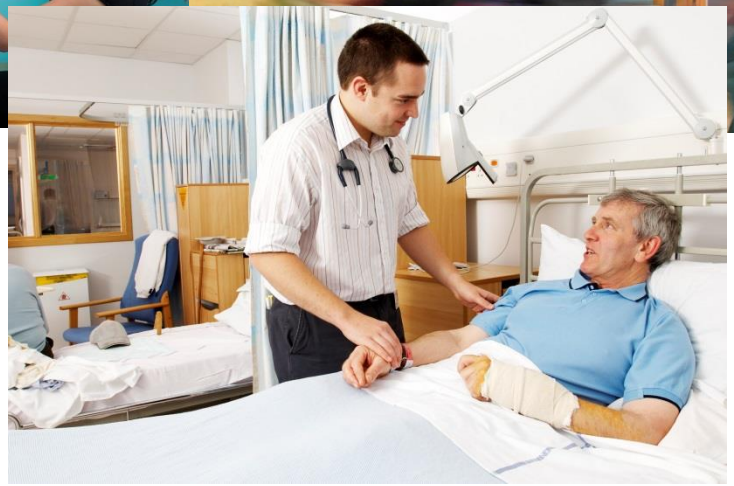
Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Annual Report and Accounts for the year ended 31 March 2018



Accessibility

This Annual Report and Accounts are available at www.ulh.nhs.uk

If you would like a copy of this document in large print or audio please call (01522) 573986.

Ja jus velaties sanemt šo dokumentu latviešu valoda, ludzam zvanit pa
Talruni (01522) 573986.

Jei Jums reikia šio dokumento lietuviu kalba, skambinkite telefonu (01522) 573986.

Jesli chciał(a)by Pan(i) uzyskac ten dokument w jezyku polskim,
prosimy zadzwonic na numer (01522) 573986.

Se necessita deste documento em Português por favor telephone para o número (01522) 573986.

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

We are really pleased to be able to share with you our Annual Report for the year 2017/18. It is a great opportunity to showcase all the work that has been taking place in the Trust over the last year. This reflects the significant efforts of our staff who have worked hard to improve the quality of the services we provide. We have been greatly impressed by the commitment of staff to do the best for patients, as well as their dedication to the Trust.

Our performance must be set in the context of 2017/18 having been another very challenging year for the NHS as a whole, with increases in demand across many services and increasing numbers of patients with complex, multiple long term illnesses.
To our disappointment the Trust remained in Special Measures for quality and was then placed in Special Measures for finance in September 2017.

We have responded positively to the Special Measures status but despite all the efforts that we have made it is regrettable that the Trust remains in a significant financial deficit, and has failed to meet national targets such as the maximum four hour wait in accident and emergency, some of the cancer targets and some key quality measures. We are working hard to address these challenges and we are encouraged by signs of improvement in different areas of the Trust.

In May / June 2017 we received fire enforcement notices covering the Lincoln and Boston sites. In addressing these the Trust has received capital loans of £9.5m in 2017/18 and re-prioritised the capital programme. The work will continue into 2018/19 with further central support agreed. The resultant works once complete will significantly improve the safety of our hospitals.

We hope this Annual 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. We've made good progress with developing the future for our services and continued to engage with staff, partners, stakeholders and the public on what this will look like.

We also invested in the future of services with significant investment being made in maternity services through a new maternity unit at Boston and complete refurbishment of the neonatal unit at Lincoln.

Despite many vacancies and a strong reliance upon temporary agency staff and the challenges this brings to improve quality, the Trust has maintained quality standards and has taken forward some innovative approaches. We opened a new bereavement centre at Lincoln, implemented new ward accreditation schemes to acknowledge quality and improvement and made great innovations in surgery and treatment. Many of our staff have won or been nominated for national, regional and Trust awards.

What are our plans for 2018/19? This will be an exciting year of transformation for the Trust. To lead the transformation of our own services, we are continuing to develop our own five year plan called the 2021 strategy which will have a big focus on quality and safety. We are also collaborating closely with our partners in the wider health and care system .

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 look to introduce new ways of working to help improve the movement of urgent care patients through our hospitals. 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.

Our foreword to this Annual Report would not be complete without thanking our dedicated and talented staff. Around 7,500 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 Elaine

Performance Report Overview

The purpose of this overview to give context to the Annual Report. It outlines and summarises the Trust's performance over the past year, where we have made improvements and where we need to do more.

About us

United Lincolnshire Hospitals Trust (ULHT) serves one of the largest geographical Areas in England with a population of around 736,700 (ONS, May 2015).

Our vision is to provide 'excellence in rural healthcare'.

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 £433 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 with a bed stock, excluding obstetrics, of 1321:

- Lincoln County Hospital (695 beds)
- Pilgrim Hospital, Boston (496 beds)
- Grantham and District Hospital (130 beds)

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 700,000 outpatients and over 130,000 inpatients, and deliver around 5,000 babies.

For 2017/18 our attendances were as follows:

- Outpatient attendances 664,505
- A&E attendances 154,888
- Inpatients 143,371

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 the Trust is the leading provider of elective care for four CCGs in Lincolnshire, Northern Lincolnshire and Goole NHS Foundation Trust and North West Anglia NHS Foundation Trust get a significant share of elective care in 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 the Chair and Chief Executive, together with a mix of other Executive and Non-Executive Directors. Collectively, the members bring a diverse range of skills and senior experience to the Board and are accountable for the delivery of the organisational objectives.

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

The Chief Executive and Executive Directors are full time employees of the Trust, appointed through open competition. The selection process includes an interview panel involving the Chair, Non-Executive Directors and independent advice.

The remuneration of Executive Directors is determined by the Remuneration and Terms of Service Committee. During 2017/18, this committee consisted of the Chair and the Non-Executive Directors.

More about our Board, Board members and committees can be found in the Corporate Governance section of this report.

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 2017/18, the Trust employed 7592 (headcount) staff.

Table 1 below shows the percentage breakdown of staff groups at the Trust by headcount. It shows the large majority (80%) of our staff were female.

In terms of the Trust's senior managers, of the 10 Executive Directors employed in the year 2017/18, two were women and eight were men. All our Executive Directors are on the Very Senior Manager Framework.

