access information about each hospital site, including where to park, how to get to the site and visiting times for each ward.

The site provides information for prospective employees to the Trust, under our new jobs section, which includes the benefits of working for ULHT, information about living in Lincolnshire as well as training and development opportunities.

Alongside the new website, we have launched new branding for the Trust under its existing strapline 'Caring for You'.

The website has also been optimised for use on mobile devices, such as mobile phones and tablets to make the content easier for people to access on the go.

The new website can be accessed from the current ULHT website address www.ulh.nhs.uk.

Cataract surgery closer to home for Lincolnshire patients
Patients needing cataract surgery are now able to have both their pre-operative assessments and operations closer to home thanks to two new services at hospitals in Gainsborough and Spalding.

The Trust invested £300,000 in eye surgery equipment at John Coupland Hospital in Gainsborough and Johnson Community Hospital in Spalding, allowing surgeons to carry out cataract operations at both hospitals as well as minor procedures such as ptosis (droopy eyelid) surgery and surgery to correct abnormal eyelid position at Spalding.

The new service means that many patients no longer have to travel to other hospitals in the county for these procedures, or for the pre-operative assessments that come before them.

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

Learning from the best with the ULH Way
Over the last few years we have used Listening into Action to listen to and engage our staff and have improved how engaged our staff feel. However, our staff engagement scores are still in the bottom 20% of NHS trusts of a similar type and so, in July 2015, we learnt from other trusts that have consistently achieved high levels of staff engagement, and developed the ULH Way.

Engaging our staff has proven benefits both for a healthy and happy workforce and also for the quality of patient care. Put simply, the more engaged our staff feel, the better the outcomes for patients. So it's important to get it right.

The ULH Way has three elements 1) training staff in engagement tools and supporting them to select and apply the tools to improve staff engagement in their ward or department. 2) a staff survey (pulse check) at Trust and at team level that identifies the things that may be enabling or inhibiting staff engagement that we use to prioritise action to improve and 3) integration of staff engagement into the way we all work every day.

We have also trained our first nine teams from wards and departments in eight engagement tools to help them improve staff engagement in their area. We will train up to 10 teams every six months.

Prestigious dementia friends' status
Lincolnshire hospital staff were among the first in England to receive backing from the Alzheimer's Society for the way they provided dementia training.

Staff at all our hospitals developed three types of training to help meet the needs of patients with dementia. These have been recognised as meeting the requirements to achieve 'Dementia Friends' status by the Alzheimer's Society. The move recognises the

Trust's dedication and work to understand what dementia means for patients and hospital visitors.

The Trust offers dementia foundation training for newly qualified nurses and healthcare support workers undertaking their NVQ. It also offers the Making a Difference in Dementia Care Course for junior staff.

More than 300 staff went through the training using Barbara's Story, developed by Guy's and St Thomas's Hospital in London which focusses on a patient with dementia and her experience in hospital. The film highlights what staff should be doing individually and collectively to understand difficulties faced by dementia patients, their families and carers.

3. Recruit the right staff to the right places

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

We went out to recruit in Eastern Europe because there are established communities from these areas in the county. We also recruited in the Philippines.
So far, 25 EU nurses have joined the Trust and we made offers to over 100 registered nurses in the Philippines. They will join us in summer/ autumn of 2016.

90 newly qualified nurses welcomed
In September, we welcomed 90 newly qualified nurses to our wards.

This fantastic success was part of the Trust's recruitment campaign and followed close partnership working with local and regional universities to encourage the new recruits to choose Lincolnshire hospitals.

The majority of the nurses came from the University of Lincoln, with others from neighbouring cities and the Open University.

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

New appointments of hospital pharmacists boost Lincolnshire teams
We recruited eight new pharmacists to work at hospitals across the county.

These successful appointments were made following a recruitment initiative in the UK and Spain.

All of the new pharmacists joined the clinical teams to provide ward based clinical services to patients at Lincoln, Boston, Grantham and Louth hospitals.

The new staff members are highly qualified and are helping us to provide a dedicated clinical pharmacy service to optimise medication for our patients and improve clinical care.

Talent academy
In June, we launched our Talent Academy as part of our long-term strategy to 'grow our own' staff. This is a great project and shows innovation in solving our recruitment problems.

Talent Academy is an initiative to help Lincolnshire's hospitals grow their own talent, raising awareness and aspirations among the Lincolnshire school community. This also involves projects encouraging work experience in job roles on hospital sites and a new apprenticeship scheme which will be launched soon.

In December we launched our school careers events, aimed at helping to improve the recruitment of staff into Lincolnshire's hospitals by focussing on the development of local talent.

4. Move towards a clinically led organisation

Celebrating 10 years of clinical research excellence
ULHT's Lincolnshire Clinical Research Facility (LCRF) celebrated its 10th birthday in May 2015.

The Trust is at the leading edge of several fields in clinical care, enabling patients to receive some of the latest drugs and treatments available.

Clinical trials that are hosted within the Trust cover a range of areas including cancer, stroke, diabetes, paediatrics, dementia and neurodegenerative diseases.

Having clinical trials of different disease areas open in ULHT mean Lincolnshire patients have access to the latest drugs/treatments available and these drugs are supplied to the NHS for free as they are part of the trial.

Since 2004, the number of clinical trials and studies undertaken in the Trust's hospitals has increased from 12 to almost 200. The number of staff in the team has increased from three to over 40 and income generated by trials has risen from £4,500 to more than £1.6 million.

5. Deliver our 2015/16 financial plan

Financial overview
We ended the year with a deficit of £56.9 million, meeting our in-year adjusted financial target but not the plan set out at the start of the year of £40.3 million. There are various reasons for our deficit, one of the most important being high spending on agency nurses and doctors to cover a shortage of permanent staff and the additional beds open. These were needed for the high number of patients who are medically fit for discharge but couldn't be discharged due to a lack of care out of hospital.

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

We have many actions and plans in place to save money and boost our income, and we are working with the wider NHS to make sure we do this. Finance is a key part of our 2016/17 integrated annual plan and our medium term plan.

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

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

90k in 90 days

The Trust embarked on a campaign to encourage all staff and visitors to take small actions each day to make big savings that can be put back into patient care.

The campaign was launched as a challenge to save £90,000 in 90 days. The idea of the campaign was to encourage long-term changes in behaviour and save even more.

Working with partners Sustainable Advantage, Cofely GDF Suez and Veolia, we encouraged staff, patients and visitors to take small actions that would have a big impact on finances and the environment, such as switching off lights when not in use, recycling more and reporting leaking taps.

The campaign was so successful that we were shortlisted in the HSJ Awards 2015, in the Improving Environmental and Social Sustainability category. The category had over 1,600 entries, so to be shortlisted was a fantastic achievement.

We will run the campaign again in 2016/17 encouraging positive sustainable behaviours with a target to reduce energy consumption by 3% to 5% during 2016/17.

200 ways staff made a difference

To reduce our deficit, we asked our staff for ideas to save money and boost our income. Some fantastic ideas were received.

One idea came from orthopaedic consultants that will save the Trust £600k a year by standardising the type of prostheses we use. This saving is without using the cheapest product available.

Another member of staff made a suggestion about the use of a piece of equipment that could save the Trust £25,000 a year. The Trust spends £80,000 every year on replacing pulse oximeter probes, much of the cost is due to wear and tear but it has been noticed that a proportion of this could be saved if the probes were stored correctly. While many of those using the probes are being conscientious in keeping them tied tightly, it causes the cables to break prematurely if they are too tight, so we stated an awareness campaign for those using the machines about their proper use and storage.

We acted on a staff suggestion to change the grading of paper available to order from 80gsm to 70gsm. Following a successful trial of the new paper, this is now in place which will make a saving of £6,784 over 12 months.

We also rolled out a staff suggestion for clinical areas to cancel rented equipment as soon as it is no longer needed. This could save £2,500 per month.

In the ophthalmology clinic at Lincoln County Hospital, savings are being made in procurement by using a traffic-light sticker system which highlights which products are expensive and which alternatives are available. The scheme is a joint campaign between NHS Supplies and the RCN called ‘small changes, big difference’ and is being rolled out across the Trust.

6. Improve performance

Meeting important 18 week target for patients
In August, the Trust met one of the key constitutional standards - referral to treatment (incomplete) within 18 weeks - for the first time in 16 months. We met the target for eight months of the year and we just missed meeting the overall annual target.

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

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

From strength to strength on complaints
We received national recognition on how we dealt with our complaints at ULHT.
The Trust was criticised by the CQC in 2013 for how we handled complaints but the complaints team, clinicians and support staff have championed our new approach – See It My Way. Responsiveness is key to helping patients and their relatives at often difficult and distressing times.

This team effort has massively reduced our number of overdue complaints down to a small number and improved how quickly we respond to patients. The quality of our responses has also improved.

Our progress was recognised in August 2015, when the Parliamentary and Health Services Ombudsman (PHSO), Dame Julie Mellor, visited the Trust. She praised the new approach and was enormously impressed by our focus on improving the complaints system by looking at it from the patient's perspective. Dame Julie took away some best practice and learning.

Patients getting straight to test for their colonoscopy
Patients needing investigative tests on their bowel are now being seen up to two weeks earlier thanks to a pilot project in Lincolnshire's hospitals.

We piloted the use of a new way of booking in colonoscopy tests for patients with suspected cancer at Lincoln County Hospital. Colonoscopies are procedures where the large intestine is examined using an endoscope often used to help in diagnosis of colon cancer and other bowel conditions.

This involved the patients being assessed for their need for testing by a specialist over the phone, rather than having to attend hospital for an outpatient appointment before their test is booked.

This reduces the waiting time for a colonoscopy by up to two weeks, and also reduces the stress and inconvenience for patients as they have one less visit to hospital. Previously, patients would have had to wait up to two weeks for an appointment with a specialist in hospital to be assessed before any further tests could be booked.

Outpatients revamp at Lincoln County
The good progress made in 2014/15 on turning Lincoln outpatients around continued.

The self-check in kiosk usage improved since the introduction of the central reception desk in February 2015. This has improved from 38.8% to 65.4%. This is freeing up significant administration time to do other tasks.

As part of the £500,000 investment into the outpatients department, Clinic 11 underwent a range of improvements including improved lighting and signage and self-check-in kiosks, all helping to enhance the patient experience.

Improving discharge of patients at Pilgrim
The experience of leaving hospital has been improved with a pilot of a new discharge process at Pilgrim Hospital.

The two wards on level six at the hospital have made changes to the way patients are discharged at the end of their stay. This not only includes making it quicker and easier, but also improves the patient experience and the quality of care provided.

Just a few of the changes to really make a difference to the patient experience of being discharged from hospital included:

- Planning a predicted date of discharge for every patient and the steps that will need to be taken to get there.
- Introduction of the Ticket Home - a ticket that contains a patient's predicted discharge date in writing so that patients and families can make arrangements to ensure the date is met.
- Simplifying documentation so that paperwork doesn't hold up a discharge.
- Encouraging pharmacy to liaise directly with the ward to ensure medicines are prepared ready for a patient to leave hospital.
- Working with transport teams to pre-empt patient transport requirements for the date of discharge.
- Reviewing the cases of all patients who have been in hospital more than 5, 10 and 15 days to see what can be done to get them home.

Emergo
ULHT demonstrated it could manage a major incident well by participating in a national emergency planning exercise. The EMERGO system is a major incident simulation tool which allows hospitals to carry out a real-time training exercise without affecting the hospital's daily business.

This training event involved staff from across the hospital who would be called upon to act during a major incident. It had been designed to aid decision making in complex emergencies and to help hospitals to plan and manage their response to incidents.

Overall, the Trust managed the response to the simulated incident extremely well with very few patients being put at risk of a preventable death or preventable complication, despite dealing with over 250 patients in a four hour period. Even with the distance between hospitals, they still communicated and worked well together. Good leadership was shown in all departments despite the pressure they were all under.

The Trust achieved all of the objectives set for the exercise and was congratulated by NHS England.

7. Set out our plans for the future

Clinical strategy in development
In 2014, ULHT launched its clinical strategy. We will reform our services and want to deliver better services in Lincolnshire. We want all hospitals and services in Lincolnshire to be safe and viable.

In 2015/16, we made significant progress with the development of our clinical strategy.

Development of the clinical strategy started with the establishment of the Clinical Strategy Implementation Group chaired by the Medical Director, Dr Suneil Kapadia.

A number of clinical project teams were established to develop the future clinical strategy for clinical services, these teams included:

- Women and children's services chaired by Dr. Shirine Boardman
- Emergency care services chaired by Dr. Neil Hepburn
- Orthopaedic services chaired by Mr. Mohit Gupta
- Breast services chaired by Dr. Gurdip Samra

These clinical project teams developed the clinical service model options that have been presented to the Trust Board. The options went through a non-financial options appraisal process, and were shared with the wider clinical teams.

Good progress has been made with the case for change being quickly identified and agreed by all in the Clinical Strategy Implementation Group. This can be summarised as follows:

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

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

Critical care services – d16 specification new requirements
NHS England has issued a new specification for critical care services (level 2 and level 3), and the specification is going to pose challenges to all three ULHT existing critical care services (Lincoln, Pilgrim and Grantham) to deliver services that meet the specification requirements. Grantham will face the hardest challenge in that to meet the new specification.

Delivery of Constitutional Standards and Good Clinical Outcomes/Patient Experience

The organisation has to cancel planned procedures on a regular basis due to a shortage of beds that have been used for medical emergencies. As a result, the patient often has to wait longer than the constitutional standard of 28 days to be re-scheduled for their surgical procedure. This is not good for the patient, and results in loss of activity for the organisation that has to be re-scheduled, at times with associated premium cost attached.

Patients needing treatment for cancer are often delayed due to shortage of beds, and again this results in cancellation of surgery, and on occasion, chemotherapy and radiotherapy, although these two treatment modalities are generally delivered in an outpatient setting. Again, this is not good for the patient from the perspective of having life-saving treatment delayed, or palliative care for symptom management delayed, and also leads to psychological stress for some patients. For the organisation, it results in failure in performance against the constitutional standards for cancer, and subsequent financial penalties imposed by the Clinical Commissioning Groups.

The case for change goes much further than summarised above, but this provides a high level summary of the challenges we are currently

Throughout the development of the clinical strategy, there has been regular interaction with key stakeholders both inside and outside of the organisation, including but not limited to: the Health Overview and Scrutiny Committee, local MPs, local councils, LHAC (Lincolnshire Health and Care programme), clinical commissioning groups and the ULHT locality forums. Each of these stakeholder groups has had an opportunity to understand the process adopted for the development of the clinical strategy, the emerging direction for ULHT, and have had opportunities to contribute to the discussions.

The ULHT clinical strategy has been shared with the LHAC partners for consideration in the LHAC programme. Work continues internally now to develop the detailed service strategies.

This performance report overview is only part of our annual report and accounts. Further information can be found in sections B and C.

A performance analysis

Overview

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

We have kept our focus on infection control, pressure ulcers and falls. This has seen improved infection control practices and lower instances of MRSA and clostridium difficile - although we acknowledge there is still more that we can do.

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

The Trust took significant steps during 2015/16 to improve its RTT position, which resulted in meeting the target for eight months running, although not the overall year target. Work will continue to maintain and improve performance in the context of significant increases in demand.

Cancer performance has been mixed during 2015/16, and the Trust has not met the 62 day standard consistently throughout the year. Performance against the 2 week wait targets has been better.

The Trust didn't meet the A&E performance within year or at year end for 2015/16. Performance has never fallen below 80%.

The Trust's performance in 2016/17 will be improved through the delivery of the integrated annual operational plan.

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

Standard	Achieved	Narrative
A&E 4 hour wait	✗	The Trust continues to experience increased patient demand which contributed to challenges around emergency care and in particular our A&E performance target of 95%. We achieved 86.5%. We have problems with flow, limited resources – beds and staff - are a recognised issue for many trusts, and delayed transfers of care are creating a shortage of available beds, contributing to difficulties with meeting the A&E target.
Planned care and referral to treatment (RTT)	✗	We met the RTT standard of 92% for eight consecutive months, demonstrating our ability to deliver sustainable performance and meet the constitutional standard in this area. However, we didn't meet the annual target.
Cancer pathways	✗	The Trust achieved improved cancer performance in some areas particularly against 14 day standards where our performance was better than the standard for a consecutive four months by the end of the year. We have had some success meeting or exceeding the 31 day standards for 10 out of 12 months. In all areas of 62 day standard, demand and patient choice continues to cause challenges to diagnose all patients within appropriate timescales.
Cancelled ops	✗	Our cancelled operations performance was 1.14%, above the national target of 0.80%. Due to increase in number of emergency admissions and a lesser extend due to the junior doctors' strikes.
Infection control	✓	We had one case of MRSA and met our C Diff target of 58 against 59. In year, we restructured our infection control team and refocused our work.
Diagnostics	✓	We continued to do well against our diagnostics standards, with the waiting times standard being achieved in 10 out of the 12 months.

A performance summary

The Trust continued its improvement journey in 2015/16, making steady progress in planned care delivery against core constitutional standards. The Trust has delivered the RTT 92% incomplete standard for eight consecutive months and continues to perform well in diagnostic access within six weeks.

The Trust has also seen improvements in its cancer performance – notably delivering higher performance against two week standards. Challenges do remain as we move into 2016/17, with a strong improvement focus on A&E and 62 day cancer standards. These areas are underpinned by system-wide action plans in collaboration with our health and social care partners. With activity levels increasing, improved efficiency and increased productivity are key. Making the best use of limited resources will be help to deliver performance against the required standards going into 2016/17.

Table 3 year on year performance data 2013/14 – 2015/16 for all standards

Target Area	2013/14	2014/15	2015/16
A&E wait	94.54%	90.67%	86.50%
Delayed transfers of care	2.65%	4.82%	6.05%
12 Hour trolley breaches	0	1	0
18 weeks to treatment - incomplete	93.07%	85.43%	91.88%
52 week breaches	6	13	14
Cancelled operations	1.42%	1.81%	1.94%
Diagnostics waits	99.22%	97.17%	99.23%
Cancer 2 week wait	93.22%	87.70%	91.81%
31 day cancer	96.90%	95.95%	97.30%
62 day cancer	81.29%	74.36%	75.08%
MRSA	3	1	1
C.Difficile	61	65	58
VTE assessment	95.96%	96.41%	94.69%
Fractured neck of femur	78.20%	78.90%	70.27%
PPCI – 90 minute door to balloon		97.26%	96.80%

Performance against national targets – a responsive organisation

A&E performance

The Trust continued to experience increased patient demand that have contributed to challenges around emergency care and in particular our A&E performance target of 95%. There is a known national challenge around A&E waiting times with statistics showing 9% of patients waiting more than four hours against a target of 5%. Problems with flow and limited resources – beds and staff - are a recognised issue for many trusts and delayed transfers of care are creating a shortage of available beds, contributing to difficulties with meeting the A&E target.

Through our ‘Perfect Week’ initiative, performance is improving as we aim to enable patients to go home as soon as they are fit to do so, freeing up valuable beds for new admissions. The Trust is also working with commissioners and health and social care partners to establish schemes – both internal and external – to improve our A&E

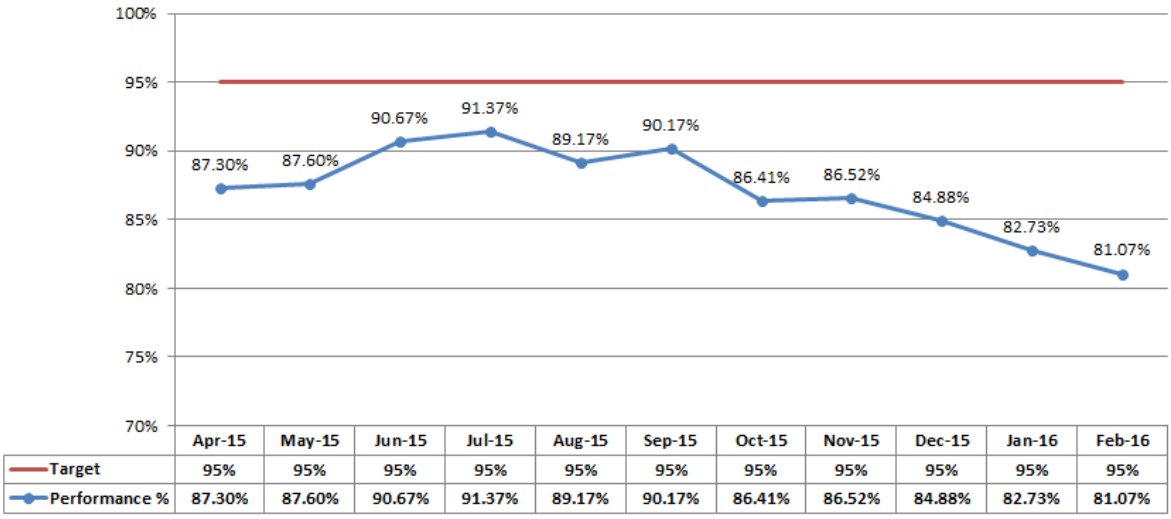
performance. This includes integrated discharge hubs, seven day working in therapies and pharmacy and increasing our short stay bed stock.

Performance by site is shown in table 4 and performance month by month is shown in graph 1.

Table 4 - A&E attendances in 2015/16 by hospital

A&E attendances 2015/16	Attendances	Breaches	Performance
Grantham	32,480	2,008	93.82%
Boston	55,660	10,881	80.45%
Lincoln	73,524	8,935	87.85%
ULHT Trust (incl. LCHS diverts)	161,664	21,824	86.50%

Graph 1 – A&E performance month by month



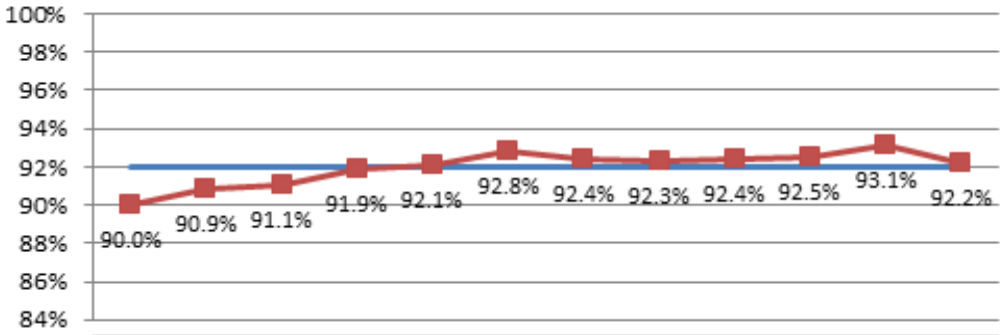
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Performance %	87.30%	87.60%	90.67%	91.37%	89.17%	90.17%	86.41%	86.52%	84.88%	82.73%	81.07%

Referral to treatment

By the end of 2015/16, we met the Referral to Treatment (RTT) standard of 92% for eight consecutive months, demonstrating our ability to deliver sustainable performance and meet the constitutional standard in this area. This is a great achievement for the Trust and is part of a national trend of improvement in treating patients within maximum waiting times. We intend to sustain this performance throughout 2016/17, to continue to drive performance upwards and ensure we meet the standard in each specialty.

Graph 2 overleaf shows month by month performance for the RTT standard.

Graph 2 – RTT performance month by month

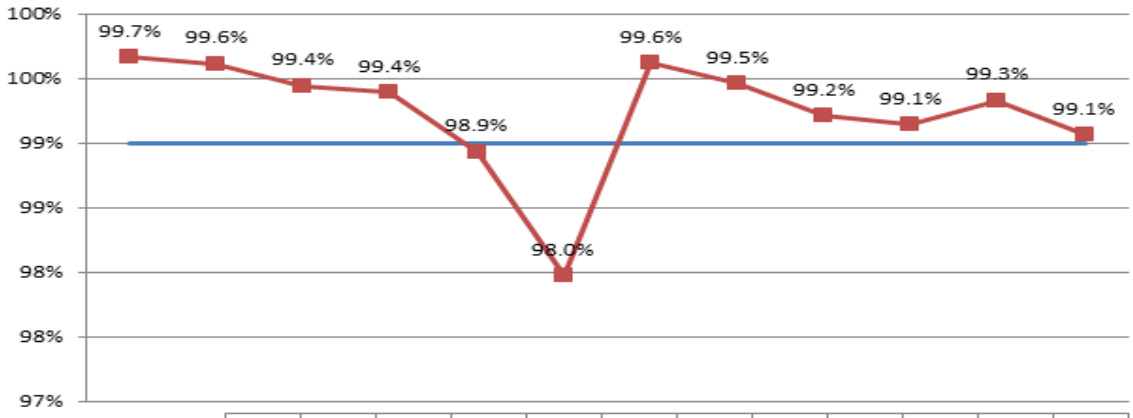


	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Performance %	90.0%	90.9%	91.1%	91.9%	92.1%	92.8%	92.4%	92.3%	92.4%	92.5%	93.1%	92.2%

Diagnostics

We continued to do well against our diagnostics standards. As shown in graph 3 below the waiting times standard was achieved in 10 out of the 12 months - a substantial move from three out of 12 last year. This is a very encouraging improvement bearing in mind the challenges around resources, speciality staffing, equipment availability and a percentage increase in demand in the area.

Graph 3 – Diagnostics 6 week wait performance month by month



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Performance %	99.7%	99.6%	99.4%	99.4%	98.9%	98.0%	99.6%	99.5%	99.2%	99.1%	99.3%	99.1%

Cancer standards

The Trust achieved improved cancer performance in some areas during 16/17, particularly against 14 day standards where our performance was better than the standard for four consecutive months by the end of the year. We have had some success meeting or exceeding the 31 day standards for 10 out of 12 months. The performance for each standard is shown in table 5 overleaf.

We are working hard to improve performance against the 62 day standard, however, in all areas demand and patient choice continues to cause challenges to diagnose all patients within appropriate timescales. With an increased number of referrals and the subsequent demand on diagnostics, such as breast diagnostics (mammograms and ultrasound), MRI and CT, we need to improve our diagnosis times to avoid patient breaches and provide patients with a quicker flow to treatment.

Our cancer performance targets remain extremely challenging but they provide a focus for collaborative working with our partners to achieve improvement.

Table 5 – Cancer target performance

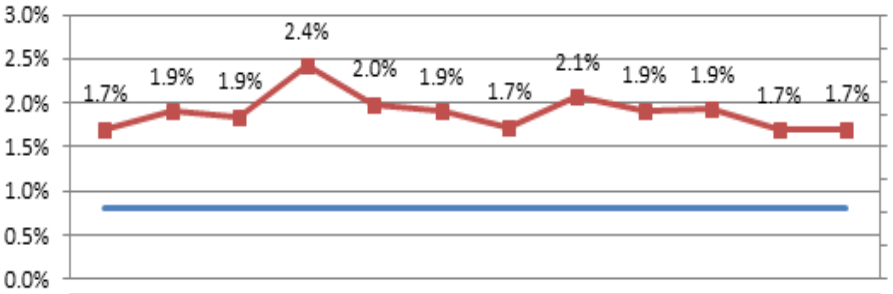
	Standard	Trust Performance
2 week wait suspected cancer	93%	91.50%
2 week wait symptomatic breast	93%	84.10%
31 day decision to treatment	96%	97.31%
31 day subsequent treatment: drug	98%	97.06%
31 day subsequent treatment: surgery	94%	93.90%
31 day subsequent treatment: radiotherapy	94%	88.52%
62 day referral to treatment	85%	75.57%
62 day screening	90%	86.13%
62 day consultant upgrade	85%	91.77%

Cancelled operations

Our cancelled operations performance is 1.14%, above the national benchmark figure of 0.80%. The Trust is committed to reducing the number of cancelled operations and is implementing audit recommendations as well as undertaking a review of bed availability and usage to inform how this can be achieved. This is largely dependent on the work we do in urgent care to try to improve bed flow to reduce the number of cancellations.