Table 1: Staff by Gender as at 31/03/2018

Staff Group	Female	Male	Total
Additional professional scientific and technical	154	71	225
Additional clinical services	1170	137	1307
Administrative and clerical	1336	260	1596
Allied health professionals	314	90	404
Estates and ancillary	589	294	883
Healthcare scientists	64	49	113
Medical and dental	279	511	790
Nursing and midwifery registered	2124	137	2261
Students	8	5	13
Total	6038	1554	7592

Vision and objectives

We have one vision, five values, three ambitions and five programmes of work.

Our vision sets out the direction of travel for the Trust to achieve our vision of Excellence in Rural Healthcare.

We want to:

- Improve our quality and performance of care in line with national standards.
- Reflect wider NHS national agendas for new ways of working.
- Treat fewer patients in our hospitals, being more efficient and effective.
- Develop new and innovative models of care.
- Attract more Lincolnshire patients to choose the Trust for their planned care.
- Consolidate services onto specific sites and develop centres of excellence.
- Becoming a national, if not an international, centre for rural healthcare.
- Change and shape of our workforce in line with the new models of care.
- Work in partnership to sell Lincolnshire as an excellent place to live and work.

Our ambitions are:

Our patients:

- Will receive consistently compassionate, safe high quality care
- Will be listened to and be involved in shaping their care around their needs
- Will be involved in shaping services around lessons learned from their care
- Will want to choose us for their care and be champions in our communities

Our services:

- Will work in partnership to develop integrated models of care
- Will involve communities in shaping our services
- Will develop centres of excellence across all our hospitals
- Will value patients time and get things right first time

Our staff:

- Will be proud to work at ULHT
- Will feel valued, motivated and adaptive to change
- Will challenge convention and improve the way we do things
- Will strive for continuous learning and development being supported to be innovative

The long-term ambition for the Trust is to develop the potential to become a national, if not international, centre for rural health and care. In February 2017 we held a rural health symposium in partnership with the Lincolnshire Economic Action Partnership (LEAP) to work towards creating a national centre for rural health and care. 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 values underpin everything that we do at United Lincolnshire Hospitals NHS Trust.

They are:

Patient-centred
Putting patients at the heart of everything we do, listening and responding to their needs and wishes.

Safety
Following the Trust's guidelines and those set out by the relevant professional bodies. Speaking up to make sure patients and staff are safe from harm.

Excellence
Striving to be the best that we can be. Innovating and learning from others.

Compassion
Caring for patients and their loved ones in ways we would want for our friends and family.

Respect
Behaving and using language that demonstrates respect and courtesy of others. Zero tolerance to bullying, inequality, prejudice or discrimination.

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, estate, pace of transformation and demographic 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 2018/19. The Trust has a corporate risk register outlining what it perceives its key challenges to be.

Performance challenges

Last year saw unprecedented demand for services and beds. Although the Trust has worked in close partnership to ensure that patients are cared for in the most appropriate environment, there have been delays in discharging medically-fit patients into the care of other organisations. The impact of this was that we needed to postpone elective work to accommodate emergency patients. There were, and remain, 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 352.98 registered nurse and midwife vacancies and 159.28 medical and dental vacancies. We worked hard to recruit staff and despite our turnover rate being low, we have an over reliance on locum and agency staff.

Due to our staffing difficulties a number of our services remain fragile. The principle services this affects, but not limited to, include urgent care, Paediatrics and breast services. As a result a number of internal and external escalation meetings took place involving the Medical Director, Director of Nursing and the Chief Operating Officer.

The A&E department unfortunately remains closed at Grantham overnight (18.30 to 08.00). Significant efforts have been made to recruit additional staff despite this sufficient staff have not been recruited to populate three rotas. Work remains in progress with partners to secure the long term model of urgent care across Lincolnshire.

During 2017/18 nurse and medical staffing within paediatrics remained challenged. Action was taken to stabilise nurse staffing through recruitment and skill mixing . This coupled with capping of inpatient children beds maintained appropriate ratios of staff to beds. Extensive National and International medical recruitment continued during 2017/18 with limited success. This would have a particular impact upon the Pilgrim Hospital.

The ongoing challenges of securing breast radiologists continued during 2017/18. As an organisation we do not have sufficient breast radiologists to meet consistently the demand for breast referrals. This has resulted in delays in access for breast services. National and international recruitment efforts continue.

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

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

Financial challenges

Like much of the rest of the NHS, the Trust faces unprecedented financial challenges and has done for several years now, but 2017/18 was particularly challenging. In some areas such as acute medicine and emergency care, rising demand for services resulted in us using additional agency staff at increased cost whilst at the same time being required to cancel income-generating elective surgery to allow emergency patients to be treated.

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

The Trust's financial position continued to deteriorate in year and this led to the Trust being placed in Financial Special Measures in September 2017. While the Trust is working hard on identifying and enacting efficiencies, the Trust's internal financial plan will not,

on its own, be sufficient to drive the scale and pace of change required to deliver our vision for clinically and financially sustainable services in the medium to long term.
The Trust is therefore working with Healthcare partners across the Lincolnshire STP to deliver clinically and financially sustainable services. The Trust will be seeking revenue and capital support via the STP and from NHSI to invest in;

- Strategic change
- Digital and sstate infrastructure
- Clinical transformation including diagnostic capacity

In 2018/19, the challenges will continue, as the Trust is required to make further efficiencies at a time when demand continues to rise.

Income

The table below is a snapshot taken from the 2017/18 accounts which breaks down the income received by the Trust.
The full accounts are included separately within this report.

Income from patient care activities (by nature)	**2017/18**	**2016/17**
	£000	**£000**
Acute services		
Elective income	55,659	61,738
Non elective income	126,160	122,437
First outpatient income	37,859	31,366
Follow up outpatient income	32,240	42,135
A & E income	20,966	18,775
Other NHS clinical income	104,215	100,531
Other services		
Private patient income	381	551
Other clinical income	17,032	14,894
Total income from activities	**394,512**	**392,427**
Other operating income totals	**38,649**	**44,897**

Total income	**433,161**	**437,324**

Sustainability and Transformation Fund (STF) income

In 2017/18 the Trust signed up to its control total of £48,564k and was therefore eligible if it achieved financial and A&E trajectories to receive a maximum Sustainability and Transformation Fund (STF) Core Income of £14,773k. Failure to achieve targets however meant the Trust did not receive any STF Core income during the financial year.
At 31st March 2018 the Department of Health and Social Care made a 'General Distribution' to Trusts based upon the variance between reported outturn position and individual control totals. The Trust received an allocation of £3,551k.

Going concern

In preparing the financial statements for 2017/18, NHS organisations are required to consider the adoption of the 'going concern' basis. It is appropriate to prepare accounts on this basis where there is an expectation the Trust will continue in operation for the foreseeable future and will be able to realise assets and discharge liabilities in the normal course of operations.

The Trust Audit Committee reviewed and discussed this at its meeting held in January 2018.
Note 1.1.2 of the Trust accounts sets out the full 'Going Concern' note concluding with the following statement:

The Trust recognises that there is material uncertainty which may cast significant doubt about the Trust's ability to continue as a 'Going Concern', however the assurance provided by the immediate continuing provision of healthcare services and cash support significantly mitigates this.

The Board of Directors is therefore satisfied and considers it appropriate that the accounts for the year ended 31 March 2018 should be prepared on a 'Going Concern' basis.

Clinical negligence

At 31 March 2018, £220,518k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of United Lincolnshire Hospitals NHS Trust (31 March 2017: £211,792k).

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

The challenges faced in recruiting A&E consultants mean that the current service configuration is not financially sustainable and in some areas is not clinically sustainable.
The recommendations coming from Sir Bruce Keogh and Professor Keith Willetts indicate a new approach nationally for urgent and emergency care. These would see hospital emergency departments caring for patients who need time critical care, and urgent care centres seeing patients who need urgent but not necessarily time critical care.

The overnight closure of Grantham A&E in 2017/18 continued and was subject to a review from the East of England Clinical Senate, as recommended by NHS Improvement. More about this is included in the Performance Analysis section of this Annual Report.

Population challenges

The population of Lincolnshire is estimated to be 736,700 (ONS, May 2015). Lincolnshire has one of the fastest growing populations in England and it is projected to rise to 838,200 by the year 2033. Greater life expectancy and increased long-term conditions will increase the demand for healthcare.

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 are not well met by the configuration of our current services. Integrating care with other health and social providers will help to ensure these citizens get the right care, in the right place and at the right time. This is being done in partnership with health and social care organisations through the STP.

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

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

Quality challenges

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

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

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

CQC inspection

In April 2017, the Trust was placed into Quality Special Measures following at inspection by the Care Quality Commission (CQC) and in September, placed into Financial Special Measures. Their report, produced following inspections at Lincoln County Hospital, Pilgrim Hospital, Boston and the A&E department at Grantham and District Hospital, identified a range of issues which the Trust is required to tackle, but also many examples of good practice.

The Trust had already made significant improvements in identifying and treating sepsis and bringing in additional senior clinicians and management at Pilgrim Hospital. The Trust had also completed an extensive piece of work to introduce ligature cutters to all clinical areas, as well as work to improve staff awareness and training around caring for patients with mental health problems and major incident planning. An anti-bullying campaign was introduced encouraging staff to raise their concerns through official channels.

In February 2018, following an unannounced inspection within Pilgrim A&E, the CQC imposed conditions on our registration as a provider in respect of a regulated activity on surgical procedures, diagnostic and screening procedures and treatment of disease, disorder of injury. As a result immediate improvement work was required to improve the functioning of the emergency department. As at 31 March 2018 these conditions remained in place.

Pace of transformational change risk

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

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

Our aim is that by 2021 our hospitals will be smaller as more patients will be treated and cared for closer to home, and all patients will receive high-quality care.

We want to prevent admissions to hospital. But those patients who need specialised hospital treatment will receive safe, high quality care at the most appropriate hospital, not always their nearest hospital. Our patients will have shorter stays and be discharged home more.

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

For staff this will mean there will be new roles and new opportunities and they will belong in well-staffed teams which often work across professions and organisations. They will have access to training and development and have opportunities to retrain and gain new qualifications. They will have access to the latest technology to help in their role and staff will be heard and have an opportunity to improve where they work.

We are working closely with our local health and care partners to deliver healthcare differently and provide more seamless care for patients. Working together gives us a unique opportunity to improve the way healthcare is delivered in Lincolnshire. Our 2021 strategy has been developed with that in mind.

Underpinning the vision, ambitions and programmes are our values: Patient-centred, safety, excellence, compassion, respect. The Trust has established values which are being supported by a behaviours framework in the form of our staff charter.

The charter sets out clear expectations on 'what we expect to see from staff' and what 'staff can expect from the Trust' as an employer. It describes how together we will deliver excellence in rural healthcare for all our patients.

Alongside this we have also produced a personal responsibility framework to support and underpin the charter's values, which give examples of the behaviours we would wish to see and those we would not wish to see, to help us create a positive, compassionate working environment.

Review of 2017/18

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

We have three ambitions underpinned by five key values Below are examples of where we have made advances to the benefit of both patients and staff against each of these.
The Quality Account once published will give further detail specifically focussing on quality delivery in the year.

Our values and ambitions

Patient-centred

Telephone clinics giving access to care from home
Telephone clinics are taking the stress out of coming to hospital by allowing some patients to access their appointment and advice from the comfort of their own home.

The rheumatology department at Lincoln County Hospital is providing telephone clinics for eligible patients. Patients are selected based on their condition being stable, them not suffering from any recent flare ups and there not being any recent changes to their medication. Patients with more complex symptoms will continue to be seen in a traditional face to face clinic. The telephone clinics have been welcomed by patients, particularly those who have no means of transport or live far away from the hospital. Being in a rural area public transport can be difficult, but by having a telephone appointment patients no longer have to rely on friends, family or a taxi service to help them travel to the hospital.

One-stop foot clinics for diabetic patients
New one-stop foot clinics in Lincolnshire have been set up to help prevent amputations in people with diabetes.

People with diabetes are much more likely to develop problems with their feet as high blood sugars can damage blood circulation and the feeling in their feet. If left untreated patients can develop foot ulcers, infections and, at worst, it can lead to amputation. There are around 25 major (above or below the knee) amputations performed each year across the county due to diabetes. Statistics show 4 out of 5 amputations can be prevented. This is why new clinics are being run at Lincoln

County Hospital and Pilgrim Hospital, bringing together the expertise of vascular and orthopaedic surgeons, podiatrists, research nurses, radiology, microbiology, cast technicians and orthotics.