Graph 4 below shows cancelled operations each month for the year.

Graph 4 Cancelled operations



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
ULHT Cancelled ops % of Elective spells	1.7%	1.9%	1.9%	2.4%	2.0%	1.9%	1.7%	2.1%	1.9%	1.9%	1.7%	1.7%
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%
ULHT - on the day cancellations	99	110	115	135	119	116	105	126	110	110	95	106

Developing an effective organisation: money and resources

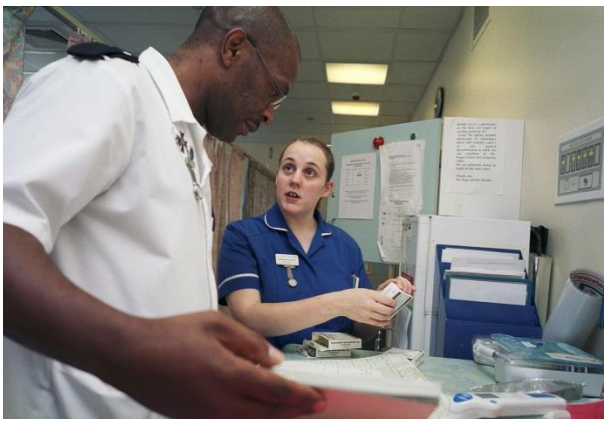
The Trust is committed to maintaining and promoting the health and wellbeing of its employees. Our key performance indicators for our workforce are staff turnover, sickness absence and performance appraisals. We also monitor performance around what we spend on agency staff to ensure a balance between having enough staff to ensure quality of patient care and adequate finances to support employing agency staff.

We are pleased that our staff turnover levels have dropped from 2.25% to 1.89%, suggesting an increase in staff wanting to stay working for the Trust. Our sickness absence performance has also reduced from 5.43% to 5.01% although this remains higher than intended. Work around skills mix and supporting staff through performance appraisals and objective setting helps to ensure they get the right training for their role, which is key to improving performance in these areas.

Our expenditure on agency staff has gone down from 5.45% at the beginning of the year to 4.99%. We are committed to further reducing what we spend on agency staff, which is a key indicator for all trusts, to ensure financial sustainability during 2016-17.

Information on how we measure performance, our KPIs, how it checks performance against those measures

Our performance management framework provides the support structure with which to make systematic, continuous improvements and enables the achievement of its objectives. The framework also helps the Trust to be publicly accountable for its performance and to allow any other person or organisation with an interest in its services to see and understand how we will work to improve that service and how they contribute. The framework is part of the Trust's wider governance framework which aims to protect the interests of all stakeholders, demonstrating ownership of performance at every level of the organisation, not just at the top.



Performance measurement, monitoring and management are key to delivering quality, efficient and patient-focused services. We aim to be a learning organisation using feedback from sources such as comments, complaints and compliments and staff surveys to drive improvement and performance.

We use a set of key performance indicators and measures across all areas of the Trust from quality and patient care through to human resources. These measures and indicators link to our objectives and tell us how well we are doing against our standards and planned activity. An overview of this performance, our integrated performance report, is provided to the Trust Board. The report gives headline information on the status of each performance indicator or measure together with associated trends and actions that identify performance successes and performance issues. Performance reporting helps to manage performance by ensuring that decisions are made at the appropriate level and action is taken to bring performance back to a satisfactory level. Alternatively, performance reporting is used to review issues so that problems can be resolved through better ways of working and performance improved. Reporting in this way also helps us to share with stakeholders where performance is good or outstanding and to celebrate successes.

Sustainability 2015/16

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

- Reducing energy consumption and our carbon footprint, and saving money, enhancing and protecting our reputation and help everyone in the fight against climate change.
- Continuing 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 reducing our CO^2 emissions at least in line with NHS guidelines. Between 2009 and 2015, ULHT reduced its carbon footprint by 13% against the national target of 10%. By investing in infrastructure and implementing initiatives ranging from installing new gas and biomass boilers and combined heat and power (CHP) to increasing staff awareness, the Trust wants to continue to be among the leading NHS Trusts for its environmental and sustainability record.

By July 2016, the Trust will approve its "Sustainable Development Management Plan" (SDMP). This is a policy document that outlines the Trust's commitment to ensuring that sustainable development becomes central to the way we do things in every aspect of the organisation.

It will address our activities and progress in reducing waste and our carbon footprint and celebrates increased efficiencies, financial savings and reductions in waste and CO_2 emissions.

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

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

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

Tackling fraud

Fraud against the NHS has a serious impact on our ability to deliver the best possible care and patient experience, and everyone has a duty to help prevent it. NHS fraud may be committed by staff, patients and suppliers of goods/services to the NHS and we maintain a standard of honesty and integrity in dealing with our assets. We are committed to the

elimination of fraud and illegal acts within the Trust and ensure rigorous investigation and disciplinary sanctions or other actions are taken where appropriate.

We adopt best practice procedures to tackle fraud, as recommended by our regulators NHS Protect. We are therefore dedicated to deterring and detecting all instances of fraud, bribery and corruption as far as possible within the Trust and ensuring that losses are reduced to an absolute minimum, thus ensuring valuable public resources are used for their intended purpose.

NHS Protect provides the national framework through which NHS organisations seek to minimise losses through fraud. The director of finance is nominated to lead counter fraud work and is supported by our resident local counter fraud specialist (LCFS). The Trust follows the guidance contained in the NHS provider standards and ensures our contractual obligations with our local clinical commissioning groups are adhered to.

The Trust has a robust fraud, bribery and corruption policy and response plan that provides a framework for responding to suspicions of fraud and provides advice and information on various aspects of fraud investigations. The Trust also has a comprehensive standard of business conduct policy to ensure that our organisation remains free from bribery and corruption. There are references to counter fraud measures and reporting processes in various other Trust policies and procedures.

An annual work plan, approved by the director of finance with oversight from the Trust's Audit Committee, has been in place over the last year. The key aims were to seek to proactively create an anti-fraud culture, implement appropriate deterrents and preventative controls and ensure that allegations of fraud are appropriately and professionally investigated to a criminal standard.

Progress reports on all aspects of counter fraud work and details of investigations are received at each meeting of the Audit Committee. As part of our processes, we provide dedicated fraud awareness training for all staff to empower them to identify and report fraud. They can do this via our local counter fraud specialist, the director of finance or via the NHS Fraud and Corruption reporting line (0800 028 40 60 or online at www.reportnhsfraud.nhs.uk) and through our whistleblowing procedures. Patients and visitors can also refer suspicions of NHS fraud to the Trust via the same channels.

As part of our determination to prevent, deter and detect fraud we have an in-house collaborative counter fraud arrangement with two other local acute NHS trusts, which allows us to have a LCFS permanently on site, supported by a small team of counter fraud specialists dedicated to combatting fraud within a secondary care setting. As a Trust, we joined our collaborative fraud arrangement partners to create a Fraud Awareness Month in November 2015 and we were pleased to be an official supporter of International Fraud Awareness Week in the same month.

Sickness absence

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

The Trust set a target of 3.5% for sickness absence levels for 2015/16, which would have been a reduction of 1.68% from the 2010/11 annual rolling absence rate of 5.18%.

The actual annual rate for 2015/16 was 4.54%, and although not in line with our target this does demonstrate the lowest reported Trust annual sickness rate since the introduction of electronic staff record (ESR) in May 2007.

Overall performance shows a trend of improvement over the last five years, with the rate reducing by 0.64% since 2010/11. Further improvement will be a key focus for the Trust.

See the accounts note 9.3 for more information.

Policy in relation to disabled employees

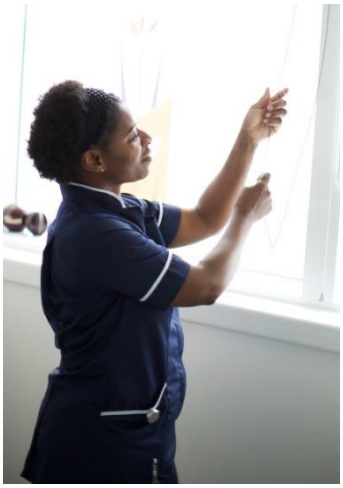
The Trust has a general policy in relation to disabled employees, which is contained within its Single Equality Scheme.

Our objective is that all HR 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 because 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 processed including disciplinary and capability policies have been through EIA to ensure that disabled employee are not subject to unlawful discrimination.

Equality and Diversity

We are 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.



The Trust recognises that everyone is different, and values the unique contribution that individual experiences, knowledge and skills make in delivering quality healthcare and becoming a model employer.

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 at work policy. 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.

We 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. policy on supporting transgender staff and interpretation and translation policy and voicing your concerns policy.

Becoming a model employer is a key goal for us. 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.

ULHT 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 organisational 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.

Looking ahead to 2016/17

For the first in 2016/17, we have written an integrated annual operational plan to clearly lay a strong foundation for sustainable improvement over the next six years. This will be year one of the transformation planned for Lincolnshire's sustainability and transformation plan (STP).

We aim to put in place the resources to deliver the STP and show our intent for long term improvement though the medium term plan. Our strategies will:

- Initiate and implement a major workforce review programme, which will focus on improving retention, thinking differently about skill mix, targeting our primary vacancies, extending roles and substantially reducing our dependency on agency staff.
- Clinical service redesign by including the Trust's clinical strategy within the Lincolnshire wide strategic service review, LHAC and aligned to the STP.
- Redress the current imbalance between elective and urgent care delivery and to repatriate previously lost market share by creating capacity through improved non-elective flows and elimination of delays for medically fit patients.
- Improve productivity and efficiency over and above the minimum national levels within the tariff inflator/deflator.

The following key strategic risks have driven our decision-making around identifying our priorities and activities:

- Culture change: Mitigation – focus on improved staff engagement and new models of working will continue to address the cultural change of the Trust.
- Lack of clinical staff: Mitigation – partnership working with other Trusts, building reputation, HEE support for new roles, developing Lincolnshire as a Centre of Rural Health and Care, building our research, development and education footprint through collaboration with and regional universities to attract medical recruitment to a centre of excellence through a 'Team Lincolnshire' approach.
- Bed capacity: Mitigation – Lincolnshire commitment to eliminate delayed transfers of care, and reduced length of stay through urgent care flow improvement.
- Agency cap delivery: Mitigation – nurse workforce action plan in place, but high risk associated with the need to permanently open additional beds.
- Lack of management staff: Mitigation – NHS Improvement support required short term, task and finish groups to be set up, focus on building a positive reputation, improving access to targeted sustainability transformation funding.
- Lack of capital (e.g. invest to save and backlog maintenance) and revenue funding (e.g. winter and 7 day services): Mitigation – Capital – NHS Improvement support, revenue – escalate safety consequences.
- System support: Mitigation – new NHS Lincolnshire leaders, STP, LHAC, NHS I support.
- LHAC programme delays: Mitigation – bring forward elements of the Trust's clinical strategy that are not dependent upon consultation.

Our headline priorities for 2016/17 year are:

1. Finance:
    - Deliver no worse than £47.9m deficit, building financial capacity to support transformation.

2. Workforce:
    - Deliver reduced agency spend, including price reduction.
    - Improve staff engagement satisfaction rates.
    - Introduce new models of working.

3. Quality:
    - Reduce mortality, with a focus on sepsis.
    - Reduce avoidable harm, with emphasis on falls.
    - Improvement in reliability of charting and checking.
    - Improve infection prevention controls.
    - Maintain safe staffing.
    - Continue to address backlog maintenance.
    - Extend seven day services, subject to commissioner funding.

4. Performance:
    - Improve emergency flow and increase elective capacity, and right size staffed bed base.
    - Maintain referral to treatment in 18 weeks and diagnostic delivery; deliver 85% 62 day cancer standard, deliver a minimum 88% A&E.

5. Develop organisational capability and capacity:
    - Create strategic capacity and capability for improved service models.
    - Strengthen the PMO and delivery mechanisms.
    - Attract and keep talent, supporting staff.

6. Accelerate the delivery of the clinical strategy.

7. Finalise the STP, in line with the Trust's medium term plan.

8. Develop a framework for partnership working.

There will be a focus on increasing our pace of change, innovation and improvement, underpinned by affordable and sustainable financial plans, outlined in the five year long term financial plan and five year capital programme to deliver our clinical strategy.

In 2016/17, using the £16.1 million general allocation from the Sustainable and Transformation Fund (STF), our plan is to deliver an agreed financial deficit of no more than £47.9 million, with STF helping to reduce our deficit; and within our financial framework to create the headroom, capability and capacity to implement our plans for new models of care.

The Accountability Report

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

ULHT Governance Statement 2015/16

Scope of responsibility

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

The Trust is accountable for the delivery of its patient services through the contracts it holds with its commissioners. The majority of ULHT contracted activity is commissioned, by the Lincolnshire clinical commissioning groups and by the area team for specialised services (NHS England).

The governance framework of the organisation

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

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

The system of internal control has been in place in United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Trust Board and Committee Structure

The Trust Board meets on a monthly basis and consists of a chair, five voting executive directors, including the chief executive and 6 non-executive directors. Three non-voting executive directors - the chief operating officer, director of estates and facilities, and the director of human resources and organisational development attend meetings of the Trust Board.

The Board has recognised that following some key personnel changes at executive and non-executive level including the appointment of a new chief executive and chair that an exercise to assess the effectiveness of the Board is required. This is planned in the Board Development Programme for early 2016/17. The chief executive and chair are currently setting board level objectives for all Trust Board members.

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

- Chief executive and chair updates on the internal and external environment at Trust Board
- Planned approach to agenda for key decisions through the year
- Monthly Board development sessions covering key strategic and development issues
- Continuous review of committee structure.

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

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

Supporting Committee Structures

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

The key committees for governance and assurance are as follows:

Audit Committee

Delegated to approve the annual accounts on behalf of the Board and provide assurance in relation to internal and external audit, counter fraud and security management, financial reporting, integrated governance, risk management and internal control, and the annual governance statement. During 2015/16 key areas of work for the committee were:

- Reviewing and approving the annual accounts and annual governance statement
- Receiving the board assurance framework
- Agreeing internal and external audit plans and monitoring progress
- Receiving reports of waivers, losses and compensations
- Monitoring counter fraud investigations
- Assurance on corporate risk register and risk processes.

Quality Governance Assurance Committee

Provided assurance to the Trust Board that appropriate and effective governance mechanisms are in place for all aspects of quality governance and risk. During 2015/16 key areas of work for the committee were:

- Review of the board assurance framework

- Receiving assurance reports from health and safety committee, safeguarding committee, infection prevention and control committee
- Assurance on the quality account
- Review of complaints, patient experience and incidents.

Finance, Performance and Investment Assurance Committee (as of March 2016 known as Finance, Service Improvement and Delivery)
Provided assurances to the Trust Board on financial and performance issues. During 2015/16 key areas of work for the committee were:

- Assurance on Trust key financial duties
- Scrutiny of savings programme
- Review of progress against capital programme
- Assurance on monitor compliance framework and performance
- Review of recovery actions against key duties.

Service Transformation Assurance Committee (as of March 2016 known as Finance, Service Improvement and Delivery)
Responsible for overseeing progress against service transformation objectives and providing appropriate assurances to the Board. During 2015/16 key areas of work for the committee were:

- Review of progress against transformational projects

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

- Assurance on key workforce priorities
- Monitoring on work to achieve the nationally set limit how much of our expenditure on nurses we can spend on agency nurses
- Review of output from staff surveys
- Consideration of learning and development strategies

Table 6: Attendance at Board and Committees (voting membership)

Board/ Committee	Attendance
Trust Board	80%
Audit Committee	92%
Quality Governance Committee	73%
Finance, Performance and Investment Committee	85%
Service Transformation Committee	72%
Workforce and OD Committee	87%

Risk assessment
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 and corporate affairs 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 Trust's 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 corporate risk register and business unit risk registers. Operational risks are captured within the business unit.

Managers identify risks in the Trust 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 Trust's objectives.

A review of the risks recorded in the Trust's risk register over the last year has seen the number of extant risks reduced considerably and the risk rating of the remaining risks has a lower aggregated value. This review has seen certain categories of risk reduced e.g. health and safety. Risks are reviewed through a risk validation group, which challenges and agrees risk ratings and ownership.

The major risks to the Trust relate to finance, the agreement of a system wide long term financial model and delivery of the clinical strategy. The risks to achieving workforce plans are nursing recruitment and nurse and medical staffing levels to achieve the reduced use of agency staff. The major clinical risks relate to the management of care relating to the incidence of harmful falls, reduction of mortality with particular emphasis on sepsis and improvement of safeguarding and infection control.

During 2015/16, the Board devoted a Board development workshop to a review and consideration of the corporate risk register. Discussing and challenging the risks to the organisations 2015/16 strategic objectives. Following this, the Board has now asked for a further review of the risk management process following gaps in assurance highlighted by the Audit Committee. This has commenced and is overseen by the Board.

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. Clinical risks and actions in response are predominantly managed through the trust patient safety and quality governance committees.

The Trust reported two data security breaches to the Information Commissioner (ICO) in 2015/2016. Both have now been closed with the agreement of the ICO. The Trust remains compliant overall with level 2 of the information governance toolkit.

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 mitigation

of risks, and the Board are committed to minimising risk using the risk register and Board Assurance Framework.

The Trust's risk management policy and procedures are in place to encourage staff to report adverse incidents and near misses in order to minimise risk and take action to prevent recurrence. During the year 2015/16 incident reporting and analysis has been reviewed and improved, with detailed 3 levels of training programmes introduced for clinical incident investigators. The Trust has also introduced, in addition to weekly serious incident review meetings chaired by clinical executives, a monthly incident review group that documents and tracks all action plans and lessons to be shared.

The structure of Trust risk registers is under development to better capture strategic, operational and local risks This gives key 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.

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

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

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

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

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

The Audit Committee assess the overall adequacy of the Assurance Framework on behalf of the accountable officer and the Board, and advise the Board in relation to the systems,

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

Throughout 2015/16, the Board identified and monitored against key objectives within its Board Assurance Framework. The Board received the controls and assurances in relation to the objectives' risks 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.

Review of the effectiveness of risk management and internal control

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

My review is also informed by:

- Care Quality Commission visits
- Delivery of internal and external audit plans
- Friends and Family Test (patient) survey results
- Staff survey results
- NHS TDA governance reviews
- Independent external reviews of finance and workforce

The Board, audit committee and the assurance committees have advised me on the implications of the result of my review of the effectiveness of the system of internal control. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The internal audit reviews undertaken during 2015/16 led to the head of internal audit providing a limited assurance opinion on the system of internal control in the Trust. In reaching this opinion, the review assessed:

- The design and operation of the assurance framework and supporting processes and the status or preparedness of the organisation with respect to risk management, control and review processes that it had in place for 2015/16
- The range of individual opinions arising from risk based audit assignments.

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

A detailed internal review of risk and incident management was conducted in June 2015 and the actions in improvement tracked through Trust governance systems.

Improvements in analysis of and response to incidents have been implemented, the risk management team has been strengthened through further training and structural problems with the underlying database corrected.

Significant Issues
During the year, the Trust identified the following significant control issues.

During February 2015, the CQC carried out a follow up inspection and found that the Trust had undertaken significant action to address areas highlighted from their 2014 inspection.

Because of this, the Trust was removed from special measures. The CQC did highlight following this review some areas which still required improvement

- Sufficient qualified and experienced staff to care for patients needs
- System to monitor and address patients in partial booking system
- Governance process in surgical and outpatients department at Louth
- Safeguarding training.

These areas have been a focus for actions by the Trust during 2015/16 and a further inspection is expected imminently.

During the year, the Trust faced significant financial challenges, which are expected to continue during 2016/17. The Trust is operating in a difficult health economy and is working with commissioners, local health and social care partners and local authorities to review care pathways and explore alternative models of care in an attempt to address these challenges and deliver a sustainable five year plan.

Workforce remains a significant strategic challenge. Plans for 2016/17 and beyond are focussing on improving retention, making Lincolnshire a more attractive place to work and reducing dependency on agency staff.

The Trust internal auditors provided the trust with a limited assurance from the head of internal audit opinion for 2015/16 and highlighted the number of their reviews which had resulted in a limited assurance being provided. Three high level risks were identified in these reviews relating to nursing rosters, financial risk attached to implementing the digital strategy and the lack of service line reporting models in the Trust. Actions have been agreed to address these issued.

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**.**

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

Accountable Officer: Mr Jan Sobieraj, Chief Executive

Organisation: United Lincolnshire Hospitals NHS Trust

Signature: 

Date: Tuesday 31 May 2016

Trust Board and committees

Board changes

During the year, we have seen some changes to the board. Jane Lewington left as chief executive in July and was replaced by Jan Sobieraj in December, and Ron Buchman left as chairman in March who was replaced by Dean Fathers. Steve Barnett non-executive director (NED) left in December to take up a post as chair at another trust.

Table 7: Board membership for 2015/16

Role	Job title	Declared interests	Term of office
Ron Buchanan	Chairman (until 6 March 2016)	None	March 2014 to March 2016
Dean Fathers	Chair (from 7 March 2016)	Chair – Nottinghamshire Healthcare NHS FT Chair – Nottinghamshire Healthcare NHS FT Charity NHS Workforce Race Equality Standard Advisory Group East Midlands Leadership Academy NHS Confederation Mental Health Network NHS Improvement Chairs Partnership Alliance East Mids Reserve Forces Employer Engagement Group Leeds Business School – Visiting Professor Cass Business School – Visiting Professor Finegreen Group – Non Exec Director JRI Orthopaedics – Sen Ind Director Higos Insurance – Sen Ind Director Institute of Mental Health – Professorial Fellow Withamside PCC – Lay Chair Diagnostic Healthcare - Shareholder KIER – Adviser Transpire – provided workshop Ind Longitudinal Evaluation of Schwartz Rounds Kings College London Wide is employed by Action on Hearing Loss	March 2016 to March 2018
Penny Owston	Non Executive Director	None	April 2010 – September 2017
Geoffrey Hayward	Non Executive Director	Wife is a volunteer for Butterfly Hospice Boston	July 2013 – July 2017
Tim Staniland	Non Executive Director	Director, Libaeration Ltd	March 2011 – March 2017
Dr Paul Grassby	Non Executive Director	Employed by University of Lincoln	July 2013 –July 2017
Kate Truscott	Non Executive Director	Trustee at Children's Links Charity	March 2014-August 2017
Professor Steve Barnett	Non Executive Director (until 31 December 2015)	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	March 2014 – Dec 2015

Role	Job title	Declared interests	Term of office
		London, Cranfield University and University of Bradford; Spouse is Chief Executive Rotherham NHS Foundation Trust	
Keith Darwin	Associate Non-Executive Director (non-voting member)	Chairman - Investors in Lincoln, Chairman - Lincolnshire Economic Action Partnership.; Trustee - St Barnabas Hospice, Governor – University of Lincoln	On-going
Gill Ponder	non executive director (from May 2015)	Employed by BT Openreach	May 2015 – May 2017
Jane Lewington	Chief Executive (until August 2015)	Non-executive director of NAVIGO Health and Social Care Community Interest Company	
Jan Sobieraj	Chief Executive (from 7 December 2015)	Trustee Combat Stress Trustee National Leadership Centre Hon Fellow Sheffield Hallam University Hon Professor de Montford university Hon Professor Plymouth University Advisory Board Member Kings Fund Wife is nurse lecturer at University of Lincoln	
Kevin Turner	Deputy Chief Executive / Acting Chief Executive (from 1 August 2015 to 6 December 2015)	None	
Suneil Kapadia	Medical Director	Member of the independent drug monitoring committee for trial with Sanofi-Pasteur	
Pauleen Pratt	Acting Chief Nurse (until 1 December 2015)	None	
Paul Boocock	Director of Estates and Facilities (non-voting member)	None	
David Pratt	Director of Finance and Corporate Affairs	None	
Ian Warren	Director of Human Resources and Organisational Development (non-voting member)	None	
Michelle Rhodes	Director of Operations (non-voting member) until 1 December 2015/ Director of Nursing (voting) from 1 December 2015	Sister employed by Park Hospital, Nottingham	
Mark Brassington	Acting Director of Performance Improvement/ Chief Operating Officer (from 1 December 2015) non-voting member	None	

Audit committee membership comprises three non-executive directors, one of whom will have considerable financial expertise. For 2015/16, membership was as follows:

Table 8: Audit committee members

Geoffrey Hayward Chair
Steve Barnett from April 2014 until December 2015
Kate Truscott from April 2014
Gill Ponder from December 2015

A Remuneration And Staff Report

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

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

Going concern
In preparing the financial statements for the year, the Trust in common with other organisations must consider whether it is appropriate to prepare them on a going concern basis. This meaning there is an expectation the Trust will continue in operation for the near future and will be able to realise assets and discharge liabilities in the normal course of operations.

In making such an assessment, management are required to take into account all the information available about our future prospects, taking a forward look for a minimum of twelve months. The extent and nature of this assessment will be driven by the historical financial position of the organisation and the knowledge of the challenges it faces.

The Trust Board and Audit Committee have given due consideration and concluded that the Trust is a 'Going Concern'. The basis of this judgement is based on the following factors:

- The long term profitability of the local health and social economy is being addressed via the Lincolnshire Health and Care (LHAC) review.
- The Trust have signed contracts in place for 2016/17 before approval of the 2015/16 accounts.
- The NHS Trust Development Agency, who from 1 April 2016 became part of NHS Improvement, have in place an escalation and support process for deficit trusts facilitating access to cash.
- Service provision is expected to continue and is evidenced within various Trust and national publications; therefore in accordance with the 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.

Remuneration
Pension benefits and salaries and allowances are shown in the tables on page 47 and 50. onwards.

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

The banded remuneration of the highest paid director in United Lincolnshire Hospitals NHS Trust in the financial year 2015-16 was £185,000 (2014-15, £181,800). This was 8.17 times (2014-15, 8.03) the median remuneration of the workforce, which was £22,636 (2014-15, £22,636).

In 2015-16, zero (2014-15, zero) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £181,800 to £3,000 (2014-15 £181,800 to £5,214).

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

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

Exit packages (audited)
Notes 9.4 - 9.5 within the 2015/16 Financial Statements provide details about payments on termination of employment which were agreed in 2015/16.

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.

A full set of accounts is shown in the appendices.

We can confirm that each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken “all the steps that he or she ought to have taken” to make himself/herself Department of Health Group Manual for Accounts 2015-16.