Jaundice monitors helping to keep new babies at home
Fewer babies are being admitted to hospital in Lincolnshire with jaundice, thanks to the introduction of new monitoring devices used in the community.

United Lincolnshire Hospitals NHS Trust's community midwives and health care support workers are using new jaundice monitors to keep an eye on jaundice in babies. This means that they can be monitored at home, rather than having to come to hospital.

The monitors are placed on the baby's torso and within a matter of seconds a reading is produced, showing how serious the baby's jaundice is. This enables the clinicians to make a judgement about whether a hospital admission is required.

In the month since the meters were introduced in December 2017, the community teams reviewed 244 babies with jaundice and of these only 25 had to be referred into hospital for paediatric review.

Respect

Unveiling of organ donation memorial tree at Pilgrim hospital
A new organ donation memorial tree was officially unveiled at Pilgrim Hospital, Boston, placed as a mark of respect for those who have donated their organs to help others.

The tree, commissioned and installed by United Lincolnshire Hospitals NHS Trust, is made of bronze, and features plaques on its branches featuring the names of past donors.

The opening ceremony was attended by families of past donors and patients who have benefitted from donor organs, as well as hospital staff and local dignitaries.

Festive food parcels and Easter eggs donated by caring NHS staff
Staff from the Trust generously donated dozens of Christmas hampers and hundreds of Easter eggs to foodbanks across the county.

Staff at all four hospital sites – Boston, Grantham, Lincoln and Louth – collected various Christmas goodies to put into the festive hampers for charity and around 500 Easter eggs were collected and delivered to food banks across the county in time for the Christmas and Easter celebrations.

Excellence

Lincolnshire Heart Centre
People who suffer a heart attack or cardiac arrest in Lincolnshire have a greater chance of survival than most areas of the country, thanks to the innovative work of the Lincolnshire Heart Centre. Since it opened in 2013 a thousand lives have been saved by patients being treated at the specialist centre rather than other hospital sites in the county.

Statistics released by the National Institute for Cardiovascular Outcomes Research (NICOR) show that the Lincolnshire Heart Centre is outperforming all of the national targets for treating heart attack patients. Also *s*urvival in Lincolnshire for non-traumatic patients suffering an out of hospital cardiac arrest where CPR is started is currently 50% compared to 7% nationally.

New antenatal and postnatal unit opens at Pilgrim hospital, Boston
Work is now complete on the unit to improve the environment for pregnant women, new mums and families in Boston and the surrounding areas after a £2.5m upgrade.

The new maternity ward replaces outdated facilities and includes six spacious, en-suite single rooms, and four larger three-bed rooms with a shared shower room. There is also a large day room for families to use a spacious ward bathroom and shower room for partners staying overnight.

For anyone wishing to feed in privacy there is a designated feeding room and a quiet room for delicate conversations. The midwife station is central to the ward and accessible to everyone.

The project was funded by the Trust to ensure patients receive care in the best possible environment. The works have included both improvements to maternity and gynaecology wards at Pilgrim.

Safety

Blood transfusions amongst the safest in the country thanks to new technology
Blood transfusions at the Trust are among the safest in the country thanks to an investment in state-of-the-art technology.

More than £800,000 has been invested in an electronic barcode blood tracking system which has been rolled out to hospitals in Lincoln, Boston, Grantham and Louth. The latest upgrade incorporates more advanced recording of all blood products given to patients and used correctly it ensures the right blood is always given to the right patient. We are one of the first Trusts in the country to use mobile devices to scan blood at a patient's bedside. Many hospitals use a system for collecting blood from the fridge, but we have gone one stage further to enable us to make transfusion at the bedside as safe as we can make it.

Innovative ankle surgery for patients at Pilgrim
Patients requiring ankle replacement surgery can now be operated on and return home the same day, thanks to a brand new way of working at Pilgrim hospital.

The innovative practice has been adopted to ensure patients only remain in hospital for as long as absolutely necessary and is being carried out by trailblazing Consultant Orthopaedic Surgeon Harish Kurup and his team.

Compassion

New bereavement centre opens at Lincoln County Hospital to provide support for bereaved families
The centre, based in the Swanpool Suite, gives a single point of contact for families, providing help and advice following bereavement away from the bustle of the hospital in new, purpose built surroundings. Staff are on hand to ensure that practical arrangements are handled in a sensitive and timely manner and to make sure that information is available regarding ongoing support.

Lincolnshire's hospitals finding new ways to support bereaved children
Children whose relatives have passed away in Lincolnshire's hospitals are being helped through their grief thanks to generous donations by healthcare staff and the public.

In January, the Trust introduced bereavement bags for children who visit seriously ill relatives in hospital or who have lost relatives.

These bags, which were the brainchild of hospital chaplain Pamela Beattie, contain items to help them remember their loved ones, to comfort and entertain them and to help them to cope.

2021 Strategy

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

The Trust has been developing our clinical strategy over the past two years, and many staff and the public have had the chance to shape what our services will look like.

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

To meet modern standards of care and clinical guidelines our services need to evolve and address the changing needs of our population

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

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

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

Our services will:

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

Our patients will:

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

Our staff will:

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

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

Seeking the views of the public and staff on our plans

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

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

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

The plan can be found on our website: www.ulh.nhs.uk

Membership

One of the regular ways we engage and inform the people of Lincolnshire is via our members. The Trust has been a membership-based organisation since early 2012 and we currently have over 1,300 members. Of those, 92 have been through an in-house training programme to become patient representatives (reps). Between them, our patient reps sit on 17 different boards and committees of the Trust.

Our patient reps have also taken part in numerous activities including sitting on 13 job interview panels for band 7 and above nursing posts, seven members sitting on the panel to appoint the new Trust chair and taking part in visits and inspections including PLACE inspections, staff awards longlisting, and ad-hoc inspections.

All members have been engaged via surveys and consultations and were regularly sent information about what's going on within the Trust. Examples included a monthly member's newsletter. They were encouraged to feedback and respond, and regularly do.

We had members meetings across the county three times per year. These are a formal mechanism for the membership to feed into the decision-making of the organisation. The agenda covers strategic planning and service development, plus an action log and questions to the panel.

Locality forum meetings took place in Skegness in June, in Lincoln in September and in Skegness in January. The topics covered were our 2021 programme, developing clinical pathways and plans for the development of our estate.