Payments to past directors and payments for loss of office

There were no payments made during 2015/16 to past directors or payments for loss of office.

Information on senior managers by band, staff numbers analysed by grouping and staff composition can be found on page 5.

Details on staff policies applied during 2015/15 ie disabled staff can be found on pages 29 and 30.

Staff sickness absence data can be found on page 28 and 29 and in the annual accounts under note 9.3 for more information.

Consultancy

Consultancy is defined within the Department of Health Group Manual for Accounts as being:

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

Table 9: consultancy expenditure in 2015/16 (further explanation of each consultancy category where cost has been incurred is provided)

Project description	Consultancy category	Supplier	Date contract signed	Initial contract value	Prior year costs of project	Expenditure 2015/16
				£000s	£000s	£000s
Work on various projects	Strategy	North Productions Limited	25/04/2013	50	75	15
Programme Director FT Application	Organisation and Change Management	SJW Solutions in Partnership Ltd	28/04/2015	106	202	30
Facilities and Estates workforce review, (fully funded by the University of Lincoln)	HR	LB Consultancy	21/01/2015	48	20	30
Legal fees re development of memo of understanding	Legal Services	Sherwood Forest NHS FT	16/06/2015	1	0	1
Tariff Modification	Strategy	Ernst and Young	01/09/2015	167	0	158
Work on various projects	Strategy	Human Reliability Associates Ltd	08/01/2015	0	0	9
Expansion of rehabilitation medicine	Strategy	University of Lincoln	01/11/2015	0	0	27

Consultancy categories:

- **Strategy**: The provision of objective advice and assistance relating to corporate strategies, appraising business structures, value for money reviews, business performance measurement, management services, product design and process and production management.
- **Organisation and change management**: Provision to management of objective advice and assistance relating to the strategy, structure management and operations of an organisation in pursuit of its purposes and objectives. Long range planning, re-organisation of structure, rationalisation of services, and general business appraisal of organisation.
- **Legal services**: The provision of external specialist legal advice and opinion in connection with the policy formulation and strategy development particularly on commercial and contractual matters.
- **Human resource, training and education**: The provision of objective advice and assistance in the formulation of recruitment, retention, manpower planning and HR strategies and advice and assistance relating to the development of training and education strategies.

Table 10: Salaries and allowances of Trust Board members for 2015/16 and 2014/15 (audited)

				2015/16					2014/15				
Name and title	Notes	Term in post		Salary (bands of £5,000)	Expense payments - taxable (total to nearest £100)	All pension-related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments - taxable (total to nearest £100)	All pension-related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total (bands of £5,000)
		Start	Finish	£000s	£00s	£000's	£00s	£000s	£000s	£00s	£000s	£00s	£000s
Ron Buchanan - Chair		Mar-14	Mar-16	40 - 45	6		5	40 - 45	40 - 45	35		29	50 - 55
Dean Fathers - Chair		Mar-16	Ongoing	0 - 5				0 - 5					
Penny Owston - Non Executive Director & Acting Chair (Jan - Feb 2014)		Apr-10	Ongoing	5 - 10	23		10	5 - 10	5 - 10	24		9	5 - 10
Tim Staniland - Non Executive Director		Mar-07	Ongoing	5 - 10	3		2	5 - 10	5 - 10	11		9	5 - 10
Nick Muntz - Non Executive Director		Jul-09	Aug-14						0 - 5				0 - 5
Geoff Hayward - Non Executive Director		Jul-13	Ongoing	5 - 10	9		8	5 - 10	5 - 10	16		13	5 - 10
Paul Grasby - Non Executive Director		Jul-13	Ongoing	5 - 10	3		1	5 - 10	5 - 10	11		3	5 - 10
Steve Barnett - Non Executive Director		Mar-14	Dec-15	0 - 5	6		3	5 - 10	5 - 10	16		15	5 - 10
Kate Truscott - Non Executive Director		Mar-14	Ongoing	5 - 10	8		3	5 - 10	5 - 10	19		7	5 - 10
Gill Ponder - Non Executive Director		May-15	Ongoing	5 - 10	6		5	5 - 10					
Keith Darwin - Associate Non Executive Director		Jan-10	Ongoing	0 - 5	6		6	0 - 5	0 - 5	9		9	0 - 5

Salaries and allowances

				2015/16					2014/15				
Name and title	Notes	Term in post		Salary (bands of £5,000)	Expense payments - taxable (total to nearest £100)	All pension-related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments - taxable (total to nearest £100)	All pension-related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total (bands of £5,000)
		Start	Finish										
Jan Sobieraj - CEO		Dec-15	Ongoing	55 - 60		22.5 - 25		80 - 85					
Jane Lewington - CEO		Dec-10	Jul-15	65 - 70				65 - 70	175 - 180	13			180 - 185
Kevin Turner - Deputy Chief Executive (Acting Chief Executive 1/8/15 - 6/12/15)		Jan-11	Ongoing	145 - 150		62.5 - 65		210 - 215	140 - 145	13			140 - 145
Mark Brassington - Acting Director of Performance Improvement (1/4/15 - 6/12/15) / Chief Operating Officer (from 7/12/15)	1	Nov-14	Ongoing	110 - 115	13	115 - 117.5		230 - 235	40 - 45	5	27.5 - 30		70 - 75
David Pratt - Director of Finance and Corporate Affairs		Oct-13	Ongoing	135 - 140	13	22.5 - 25		160 - 165	135 - 140	28	72.5 - 75		215 - 220
Peter Hollinshead - Interim Director of Finance and Corporate Affairs	2	Oct-15	Jan-16										
Jason Burn - Interim Director of Finance and Corporate Affairs	3	Jan-16	Ongoing										
Michelle Rhodes - Director of Operations (1/4/15 - 6/12/15) / Director of Nursing (from 7/12/15)		Oct-10	Ongoing	115 - 120	7	7.5 - 10		125 - 130	115 - 120	25			120 - 125
Pauline Pratt - Acting Director of Nursing		May-14	Dec-15	,85 - 90	9			85 - 90	105 - 110	33	277.5 - 280		385 - 390
Suneil Kapadia - Medical Director (also Deputy Chief Executive - 7/12/15)		Jul-13	Ongoing	185 - 190	8	67.5 - 70		255 - 260	180 - 185	108	90 - 92.5		280 - 285
Ian Warren - Director of HR and OD		Feb-13	Ongoing	115 - 120		22.5 - 25		140 - 145	110 - 115	9	22.5 - 25		135 - 140
Paul Boocock - Director of Estates and Facilities		Oct-13	Ongoing	90 - 95	12	12.5 - 15		100 - 105	85 - 90	22	25 - 27.5		115 - 120

Notes:

1. Mark Brassington was seconded from Nottingham University Hospitals NHS Trust in 2015/16 at a cost of £143,368 (2014/15: £58,887).

2. The remuneration for Peter Hollinshead was paid to the trading company Brandhill Financial Services Ltd. This is a commercial rate covering all away from home expenses, business overheads and VAT. As a result of the payments being made to a trading company the Trust did not incur any additional costs (such as tax, national insurance, pension payments). The liability for making such payments rests with the trading company, Brandhill Financial Services Ltd. The total paid between October 2015 - January 2016 was £102,634.

3. Jason Burn was employed through Allen Lane Ltd at a cost of £53,856.

Definitions:

Salary

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

Taxable benefits

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

Benefits in kind

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

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 2014/15 or 2015/16.

Pension benefits 2015/16

Table 11: Pension benefits of Board members for 2015/16 (audited)

Name and title	Notes	Real increase in pension at pension age (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015	Real increase / (decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension
		£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Jan Sobieraj - Chief Executive		0 - 2.5	2.5 - 5	70 - 75	220 - 225	1,529	35	1,657	
Jane Lewington - Chief Executive	1								
Kevin Turner - Deputy Chief Executive (Acting Chief Executive 1/8/15 - 6/12/15)		2.5 - 5	10 - 12.5	65 - 70	200 - 205	1,269	85	1,370	
Mark Brassington - Acting Director of Performance Improvement (1/4/15 - 6/12/15) / Chief Operating Officer (from 7/12/15)	2	5 - 7.5	10 - 12.5	25 - 30	70 - 75	257	67	327	
David Pratt - Director of Finance & Corporate Affairs		0 - 2.5	0	30 - 35	90 - 95	512	23	541	
Peter Hollinshead - Interim Director of Finance and Corporate Affairs	3								
Jason Burn - Interim Director of Finance and Corporate Affairs	4								
Michelle Rhodes - Director of Operations (1/4/15 - 6/12/15) / Director of Nursing (from 7/12/15)		0 - 2.5	2.5 - 5	30 - 35	100 - 105	552	24	582	
Pauleen Pratt - Acting Director of Nursing		0	0	40 - 45	125 - 130	739	3	751	
Suneil Kapadia - Medical Director (also Deputy Chief Executive - 7/12/15)		2.5 - 5	10 - 12.5	80 - 85	250 - 255	1,640	101	1,760	
Ian Warren - Director of Human Resources and OD	5	0 - 2.5	0	10 - 15	0	134	25	161	
Paul Boocock - Director of Estates and Facilities		0 - 2.5	0	30 - 35	85 - 90	446	12	463	

Notes:

1. Greenbury only applies to members who contributed to one of the NHS Pension Schemes at any time during the period 01/04/15-31/03/16. Jane Lewington was not a member during 2015/2016.
2. Mark Brassington was seconded from Nottingham University Hospitals NHS Trust.
3. Peter Hollinshead was employed through Brandhill Financial Services Ltd and not a member of the NHS Pension Scheme.
4. Jason Burn was employed through Allen Lane Ltd and was not a member of the NHS Pension Scheme.
5. Ian Warren is a member of the NHS Pension Scheme under the 2008 section rules. Under this section no automatic lump sum is payable.

Pension benefits 2015/16

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. Exit packages are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (inc
factors for the start and end of the period.

Off-payroll engagements

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

Treasury requires public sector bodies to report arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements).

Table 12: Off-payroll engagements Table 1 for all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016	9
Of which, the number that have existed:	
for less than one year at the time of reporting	6
for between one and two years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	3

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

Table 13: Off-payroll engagements Table 2 for all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	7
Number of new engagements which include contractual clauses giving the United Lincolnshire Hospitals NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	1
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0
assurance has not been received	0

The Trust is continuing to embed processes to ensure ‘off-payroll’ engagements are assessed prior to commencement. This has proven to be particularly challenging in the current year where a number of staff have been engaged through agencies for initially unspecified time periods.

Table 14: Off-payroll engagements Table 3 for any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	2
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure includes both on payroll and off-payroll engagements.	12

United Lincolnshire Hospitals NHS Trust

Annual Accounts for the period

1 April 2015 to 31 March 2016

CONTENTS

FOREWORD TO THE ACCOUNTS

Financial Review - year ended 31 March 2016

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**		
	2015-16		2014-15
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)	**(65,800)**	**Surplus / (Deficit)**	(15,278)
	8,048	**Impairments**	899
	623	**IFRIC 12 adjustments**	(827)
	212	**Other adjustments**	45
	(56,917)	**Reported Performance**	(15,161)
	(105,974)	**Cumulative position against breakeven duty surplus / (deficit)**	(49,057)
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	**£0.17m**	**Undershoot**	£0.04m
To operate within a Capital Resource Limit set by the Department of Health	**£0.05m**	**Underspent**	£0.26m
To pay 95% of creditor invoices within 30 days (by number of invoices)	**85%**	**Trade (Non NHS)**	87%
	70%	**NHS**	84%

Jason Burn
Interim Director of Finance and Corporate Affairs
May 2016

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

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

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

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

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

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

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

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

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

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

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

Date: **31st May 2016**

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

By order of the Board

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

Signed **Jason Burn** **Interim Director of Finance and Corporate Affairs**

Date: **31st May 2016**

KPMG

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

We have audited the financial statements of United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2016 on pages 11 to 53 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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

Respective responsibilities of Directors, the Accountable Officer and auditor

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

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

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

Scope of the audit of the financial statements

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and

- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and

- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or

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

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

We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 31 May 2016 we referred a matter to the Secretary of State under section 30 (1)(a) of the 2014 Act because we had reason to believe that the Trust had breached its 'breakeven duty' set out at paragraph 2(1) of Schedule 5 to the National Health Service Act 2006. The Trust reported an in-year deficit of £56.9m in 2015/16, a cumulative deficit of £105.9m and is forecasting a deficit of £47.9m for 2016/17.

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

Basis for qualified conclusion

In considering the Trust's arrangements for challenging how it secures economy, efficiency and effectiveness in its use of resources, we identified that the Trust has reported a deficit of £56.9 million in 2015/16, which was greater than the £40.3m deficit forecast in its revised operational plan and the £17.4m deficit originally forecast for that year in the 2014 financial plan agreed with the Trust Development Authority. The Trust has not been meeting its key national performance targets in the year (particularly those for A&E waiting times, RTT, cancer and cancelled operations).

On the basis of our work, the matters reported in the basis for qualified conclusion paragraph above prevent us from being satisfied that, in all material respects United Lincolnshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2016.

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 Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Tony Crawley for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St Nicholas House
Park Row
Nottingham
NG1 6FQ

2 June 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	9.1	**(305,876)**	(290,059)
Other operating costs	7	**(177,208)**	(151,993)
Revenue from patient care activities	4	**386,840**	395,007
Other operating revenue	5	**36,588**	38,243
Operating surplus/(deficit)		**(59,656)**	(8,802)
Investment revenue	11	**70**	45
Other gains and (losses)	12	**(50)**	11
Finance costs	13	**(906)**	(84)
Surplus/(deficit) for the financial year		**(60,542)**	(8,830)
Public dividend capital dividends payable		**(5,258)**	(6,448)
Retained surplus/(deficit) for the year		**(65,800)**	(15,278)

Other Comprehensive Income

	2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve	**(16,558)**	519
Net gain/(loss) on revaluation of property, plant & equipment	**2,913**	5,466
Total comprehensive income for the year	**(79,445)**	(9,293)

Financial performance for the year

Retained surplus/(deficit) for the year	**(65,800)**	(15,278)
IFRIC 12 adjustment (including IFRIC 12 impairments)	**623**	(827)
Impairments (excluding IFRIC 12 impairments)	**8,048**	899
Adjustments in respect of donated gov't grant asset reserve elimination	**212**	45
Adjusted retained surplus/(deficit)	**(56,917)**	(15,161)

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 15 to 53 form part of this account.

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	14	**215,768**	229,154
Intangible assets	15	**5,607**	5,777
Trade and other receivables	20.1	**1,477**	1,345
Total non-current assets		**222,852**	236,276
Current assets:			
Inventories	19	**7,130**	7,738
Trade and other receivables	20.1	**21,127**	21,615
Cash and cash equivalents	21	**1,166**	1,010
Sub-total current assets		**29,423**	30,363
Non-current assets held for sale	22	**1,075**	0
Total current assets		**30,498**	30,363
Total assets		**253,350**	266,639
Current liabilities			
Trade and other payables	23	**(42,020)**	(37,143)
Other liabilities	24	**(503)**	(503)
Provisions	29	**(1,364)**	(2,223)
Borrowings	25	**(299)**	(282)
DH revenue support loan	25	**0**	0
Total current liabilities		**(44,186)**	(40,151)
Net current assets/(liabilities)		**(13,688)**	(9,788)
Total assets less current liabilities		**209,164**	226,488
Non-current liabilities			
Other liabilities	24	**(14,591)**	(15,094)
Provisions	29	**(2,484)**	(2,582)
Borrowings	25	**(178)**	(477)
Other financial liabilities		**0**	0
DH revenue support loan	25	**(54,000)**	0
Total non-current liabilities		**(71,253)**	(18,153)
Total assets employed:		**137,911**	208,335
FINANCED BY:			
Public Dividend Capital		**251,746**	242,724
Retained earnings		**(157,029)**	(92,640)
Revaluation reserve		**43,004**	58,061
Other reserves		**190**	190
Total Taxpayers' Equity:		**137,911**	208,335

The notes on pages 15 to 53 form part of this account.

The financial statements on pages *11 to 53* were approved by the Board on *31 May 2016* and signed on its behalf by

Chief Executive: **Jan Sobieraj** Date: **31st May 2016**

Interim Director of Finance and Corporate Affairs: **Jason Burn** Date: **31st May 2016**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**242,724**	**(92,640)**	**58,061**	**190**	**208,335**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(65,800)			**(65,800)**
Net gain / (loss) on revaluation of property, plant, equipment			2,913		**2,913**
Impairments and reversals			(16,558)		**(16,558)**
Transfers between reserves		1,411	(1,411)	0	**0**
Permanent PDC received - cash	9,022				**9,022**
Other movements	0	0	(1)	0	**(1)**
Net recognised revenue/(expense) for the year	**9,022**	**(64,389)**	**(15,057)**	**0**	**(70,424)**
Balance at 31 March 2016	**251,746**	**(157,029)**	**43,004**	**190**	**137,911**
Balance at 1 April 2014	**218,723**	**(79,301)**	**54,014**	**190**	**193,626**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		(15,278)			(15,278)
Net gain / (loss) 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**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(59,656)**	(8,802)
Depreciation and amortisation	7	**11,448**	10,508
Impairments and reversals	16	**8,557**	(2)
Donated Assets received credited to revenue but non-cash	5	**(138)**	(304)
Interest paid		**(681)**	(35)
PDC Dividend (paid)/refunded		**(5,597)**	(6,679)
(Increase)/Decrease in Inventories		**608**	(283)
(Increase)/Decrease in Trade and Other Receivables		**319**	2,028
(Increase)/Decrease in Other Current Assets		**0**	6
Increase/(Decrease) in Trade and Other Payables		**5,877**	1,290
(Increase)/Decrease in Other Current Liabilities		**(503)**	(503)
Provisions utilised		**(1,230)**	(1,288)
Increase/(Decrease) in movement in non cash provisions		**247**	(384)
Net Cash Inflow/(Outflow) from Operating Activities		**(40,749)**	(4,448)
Cash Flows from Investing Activities			
Interest Received		**70**	46
(Payments) for Property, Plant and Equipment		**(21,167)**	(17,715)
(Payments) for Intangible Assets		**(852)**	(2,177)
Proceeds of disposal of assets held for sale (PPE)		**114**	55
Net Cash Inflow/(Outflow) from Investing Activities		**(21,835)**	(19,791)
Net Cash Inform / (outflow) before Financing		**(62,584)**	(24,239)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		**9,022**	38,001
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**0**	(14,000)
Loans received from DH - New Revenue Support Loans		**85,403**	0
Other Loans Received		**0**	474
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(31,403)**	0
Other Loans Repaid		**(118)**	(60)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(164)**	(149)
Net Cash Inflow/(Outflow) from Financing Activities		**62,740**	24,266
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**156**	27
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,010**	983
Cash and Cash Equivalents (and Bank Overdraft) at year end	**21**	**1,166**	1,010

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 2015-16 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 2015-16 is a £56.9 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 - contracts have been agreed with commissioners for the new financial year 2016-17.

- NHS Improvement (NHSI) within which the NHS Trust Development Authority has been subsumed has in place an escalation and support process for Trusts in financial deficit to access cash.

- NHSI 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 continuing to 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.

- The Lincolnshire Health Community is developing its STP (Sustainability and Transformation Plan) by June 2016, which will set out the 5-year programme to work towards financial sustainability. This draws from the development of 5 themes being: Clinical Service Redesign, Capacity Optimisation, Commissioning of Services, Workforce Redesign & Provider Efficiency. The Trust's own medium term plan covering the same period will reflect the finally agreed STP.

- 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 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.

NOTES TO THE ACCOUNTS

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

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

Completed activity under Payment by results is billed one month in arrears. Any disputed activity must then be queried and that query resolved within 2 months. The Trust has assumed that all invoiced activity recorded as income as at 31 March 2016, will be paid in full.

1.3.2 Key sources of estimation uncertainty

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

An annual revaluation of Trust Property, Plant and Equipment is conducted by Cushman & Wakefield formerly (DTZ Debenham Tie Leung Ltd (DTZ)). As part of this revaluation process the Trust reviews the remaining useful life of its buildings in accordance with advice received from 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 £189.2m and is detailed in note 14.1.

Note 9.6, 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 2016.

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 2016, the estimated income from partially completed spells was £4.8m (31 March 2015: £5.5m). Similarly income received for the period of antenatal care has been deferred where this provision has not been completed, this totalled £1.5m (31 March 2015: £2.1m).

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 29 details the Provisions recognised by the Trust at 31 March 2016. 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 2016 were £3.8m (31 March 2015: £4.8m).

Note 30, 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 £0.3m at 31 March 2016 (31 March 2015: £1.35m).

NOTES TO THE ACCOUNTS

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

The Trust information systems are unable to accurately identify the figures for 'Inventories recognised as expenses' under Note 19. The Trust has therefore estimated this figure using data extracted from the Ascribe stock system for drugs (£39.5m) and purchases through NHS Supply Chain (£11.9m).

The Trust entered into a contract with a third party in 2006 in which they provide accommodation to Trust employees. As part of the contract a minimum occupancy level was guaranteed. Costs of under-occupancy are met by the Trust. Future under-occupancy charges have been estimated for the relevant properties based upon trends over the preceding 6, 12 and 24 months (after excluding any identified short term fluctuations) ending February 2016. The assets associated with this 'onerous' contract are impaired based upon this assessment.

Outstanding pay liabilities included within Note 23, trade and other payables incorporate estimates for:
• Annual Leave - based upon average pay rates for 2015-16 and leave carried forward as assessed through a Trust wide sample and reports extracted from the Trust Rostering system.
• Overtime and enhancements relating to March 2016 - based upon actual payments for a 'similar' accounting period.

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from 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.

1.5 Employee Benefits

Short-term employee benefits

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

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

Retirement benefit costs

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

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

1.6 Other expenses

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

NOTES TO THE ACCOUNTS

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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 ceased. The carrying value of existing assets at that date is written off over their remaining useful lives. New fixtures and equipment are 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

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

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

1.8 Intangible assets

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

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

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

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

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

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

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

NOTES TO THE ACCOUNTS

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

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.

1.10 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.

1.11 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.12 Non-current assets held for sale

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

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

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

1.13 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate 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.

NOTES TO THE ACCOUNTS

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.

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

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value 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.

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

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

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

NOTES TO THE ACCOUNTS

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.
The discount rates applicable are 1.55% (0-5 years), 1.00% (6-10 years) and 0.80% (over 10 years) in real terms (1.37% 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.

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

1.18 Clinical negligence costs

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

1.19 Non-clinical risk pooling

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

1.20 Contingencies

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

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

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

1.21 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.

NOTES TO THE ACCOUNTS

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

Loans and receivables

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

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

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

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

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

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

1.22 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.

1.23 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.

1.24 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.

1.25 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 38 to the accounts.

NOTES TO THE ACCOUNTS

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

1.26 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.

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

1.27 Losses and Special Payments

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

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

1.28 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.

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

● IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.30 Other Reserves

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

2. Operating segments

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

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

Revenue from activities (medical treatment of patients) is analysed by customer type in note 4 to the financial statements on page 26.
Other operating revenue is analysed in note 5 to the financial statements on page 26 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.

	2015-16		2014-15	
	£000s	**%**	£000s	%
Revenue from whole HM Government	**411,686**	**97.2**	422,447	97.4
Revenue from non HM Government sources	**11,742**	**2.8**	10,803	2.6
Total	**423,428**	**100.0**	433,250	100.0

3. Income generation activities

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

Summary Table - aggregate of all schemes	**2015-16**	2014-15
	£000s	£000s
Income	**4,461**	4,372
Full cost	**(2,645)**	(2,760)
Surplus/(deficit)	**1,816**	1,612

2015-16 and 2014-15 figures comprise catering and car parking income from the public and staff.

Catering	**2015-16**	2014-15
	£000s	£000s
Income	**1936**	1,858
Full cost	**(2,062)**	(1,952)
Surplus/(deficit)	**(126)**	(94)

Car Parking	**2015-16**	2014-15
	£000s	£000s
Income	**2525**	2,514
Full cost	**(583)**	(808)
Surplus/(deficit)	**1,942**	1,706

4. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**361**	98
NHS England	**61,726**	59,672
Clinical Commissioning Groups	**316,286**	322,563
Foundation Trusts	**52**	4
Department of Health	**16**	0
NHS Other (including Public Health England and Prop Co)	**254**	175
Additional income for delivery of healthcare services	**5,000**	10,000
Non-NHS:		
Local Authorities	**0**	76
Private patients	**536**	533
Overseas patients (non-reciprocal)	**34**	80
Injury costs recovery	**1,420**	1,368
Other	**1,155**	438
Total Revenue from patient care activities	**386,840**	395,007

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

The 2014-15 additional income was allocated by the Department of Health in recognition of the financial challenges faced by the Trust.

5. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**2,179**	2,016
Education, training and research	**18,528**	19,458
Receipt of donations for capital acquisitions - Charity	**138**	304
Non-patient care services to other bodies	**6,553**	4,886
Income generation (Other fees and charges)	**4,461**	4,372
Rental revenue from finance leases	**161**	177
Rental revenue from operating leases	**485**	579
Other revenue	**4,083**	6,451
Total Other Operating Revenue	**36,588**	38,243
Total operating revenue	**423,428**	433,250

6. Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**34**	80
Cash payments received in-year (re receivables at 31 March 2015)	**11**	10
Cash payments received in-year (from invoices issued 2015-16)	**13**	42
Amounts added to provision for impairment of receivables (re receivables at 31 March 2015)	**0**	0
Amounts added to provision for impairment of receivables (from invoices issued 2015-16)	**6**	25
Amounts written off in-year (irrespective of year of recognition)	**6**	1

7. Operating expenses

	2015-16 £000s	2014-15 £000s
Trust Chair and Non-executive Directors	**93**	91
Supplies and services - clinical	**105,138**	95,259
Supplies and services - general	**7,268**	7,131
Consultancy services	**283**	257
Establishment	**4,998**	4,513
Transport	**909**	984
Business rates paid to local authorities	**1,633**	1,774
Premises	**16,035**	15,834
Hospitality	**9**	12
Insurance	**40**	37
Legal Fees	**279**	718
Impairments and Reversals of Receivables	**52**	(6)
Inventories write down	**541**	200
Depreciation	**10,242**	9,523
Amortisation	**1,206**	985
Impairments and reversals of property, plant and equipment	**8,557**	(2)
Internal Audit Fees	**137**	158
Audit fees	**110**	155
Other auditor's remuneration *	**12**	54
Clinical negligence	**17,655**	11,525
Education and Training	**1,035**	1,222
Change in Discount Rate	**(10)**	128
Other	**986**	1,441
Total Operating expenses (excluding employee benefits)	**177,208**	151,993
Employee Benefits		
Employee benefits excluding Board members	**304,584**	288,677
Board members	**1,292**	1,382
Total Employee Benefits	**305,876**	290,059
Total Operating Expenses	**483,084**	442,052

*Other auditor's remuneration in 2014-15 relates to the development of an activity model for the Trust.

8. Operating Leases

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

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

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

The Trust leases various items of medical equipment, these leases expire in the period to December 2016.
The Trust has numerous vehicles leased which expire before December 2020.