Community engagement

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

During the year we identified and contacted a large number of groups to engage with across the county. These groups covered a wide range of locations, communities and also covered the nine protected characteristics. We met with more than 15 different community groups across Lincolnshire to engage with them on a range of issues. A snapshot of the groups we've spoken to includes:

- Parish councils
- Children's centre groups
- Boston Youth Council

- Skegness Parkinson's Support Group
- Lincoln Macular Society

We sought people's views and input on a wide range of issues to inform our strategies and plans, and review our services. This included developing the STP and our own 2021 plan, continuing engagement with the population of Grantham to understand the impact of the temporary overnight closure of A&E on the population, and targeted engagement around the delivery of paediatric services in the East coast area of the county.

A report on what we've heard through our engagement activities is shared with our workstream leads for our 2021 programme, the STP programme and service leads. We feed back to the public via our members' newsletter.

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

Surveys
Between March and July 2017, we launched an online survey to gather public feedback, opinion and intelligence around our 2021 plans. This was widely promoted in the media, on social media, and shared with community groups.

This survey had 805 responses. This resulted in a large number of potential money saving ideas which were fed straight back to the finance team. Themes from the survey were also shared with the workstream leads for our 2021 programme and helped shape the final 2021 strategy.

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

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

- Sending out information to groups
- Wider public surveys

We have visited more than 15 groups. Overall, we have engaged with more than 1,060 people in meetings and via surveys. These views will be taken into account before finalising our plans.

Performance analysis

Overview

Performance has remained below our expectations during 2017/18. In spite of our challenges, there have been developments and some improvements across the Trust this year.

We have kept our focus on infection control and constitutional standards. During the year compliance with infection control practices has significantly improved as evidenced by site visits undertaken by NHS Improvement's Infection Prevention and Control Lead Clinician to inspect systems and processes. From a rating of Red in early 2017 the Trust was re-assessed in November as Amber and more recently in May 2018 received a Green rating.
The Trust's performance in its key national target areas of referral-to-treatment (RTT), cancer waiting times and A&E waiting times, diagnostics, cancer and Referral to Treatment (RTT) have not been delivered to the standard we would expect this year. The poor position against the constitutional standards is well understood and is driven by

- increasing urgent care demand on the bed base, displacing elective care
- increasing cancer demand (over twice that seen nationally), displacing elective care
- demand for services overwhelming the available staff across all parts of the urgent and elective care pathways also including radiology and pathology

Despite this there has been some early progress in meeting the cancer constitutional standards – although we acknowledge there is still more that we must do.

Performance Indicator	Target	Quarter 1 April to June	Quarter 2 July to Sept	Quarter 3 Oct to Dec	Quarter 4 Jan to March	2017/18
A&E: Proportion of patients spending less than 4 hours in A&E	95%	80.08%	77.59%	75.45%	67.05%	75.07%
A&E: 12 hour trolley waits	0	0	0	1	2	3

Performance Indicator	Target	Quarter 1 April to June	Quarter 2 July to Sept	Quarter 3 Oct to Dec	Quarter 4 Jan to March	2017/18
Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>99%	99.44%	98.22%	96.98%	96.25%	98.1%
Cancer: % of 2 week GP referral to 1st outpatient appointment	93%	90.5%	87.5%	91.2%	83.4%	88.2%
Cancer: % of 2 week GP referral to 1st outpatient- breast symptoms	93%	75.4%	91.7%	89.6%	54.9%	74.1%
Cancer: % of patients treated within 62 days of referral from screening	90%	84.1%	87.9%	90.1%	87.2%	87.6%
Cancer: % of patients treated within 62 days of referral from hospital specialist	85%	84.6%	89.9%	82.2%	90.1%	86.6%
Cancer: % of patients treated within 62 days of referral to treatment of all cancers	85%	69.9%	69%	70.9%	75.5%	71.3%
Cancer: % of patients treated within 31 days	96%	95.8%	96.4%	96.8%	96.9%	96.5%
Cancer: % of patients for second or subsequent treatment treated within 31 days – surgery	94%	91.4%	91.7%	96.6%	90.7%	92.4%
Cancer: % of patients for second or subsequent treatment treated within 31 days –	98%	99%	99.6%	98.1%	99.3%	99%

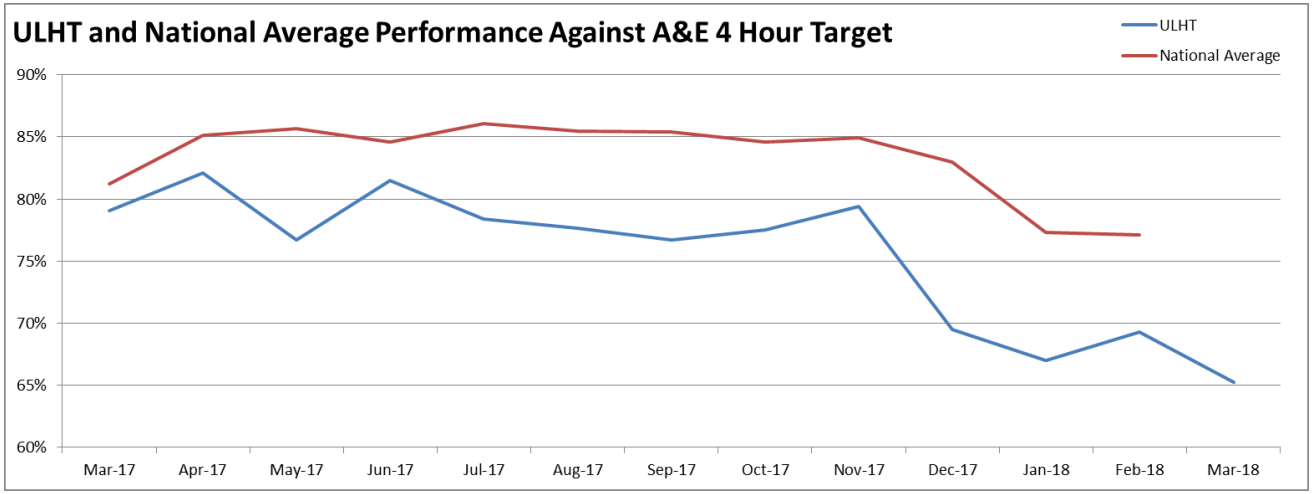
Performance Indicator	Target	Quarter 1 April to June	Quarter 2 July to Sept	Quarter 3 Oct to Dec	Quarter 4 Jan to March	2017/18
drug						
Cancer: % of patients for second or subsequent treatment treated within 31 days – radiotherapy	94%	93.4%	96%	97.3%	97.8%	96.2%
Referral To Treatment (RTT) waiting times incomplete pathways (18 weeks)	92%	89.82%	88.54%	86.57%	86.08%	87.27%
RTT over 52 weeks	0	33	13	2	37	85

Challenges do remain as we move into 2018/19, 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. However targeted investment and successful recruitment will also be required in order to meet the demand upon our services.