8.1. United Lincolnshire Hospitals NHS Trust as lessee

	Land £000s	**Buildings £000s**	**Other £000s**	**2015-16 Total £000s**	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**1,618**	1,745
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**1,618**	1,745
Payable:					
No later than one year	1,282	0	271	**1,553**	1,648
Between one and five years	2,244	0	326	**2,570**	2,674
After five years	0	0	0	**0**	0
Total	**3,526**	**0**	**597**	**4,123**	4,322
Total future sublease payments expected to be received:				0	0

8.2. United Lincolnshire Hospitals NHS Trust as lessor

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

	2015-16 £000	2014-15 £000s
Recognised as revenue		
Rental revenue	427	427
Contingent rents	58	152
Total	**485**	579
Receivable:		
No later than one year	192	276
Between one and five years	315	816
After five years	585	550
Total	**1,092**	1,642

An error was identified in the 2014-15 reported receivable between 1-5 years. The amended comparitor should be £605,000

9. Employee benefits and staff numbers

9.1. Employee benefits

	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure 2015-16			
Salaries and wages	**262,341**	216,849	45,492
Social security costs	**17,008**	17,008	0
Employer Contributions to NHS BSA - Pensions Division	**26,607**	26,607	0
Other pension costs	**17**	17	0
Termination benefits	**271**	271	0
Total employee benefits	**306,244**	**260,752**	**45,492**
Employee costs capitalised	**368**	312	56
Gross Employee Benefits excluding capitalised costs	**305,876**	**260,440**	**45,436**

Employee Benefits - Gross Expenditure 2014-15	Total £000s	Permanently employed £000s	Other £000s
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 - including capitalised costs	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

'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.

9.2. Staff Numbers

	2015-16			2014-15
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**942**	801	141	926
Administration and estates	**1,141**	1,099	42	1,106
Healthcare assistants and other support staff	**815**	757	58	1,951
Nursing, midwifery and health visiting staff	**3,111**	2,757	354	2,138
Scientific, therapeutic and technical staff	**789**	763	26	615
Healthcare Science Staff	**153**	149	4	120
TOTAL	**6,951**	**6,326**	**625**	6,856
Of the above - staff engaged on capital projects	**12**	10	2	39

During 2015-16 a review of coding was undertaken against the Health & Social Care Information Centre's NHS Occupational code Manual. As a result of this review the figures reported for 2014-15 and 2015-16 in the above table are not directly comparable.
2014-15 revised comparitors for the affected categories are:

Healthcare assistants and other support staff:	931
Nursing midwifery and health visiting staff:	2940
Scientific, therapeutic and technical staff:	796
Healthcare Science staff:	157

9.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	66,534	68,232
Total Staff Years	6,260	6,389
Average working Days Lost	10.63	10.68

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**7**	15
	£000s	£000s
Total additional pensions liabilities accrued in the year	**318**	774

9.4. Exit Packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£**
Less than £10,000	0	0	12	55,821	**12**	**55,821**	0	0
£10,000-£25,000	0	0	1	12,682	**1**	**12,682**	0	0
£25,001-£50,000	0	0	3	99,518	**3**	**99,518**	0	0
£50,001-£100,000	1	81,928	1	76,667	**2**	**158,595**	0	0
Total	**1**	**81,928**	**17**	**244,688**	**18**	**326,616**	**0**	**0**

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£**
Less than £10,000	0	0	29	89,089	**29**	**89,089**	0	0
£10,000-£25,000	1	15,949	1	13,267	**2**	**29,216**	0	0
£25,001-£50,000	0	0	0	0	**0**	**0**	0	0
£50,001-£100,000	1	100,000	0	0	**1**	**100,000**	0	0
Total	**2**	**115,949**	**30**	**102,356**	**32**	**218,305**	**0**	**0**

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

The Trust operated a Mutually Agreed Resignation Scheme (MARS) in 2015-16. The scheme operated was based on the National MARS.
Under the provisions of the scheme an individual with the agreement of the employer could choose to leave employment voluntarily in return for a severence payment.
Five MARS applications were approved in 2015/16 at a cost of £188,867, these are reported within 'other departures agreed'.

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.

9.5. Exit packages - Other Departures analysis

	2015-16		2014-15	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£000s**	Number	£000s
Mutually agreed resignations (MARS) contractual costs	5	189	0	0
Contractual payments in lieu of notice	12	56	30	102
Total	17	245	30	102
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 9.4 which will be the number of individuals.

9.6. Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

10. Better Payment Practice Code

10.1. Measure of compliance

	2015-16		2014-15	
	Number	**£000s**	Number	£000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**124,975**	**168,197**	101,531	161,260
Total Non-NHS Trade Invoices Paid Within Target	**106,663**	**138,397**	88,005	134,738
Percentage of NHS Trade Invoices Paid Within Target	**85.35%**	**82.28%**	86.68%	83.55%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,929**	**37,262**	3,244	22,013
Total NHS Trade Invoices Paid Within Target	**1,345**	**31,973**	2,741	16,262
Percentage of NHS Trade Invoices Paid Within Target	**69.73%**	**85.81%**	84.49%	73.87%

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.

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

	2015-16	2014-15
	£000s	£000s
Amounts included in finance costs from claims made under this legislation	**1**	5
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**1**	5

11. Investment Revenue

	2015-16	2014-15
	£000s	£000s
Interest revenue		
Bank interest	**70**	45
Total investment revenue	**70**	45

12. Other Gains and Losses

	2015-16	2014-15
	£000s	£000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(76)**	(14)
Gain (Loss) on disposal of assets held for sale	**26**	25
Total	**(50)**	11

13. Finance Costs

	2015-16	2014-15
	£000s	£000s
Interest		
Interest on loans and overdrafts	**850**	0
Interest on obligations under finance leases	**19**	30
Interest on late payment of commercial debt	**1**	5
Total interest expense	**870**	35
Provisions - unwinding of discount	**36**	49
Total	**906**	84

14.1. Property, plant and equipment

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

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	1,403	47,545	9,073	0	40	0	0	0	**58,061**
Movements:									
Excess Depreciation	0	(1,250)	(141)	0	(21)	0	0	0	**(1,412)**
Revaluations / Impairments	1,276	(15,256)	335	0	0	0	0	0	**(13,645)**
At 31 March 2016	**2,679**	**31,039**	**9,267**	**0**	**19**	**0**	**0**	**0**	**43,004**

Additions to Assets Under Construction in 2015-16

Buildings excl Dwellings	14,514
Plant & Machinery	3,582
Balance as at YTD	**18,096**

14.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	9,888	158,288	22,767	2,576	49,761	779	8,049	302	**252,410**
Additions of Assets Under Construction				13,781					**13,781**
Additions Purchased	0	2,398	0		4,824	14	2,261	55	**9,552**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	225	54	12	13	**304**
Reclassifications	0	807	0	(5,338)	0	0	0	0	**(4,531)**
Reclassifications as Held for Sale and Reversals	0	0	0	0	(1,252)	(28)	(21)	0	**(1,301)**
Disposals other than for sale	0	0	0	0	(1,788)	0	(1,277)	0	**(3,065)**
Revaluation	1,257	(347)	901	0	0	0	0	0	**1,811**
Impairments/negative indexation charged to reserves	0	(1,421)	0	0	0	0	0	0	**(1,421)**
Reversal of Impairments charged to reserves	840	1,100	0	0	0	0	0	0	**1,940**
At 31 March 2015	**11,985**	**160,825**	**23,668**	**11,019**	**51,770**	**819**	**9,024**	**370**	**269,480**
Depreciation									
At 1 April 2014	0	0	0	0	33,484	491	4,638	132	**38,745**
Reclassifications as Held for Sale and Reversals	0	0	0		(1,252)	(25)	(21)	0	**(1,298)**
Disposals other than for sale	0	0	0		(1,710)	0	(1,277)	0	**(2,987)**
Revaluation / positive indexation	870	(5,107)	582		0	0	0	0	**(3,655)**
Impairments/negative indexation charged to operating expenses	0	1,487	536	437	0	0	0	0	**2,460**
Reversal of Impairments charged to operating expenses	(870)	(155)	(1,437)	0	0	0	0	0	**(2,462)**
Charged During the Year	0	3,775	319		4,266	59	1,069	35	**9,523**
At 31 March 2015	**0**	**0**	**0**	**437**	**34,788**	**525**	**4,409**	**167**	**40,326**
Net Book Value at 31 March 2015	**11,985**	**160,825**	**23,668**	**10,582**	**16,982**	**294**	**4,615**	**203**	**229,154**
Asset financing:									
Owned - Purchased	11,985	160,233	0	10,582	15,906	225	4,549	190	**203,670**
Owned - Donated	0	525	0	0	849	69	66	13	**1,522**
Owned - Government Granted	0	67	0	0	0	0	0	0	**67**
Held on finance lease	0	0	0	0	227	0	0	0	**227**
On-SOFP PFI contracts	0	0	23,668	0	0	0	0	0	**23,668**
Total at 31 March 2015	**11,985**	**160,825**	**23,668**	**10,582**	**16,982**	**294**	**4,615**	**203**	**229,154**

14.3. (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	117
Grantham Hospital League of Friends	6
Boston Hospital League of Friends	9
Pentax UK Ltd	6
Total Donated assets received in 2015-16	**138**

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

The Trust commissioned a desktop revaluation of land, buildings and dwellings in March 2016. This revaluation was conducted by Mr D.M. Wilson MRICS of Cushman & Wakefield formerly (DTZ Debenham Tie Leung Ltd (DTZ)) and was based upon depreciated replacement cost using the modern equivalent basis of valuation.

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 Accommodation units are valued at open market value based on existing use.

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

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

The following table provides details of property valued on an open market	**2015-16**	2014-15
	£000s	£000s
Land	815	60
Dwellings	23,159	23,668
Buildings	116	116
Total	**24,090**	23,844

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

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

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

	Asset Life	
Intangibles	**Minimum**	**Maximum**
Software Licences	3	15
IT - in house & 3rd Party Software	5	5
Property, Plant and Equipment		
Buildings exc Dwellings	4	84
Dwellings	56	73
Plant and Machinery	3	15
Transport Equipment	5	11
Information Technology	3	10
Furniture and fittings	3	10

The gross value of fully depreciated assets still in use is £17.93m (2014-15 £19.13m).

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 2016 was £2.43m as set out in the table below:

	2015-16	2014-15
	£000s	£000s
Net book value 1 April	5,374	5,237
Additions	232	33
Disposals	(3,225)	0
Depreciation	(74)	(111)
Increase in valuation 31 March 2015	456	199
Reversal of previous impairments	(334)	16
Net book value 31 March	**2,429**	**5,374**

15. Intangible non-current assets

15.1. Intangible non-current assets

2015-16	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	**20**	**9,122**	**0**	**0**	**0**	**9,142**
Additions Purchased	0	478	0	0	0	**478**
Reclassifications	0	558	0	0	0	**558**
Disposals other than by sale	0	(196)	0	0	0	**(196)**
At 31 March 2016	**20**	**9,962**	**0**	**0**	**0**	**9,982**
Amortisation						
At 1 April 2015	**20**	**3,345**	**0**	**0**	**0**	**3,365**
Disposals other than by sale	0	(196)	0	0	0	**(196)**
Charged During the Year	0	1,206	0	0	0	**1,206**
At 31 March 2016	**20**	**4,355**	**0**	**0**	**0**	**4,375**
Net Book Value at 31 March 2016	**0**	**5,607**	**0**	**0**	**0**	**5,607**
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	0	5,581	0	0	0	**5,581**
Donated	0	26	0	0	0	**26**
Total at 31 March 2016	**0**	**5,607**	**0**	**0**	**0**	**5,607**

Revaluation reserve balance for intangible non-current assets						
						£000's
At 1 April 2015	0	0	0	0	0	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**

15.2. Intangible non-current assets prior year

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	20	4,198	0	0	0	4,218
Additions - purchased	0	393	0	0	0	393
Reclassifications	0	4,531	0	0	0	4,531
At 31 March 2015	20	9,122	0	0	0	9,142
Amortisation						
At 1 April 2014	19	2,361	0	0	0	2,380
Charged during the year	1	984	0	0	0	985
At 31 March 2015	20	3,345	0	0	0	3,365
Net book value at 31 March 2015	0	5,777	0	0	0	5,777
Net book value at 31 March 2015 comprises:						
Purchased		5,744				5,744
Donated		33				33
Total at 31 March 2015	0	5,777	0	0	0	5,777

15.3. Intangible non-current assets

All intangible assets are held at historical cost, less accumulated amortisation, and are generally amortised on a straight line basis over 5 years.
IT - in-house & 3rd party software showing as fully depreciated relates to one internally developed asset which is still in use.
Other fully amoritised assets still in use and reported within Computer Licenses had an original purchase cost of £1.4m.

16. Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	**£000s**
Impairments and reversals taken to SoCI	0	0	0	0	
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
	0	0	0	0	
Other	6,600	0	0	0	**6,600**
Changes in market price	1,957	0	0	0	**1,957**
Total charged to Annually Managed Expenditure	**8,557**	**0**	**0**	**0**	**8,557**
Total Impairments of Property, Plant and Equipment changed to SoCI	**8,557**	**0**	**0**	**0**	**8,557**

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**

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		
Radiotherapy new build charged to SOCI in 2014-15		
- reversed and charged to revaluation reserve 2015-16	(437)	
Other - buildings	(311)	
		(748)
Impairments Charged to SOCI in current year		
Maternity Modular new build : Boston	2,428	
Other buildings	277	
		2,705
		1,957

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

	£000s	£000s
Reversals of previous impairments charged to SOCI in previous years		0
Impairments Charged to SOCI in current year		
Buildings to be demolished / out of use*	350	
Other buildings impaired due to obsolecence*	5,741	
Progress Housing Onerous Contract net reversal (see below**)	509	
		6,600
		6,600

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

**As set out in notes 1.3.2 and 31, the Trust entered into a contract with a third party in 2006 in which accommodation is provided to Trust employees at Lincoln, Boston and Grantham sites. As part of the contract, a minimum occupancy level was guaranteed. Costs of under occupancy are met by the Trust.

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

Impairments charged / (reversed) in 2015-16 against this contract were:

Site:	**£000s**
Lincoln	0
Boston	1,135
Grantham	(626)
Total	**509**

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Other	14,997
Changes in market price	1,561
Total impairments for PPE charged to reserves	**16,558**

17. Commitments

17.1. Capital commitments

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

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	**2,655**	6,749
Intangible assets	**0**	0
Total	**2,655**	6,749

18. Intra-Government and other balances

	Current receivables	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000s	**£000s**	**£000s**	**£000s**
Balances with Other Central Government Bodies	911	0	9,118	0
Balances with Local Authorities	61	0	126	0
Balances with NHS bodies outside the Departmental Group	0	0	6	0
Balances with NHS bodies inside the Departmental Group	13,679	0	4,148	54,000
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	6,476	1,477	29,424	14,769
At 31 March 2016	**21,127**	**1,477**	**42,822**	**68,769**
prior period:				
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**

19. Inventories

	Energy	Drugs	Consumables	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**12**	**2,896**	**4,830**	**7,738**	7,738
Additions	101	39,530	11,939	**51,570**	51,570
Inventories recognised as an expense in the period	(96)	(39,658)	(11,883)	**(51,637)**	(51,637)
Write-down of inventories (including losses)	0	(157)	(384)	**(541)**	(541)
Balance at 31 March 2016	**17**	**2,611**	**4,502**	**7,130**	**7,130**

20.1. Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**3,107**	6,054	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**10,164**	8,774	**0**	0
Non-NHS receivables - revenue	**835**	904	**0**	0
Non-NHS receivables - capital	**0**	37	**0**	0
Non-NHS prepayments and accrued income	**4,328**	3,305	**0**	0
PDC Dividend prepaid to DH	**408**	69		
Provision for the impairment of receivables	**(381)**	(455)	**(416)**	(313)
VAT	**880**	944	**0**	0
Operating lease receivables	**57**	59	**0**	0
Other receivables	**1,729**	1,924	**1,893**	1,658
Total	**21,127**	21,615	**1,477**	1,345
Total current and non current	**22,604**	22,960		
Included in NHS receivables are prepaid pension contributions:	**0**			

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

Other receivables includes £3.2m (of which £1.9m is non current) relating to the injury cost recovery scheme administered by the Department of Work and Pensions.

20.2. Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**1,220**	2,694
By three to six months	**7**	531
By more than six months	**279**	462
Total	**1,506**	3,687

20.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(768)**	(823)
Amount written off during the year	**23**	49
Amount recovered during the year	**107**	126
(Increase)/decrease in receivables impaired	**(159)**	(120)
Balance at 31 March 2016	**(797)**	(768)

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: £102,000 (2014-15 £149,000)
- a general provision of 21.99% (2014-15: 18.9%) against income receivable from the Compensation Recovery Unit (CRU): £695,000 (2014-15 £619,000).

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

21. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**1,010**	983
Net change in year	**156**	27
Closing balance	**1,166**	1,010
Made up of		
Cash with Government Banking Service	**1,155**	1,000
Cash in hand	**11**	10
Cash and cash equivalents as in statement of financial position	**1,166**	1,010
Cash and cash equivalents as in statement of cash flows	**1,166**	1,010

22. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	1,075	0	7	0	0	0	**1,082**
Less assets sold in the year	0	0	(7)	0	0	0	**(7)**
Less impairment of assets held for sale	0	0	0	0	0	0	**0**
Balance at 31 March 2016	**1,075**	**0**	**0**	**0**	**0**	**0**	**1,075**
Liabilities associated with assets held for sale at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2014	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	3	0	0	**3**
Less assets sold in the year	0	0	0	(3)	0	0	**(3)**
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2015	0	0	0	0	0	0	0

In 2015-16 the Trust has re-classified land at Welland previously used as Hospital buildings as 'held for sale'.
The property is currently vacant and is being actively marketed.

As part of the 31 March 2016 revaluation, the Welland site has been revalued upwards from £0.355m based on value in existing use to £1.1m based upon fair value (highest alternative use valuation).
The Trust is seeking to gain planning permission prior to planned disposal as a mixed retail and housing development during 2016-17.

Equipment sold in 2015-16 related predominantly to various medical equipment items with nil net book value which were sold to external parties at a profit of £25,763.

23. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**2,624**	1,765	**0**	0
NHS accruals and deferred income	**1,524**	2,285	**0**	0
Non-NHS payables - revenue	**12,715**	8,928	**0**	0
Non-NHS payables - capital	**4,667**	5,527	**0**	0
Non-NHS accruals and deferred income	**10,813**	9,342	**0**	0
Social security costs	**2,801**	2,754		
Accrued Interest on DH Loans	**199**			
Tax	**2,608**	2,631		
Other	**4,069**	3,911	**0**	0
Total	**42,020**	37,143	**0**	0
Total payables (current and non-current)	**42,020**	**37,143**		
Included above:				
outstanding Pension Contributions at the year end	**3,713**	3,624		

24. Other liabilities

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Lease incentives	**24**	24	**704**	728
Other	**479**	479	**13,887**	14,366
Total	**503**	503	**14,591**	15,094
Total other liabilities (current and non-current)	**15,094**	**15,597**		

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.

25. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Loans from Department of Health	**0**	0	**54,000**	0
Loans from other entities	**118**	118	**178**	296
Finance lease liabilities	**181**	164	**0**	181
Total	**299**	**282**	**54,178**	**477**
Total borrowings (current and non-current)	**54,477**	**759**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH £000s	**Other £000s**	**Total £000s**
0 - 1 Years	0	299	**299**
1 - 2 Years	0	118	**118**
2 - 5 Years	54,000	60	**54,060**
Over 5 Years	0	0	**0**
TOTAL	**54,000**	**477**	**54,477**

26. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**2,920**	2,519	**0**	0
Deferred revenue addition	**2,331**	2,920	**0**	0
Transfer of deferred revenue	**(2,920)**	(2,519)	**0**	0
Current deferred Income at 31 March 2016	**2,331**	2,920	**0**	0
Total deferred income (current and non-current)	**2,331**	2,920		

27. 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**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**188**	183	**181**	164
Between one and five years	**0**	188	**0**	181
After five years	**0**	0	**0**	0
Less future finance charges	(7)	(26)		
Minimum Lease Payments / Present value of minimum lease payments	**181**	345	**181**	345
Included in:				
Current borrowings			**181**	164
Non-current borrowings			**0**	181
			181	345

Finance leases as lessee	**31 March 2016 £000s**	31 March 2015 £000s
Future Sublease Payments Expected to be received	0	0
Contingent Rents Recognised as an Expense	0	0

28. Finance lease receivables as lessor

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

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

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

Rental revenue	**31 March 2016**	31 March 2015
Contingent rent	**161**	177
Other	**0**	0
Total rental revenue	**161**	177

29. Provisions

		Comprising:			
	Total	**Early Departure Costs**	**Legal Claims**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**4,805**	2,767	1,913	44	81
Arising during the year	**1,233**	67	1,145	21	0
Utilised during the year	**(1,230)**	(189)	(944)	(16)	(81)
Reversed unused	**(986)**	0	(961)	(25)	0
Unwinding of discount	**36**	36	0	0	0
Change in discount rate	**(10)**	(10)	0	0	0
Balance at 31 March 2016	**3,848**	**2,671**	**1,153**	**24**	**0**
Expected Timing of Cash Flows:					
No Later than One Year	**1,364**	187	1,153	24	0
Later than One Year and not later than Five Years	**722**	722	0	0	0
Later than Five Years	**1,762**	1,762	0	0	0

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

	£000s
As at 31 March 2016	193,591
As at 31 March 2015	109,308

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 30. The Trust's legal advisors have assessed each claim and a provision has been made based upon the expected outcome of the claim, the related probability and the expected settlement date.

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

30. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**0**	(3)
Employment Tribunal and other employee related litigation	**(240)**	(541)
Other	**(70)**	(806)
Net value of contingent liabilities	**(310)**	(1,350)
Contingent assets		
Contingent assets	**20**	0
Net value of contingent assets	**20**	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 a litigation case brought by the Health and Safety Executive.
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.

The contingent asset reported relates to a legal case brought against the Trust where the judgement passed requires the claimant to pay costs. The judgement has been appealed.

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

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

Under the arrangement, Progress 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

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

	2015-16	2014-15
	£000s	£000s
No Later than One Year	**503**	503
Later than One Year, No Later than Five Years	**2,012**	2,012
Later than Five Years	**12,579**	13,082
Subtotal	**15,094**	15,597
Less: Interest Element	**0**	0
Total	**15,094**	15,597

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2015-16**	2014-15
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**503**	503
Later than One Year, No Later than Five Years	**2,012**	2,012
Later than Five Years	**12,579**	13,082
Total	**15,094**	15,597

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

32. Impact of IFRS treatment - current year

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

	2015-16 Income £000s	**Expenditure £000s**	2014-15 Income £000s	Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)				
Depreciation charges		335		319
Impairment charge - AME		509		0
Impairment charge - DEL		0		(901)
Revenue Receivable from subleasing	(503)		0	
Impact on PDC dividend payable		282		258
Total IFRS Expenditure (IFRIC12)	**(503)**	**1,126**	**0**	**(324)**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		0		503
Net IFRS change (IFRIC12)		**623**		**(827)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		**0**		0
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		**0**		0

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

33. Financial Instruments

33.1. Financial risk management

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

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

Currency risk

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

Interest rate risk

The United Lincolnshire Hospitals NHS Trust borrows from government for capital expenditure, subject to affordability as confirmed by 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 United Lincolnshire Hospitals NHS Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

33.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS		13,253		**13,253**
Receivables - non-NHS		4,966		**4,966**
Cash at bank and in hand		1,166		**1,166**
Total at 31 March 2016	**0**	**19,385**	**0**	**19,385**
Receivables - non-NHS		1,345		1,345
Cash at bank and in hand		1,010		1,010
Total at 31 March 2015	0	2,355	0	2,355

33.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables		4,148	**4,148**
Non-NHS payables		32,463	**32,463**
Other borrowings		54,296	**54,296**
PFI & finance lease obligations		15,275	**15,275**
Other financial liabilities	0	5,309	**5,309**
Total at 31 March 2016	**0**	**111,491**	**111,491**
Other borrowings		414	414
PFI & finance lease obligations		15,942	15,942
Other financial liabilities	0	4,902	4,902
Total at 31 March 2015	0	21,258	21,258

34. 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 31 May 2016 that require further disclosure.

35. Related party transactions

IAS 24, 'Related Party Disclosures' requires material transactions between the Trust and directors / key management and / or close families / entities controlled by any of these to be disclosed.
The details below represent those material transactions in 2015/16 between the Trust and Organisations with whom Trust Senior Executives hold positions of influence.
The income / expenditure values quoted are those attributable to the named related party and do not represent earnings of the individual.

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Mr D Fathers - Chairman ULHT / Vice Chair Mental Health Network - NHS Confederation	7,172	0	9,973	0
Mr D Fathers - Chairman ULHT / Chair - Nottinghamshire Healthcare NHS Foundation Trust	52,773	0	0	0
Mr K Darwin - Associate Non Executive Director ULHT / Trustee - St Barnabas Hospice	157,819	1,194,669	64,800	134,957
Mr K Darwin - Associate Non Executive Director ULHT / Governor - University of Lincoln	191,795	221,534	730	16,723
Mr K Darwin - Associate Non Executive Director ULHT / Chairman - Investors in Lincoln	10,360	0	0	0
Prof S Barnett - Non Executive Director ULHT / Chief Executive Officer Rotherham NHS FT (spouse)	0	0	0	561
Mr P Hollinshead -Interim Director of Finance and Corporate Services ULHT / Partner - Brandhill Financial Services Ltd	102,634	96	0	0
Mr M Oko (ENT Consultant) / The Snoring Disorders Centre Ltd	2,359,306	0	0	0

The Trust employs a number of consultants who in addition to their NHS duties derive varying levels of income from their work at the Trust's private patient unit. In 2015-16 this amounted to £236,444.

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, Health Education England, NHS Property Services, the City of Lincoln, Boston, North Kesteven and South Kesteven District Councils and Lincolnshire County Council.

The Trust has also received donations of £122,879 (2014-15: £303,556) to fund capital acquisitions from a number of charitable funds, the Corporate Trustee of which is the Trust board.

36. Losses and special payments

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

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

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

Included within the losses figure are losses resulting from the disposal / write off of out of date and obsolete stocks (£0.5m).

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

37. Financial performance targets

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

37.1. Breakeven performance

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

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

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

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

37.2. Capital cost absorption rate

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

37.3. External financing

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

		2015-16 £000s		2014-15 £000s
External financing limit (EFL)		**62,750**		24,274
Cash flow financing	**62,584**		24,239	
External financing requirement		**62,584**		24,239
Under/(over) spend against EFL		**166**		35

37.4. Capital resource limit

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

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**21,297**	24,030
Less: book value of assets disposed of	**(128)**	(81)
Less: donations towards the acquisition of non-current assets	**(138)**	(304)
Charge against the capital resource limit	**21,031**	23,645
Capital resource limit	**21,081**	23,907
(Over)/underspend against the capital resource limit	**50**	262

38. Third party assets

The United Lincolnshire Hospitals NHS 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 2016 £000s	31 March 2015 £000s
Third party assets held	**0**	0