Performance against national targets

A&E performance

The Trusts performance for urgent care has been below our improvement trajectory and significantly below the national average throughout the last year.



The key drivers for this poor performance include;

- Increased attendances to A&E
- Inability to reduce further the number of ambulance conveyances to each department
- Ongoing staffing difficulties across urgent care and particularly within Lincoln and Pilgrim A&Es
- More urgent medical admissions than planned increasing the demand upon the already constrained bed base
- Inability to reduce further our top quartile length of stay for emergency patients
- Inability to reduce the number of delayed transfers of care to 3%

As a result of the above drivers bed occupancy within the hospital sites remained above 92% during the year regularly peaking in excess of 100% during winter. This caused delays to admit patients into hospital beds resulting in often overcrowded emergency departments causing delays in ambulance handovers.
Key actions have been taken during 2017/18 to underpin the required improvement. These have included;

- Redesign of the ambulance handover process
- Increased the number of cubicles at Lincoln to support Minors
- Introduced Primary Care Streaming at Lincoln and Pilgrim
- Invested in the nursing and medical rotas to right size the staffing to meet demand (recruitment continues)
- Re-invigorated the SAFER flow bundle which are a series of good practice initiatives to reduce waiting for patients. This also included “Red2Green”, “end PJ paralysis”, “perfect weeks” and “Multi Agency Discharge Events (MADE)”
- Implementation of a range of schemes during winter to support the increased demand including opening additional beds at Lincoln County in partnership with Lincolnshire Community health Services

Ongoing plans are in place for improvement in 2018/19. These include;

- Ambulance handovers and conveyance.
- Streaming to services co-located or outside of the emergency department.
- Pilgrim and Lincoln emergency department staffing and emergency department processes.
- Admissions areas and flow management.
- Large scale Trust bed reconfiguration.

These actions will support the following improvement trajectory;

Lincolnshire 4 hour standard trajectory 2018/19												
	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
ULHT Type I	69.69%	72.03%	74.38%	76.72%	79.07%	81.41%	82.22%	83.02%	79.07%	76.72%	77.53%	86.24%
ULHT + Streaming	72.04%	74.33%	76.63%	78.92%	81.22%	83.51%	84.39%	85.26%	81.22%	78.92%	79.79%	88.74%
ULHT + Streaming & Type 3	82.07%	83.68%	85.30%	86.91%	88.52%	90.13%	90.94%	91.75%	88.52%	86.91%	87.72%	95.00%

The overnight closure of Grantham A&E continued throughout 2017/18. In December 2017 the Board agreed to accept the East of England Clinical Senate's recommendation to not change the opening hours of Grantham A&E on the grounds of patient safety for Lincolnshire residents. This was also in line with NHS Improvement's advice.

In line with the Senate's recommendations, the Board also agreed to move to a single A&E team across the three departments and to standardise systems and processes. It was also hoped to provide better training opportunities for staff and better patient experiences. The Trust Board also urged the clinical commissioning group to agree at pace a future model on emergency care in Grantham.

Diagnostic Performance

Performance against this standard has been difficult throughout the year due to a mixture of staffing and physical capacity issues.

CT, MRI and endoscopy have struggled with physical capacity constraints. Business cases for all areas have been approved with expansion expected during 2018/19.

Staffing remains challenging within urodynamic and echocardiography. Pathway and role redesign have been completed during 2017/18.

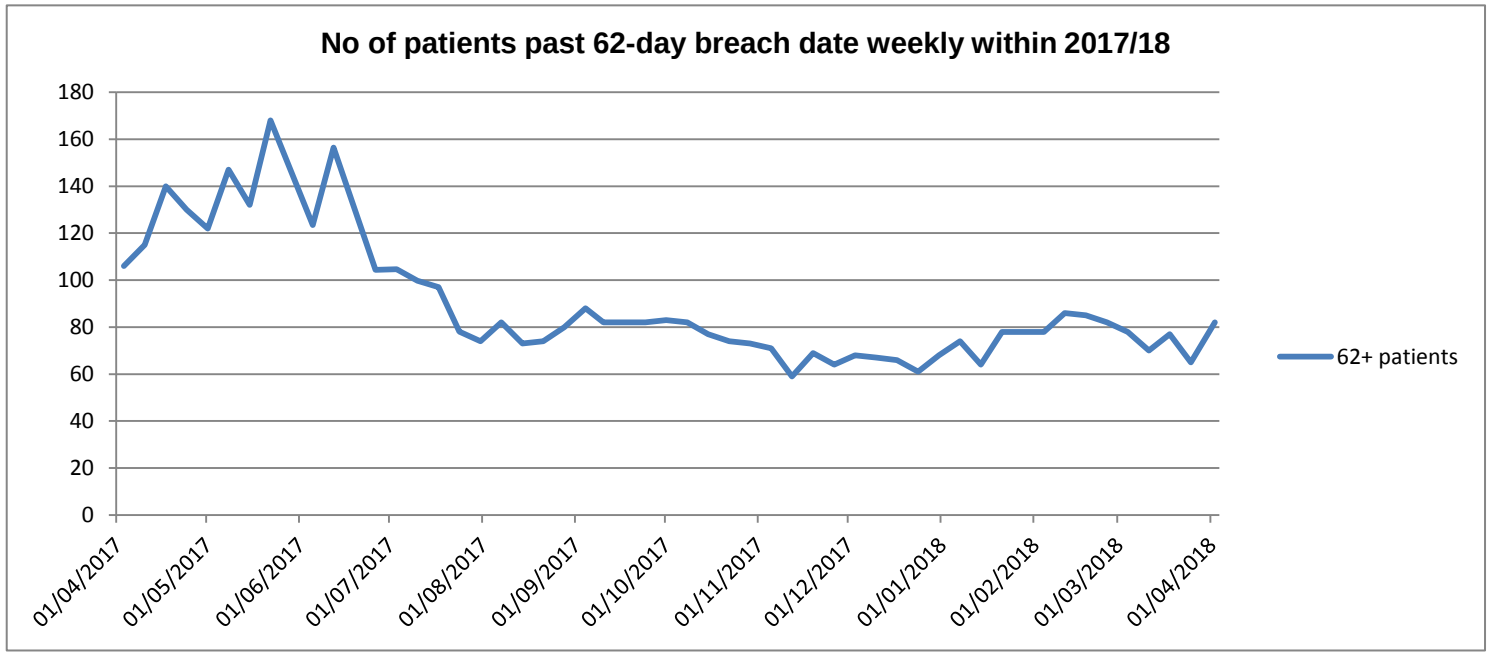
Following these actions recovery of this standard is expected in June 2018.

Cancer

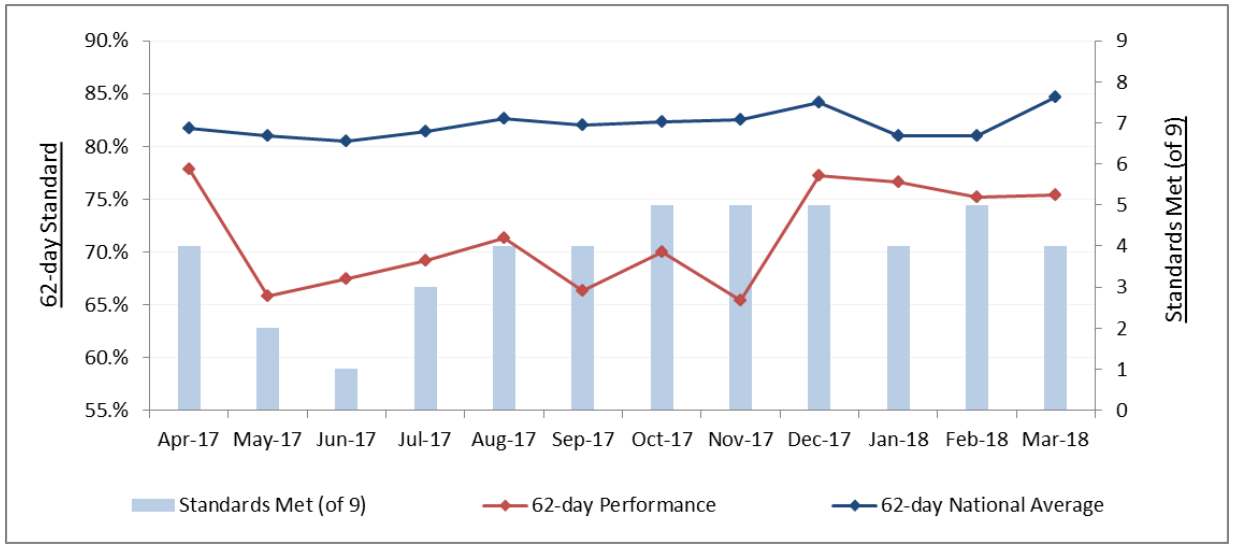
Cancer performance within the Trust was below the national standards for 14-day and 62-day during 2017/18. 31-day, first treatment subsequent chemotherapy and radiotherapy were achieved during 10 of the 12 months; however 31-day subsequent surgery performance has been less consistent.

During 2017/18 there was a 9% increase in referrals on the suspected cancer pathway compared with the previous year. Nationally there was a 4% increase comparing the same periods. However, conversion rates remained broadly in line with the national average. The increase in two week wait referrals into the Trust between 2016/17 and 2017/18 was particularly significant in the following tumour sites – breast (17.6%), skin (14%) and lower GI (12.9%).

In addition, the delivery of cancer treatments was significantly affected during the winter by the impact of urgent care pressures and adverse weather, with over 35 surgical cases for cancer patients cancelled during quarter 4.



The Trust focused on reduction of the backlog of patients over 62-days during the first part of 2017/18, with 62-day performance improving towards the end of year. At the end of 2017/18 the Trust achieved four consecutive months in excess of 75% for the first time since 2014. Despite this improvement here remains significant improvement required to meet the constitutional standard of 85%.



Actions undertaken to improve performance

During the course of 2017/18 a programme of improvement has been undertaken within the Trust in order to improve the timeliness of assessment, diagnosis and treatment of patients on cancer pathways. This improvement programme was overseen at a corporate level via the fortnightly cancer recovery and delivery group chaired by the deputy director of operations for planned care. Key changes implemented during 2017/18 include:

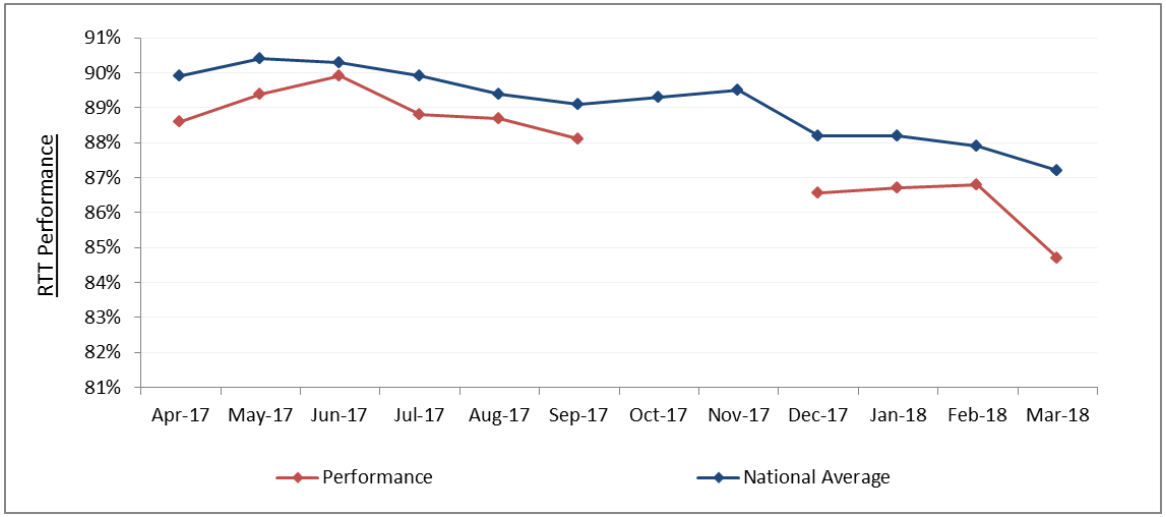
- Lower GI nurse led triage implemented across the whole Trust, in order to reduce the time between referral and diagnosis by identifying the appropriate initial testing which is required.
- Introduction of level one beds at Lincoln, designed to reduce cancellations of surgery related to Intensive Care capacity constraints. The impact of this has been restricted by bed pressures from urgent care.
- Upper GI straight to test pathway established, in order to ensure that the patient has undergone initial diagnostics prior to their first outpatient appointment.
- Review and redesign of chemotherapy pathways, streamlining the blood test and booking processes.
- Introduction of chemotherapy-scheduler roles to keep oversight of chemotherapy treatment in relation to the patient's 62-day target date.
- Review and redesign of diagnostic flow processes, in order to prioritise cancer cases, with the aim of achieving 90% of cases from referral to a radiology report within seven days and referral to endoscopy within 10 days. As at the end of April 2018, radiology is performing at 68% and endoscopy 91% against these measures.
- Same-day radiology and endoscopy booking commenced, enabling the patient to leave the hospital after an outpatient appointment with confirmation of the next step in their pathway, reducing the delays which are introduced during the standard booking process.
- Redesign of the urology pathway, introducing specific two week wait new appointment clinics to optimise decision making and reducing time between MDT and follow-up appointments.
- Development and approval of CT business case. This is to be fully operational, providing increased access to outpatient CT scanning capacity seven days per week on all sites from September 2018.
- Development and approval of endoscopy business case to deliver increased endoscopy capacity. All day weekend lists at Lincoln and Pilgrim to be delivered from May 2018 and in September, extending to Grantham and evening lists to be delivered on the Lincoln and Pilgrim sites.
- Development and approval of MRI business case, to be implemented on all sites from July 2018.
- Standardisation of transfer process between tumour sites in order to prevent delays in patient pathways once a decision has been reached to transfer to a new tumour site.
- Worked with partners to introduce PET service within Lincolnshire, which is now provided two days per week from the Lincoln site.
- Re-design and commence implementation of optimised lung pathway, with straight to test CT introduced in January in order to improve the effectiveness of the first OPA by having the CT results available to review during the appointment.
- Path Links procured and commenced utilisation of outsourcing capacity in order to enable prioritisation of cancer workload.
- Developed new tertiary pathways for head and neck and urology cases, in line with quality surveillance recommendations.

- Commenced allocation of oncology appointments within MDTs, in order to enable early appointment planning
- Standardisation of cancer communications project, to support our administrative staff during conversations with patients to ensure that they make informed decisions when booking subsequent appointments.

Significant ongoing actions to improve performance remain in place and as a result performance against the 62 day standard is expected to achieve in September 2018.

Referral to treatment (RTT)

RTT performance deteriorated during 2017/18 within the Trust and the country as a whole, as illustrated by the below graph. The Trust's performance in April 2017 was 88.6%, and had deteriorated to 84.7% by March 2018.



There are four reasons for this:

- During October and November the Trust's Patient Admin System (Medway) was upgraded giving enhanced reporting functionality. No performance data is available for these two months. The Medway upgrade has enabled patients at the pre-operative stage between outpatients and inpatients to be included within the reported figures; whilst providing a more accurate picture this has contributed to the deterioration within the Trust's reported performance.

- The level of cancelled operations during 2017/18 has led to a significant increase in the backlog of patients waiting over 18 weeks on an admitted pathway. During 2017/18, 4853 operations were cancelled on the day or day before surgery, which is an 83% increase compared with 2016/17. The most common reason for cancellation was the lack of beds as a result of urgent care pressures. The volume of patients waiting over 18 weeks for an operation rose from 1018 at the end of April 2017 to 2456 at the end of March 2018.

- The third key factor within the deterioration of the Trust's RTT performance at the end of the year was the cancellation of around 2750 outpatient appointments in late February/ early March as a result of the adverse weather conditions.

Specialities such as Ear, Nose and Throat and Breast have seen a reduction in the number of adhoc clinics provided. Specialties such as these have had a historic reliance on adhoc capacity due to staffing constraints and difficulties recruiting. During 2018/19 the expectation of hospitals is to maintain the waiting list size during the year so the March 2019 position is no bigger than March 2018. Internally the ambition is to return to at least the National average level of performance.

Sustainability

Despite increasing financial and operational pressures, the Trust retains sustainability, energy efficiency and carbon reduction at the heart of its management policy.

Last year the Trust launched its new 2021 strategy roadmap which sets out our vision to provide excellence in rural healthcare. 'Improving our environment, improving quality and reducing our costs' is one of the five programmes within 2021 strategy and this includes reducing energy consumption which can bring immediate benefits and of course contribute to our social responsibility to improve the environment.

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

its CO_2 emissions by a further 15% to 28% by 2021. By investing in its infrastructure, increasing staff awareness, and by encouraging and embedding sustainable behaviours into the organisation, the Trust seeks to continue to be among leading NHS Trusts for its environmental and sustainability track record.

The Trust Board recently approved its first Sustainable Development Management Plan (SDMP). This document sets out our track record on sustainability and also outlines a 'route map' for the whole of the Trust over the next few years to build on the good work we've already accomplished as part of our journey to excellence.

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

To demonstrate Trust commitment and enhance its reputation, during 2018 the Trust is working its way towards achieving a leading sustainability accreditation "Investors in the Environment" (iiE). The certification manages and measures the Trust's environmental performance, but under the criteria, there is also a requirement to review and work towards its greater impacts – namely health and wellbeing (of both patients and staff).

iiE offers support and help to organisations to improve their impact on the environment by providing a range of audit tools, checklists and a robust process to independently evaluate and verify that the Trust is taking effective actions and delivering measurable improvements to the environment.

Investors in the Environment is more than just an accreditation scheme. It requires organisations to not only focus on their environmental performance, it also requires regular communication and engagement with all staff and management. Projects need to include campaigns and promotions, which not only make a significant environmental impact, but they also need to have a staff and community impact within the local areas surrounding the organisation.

The Trust is striving to achieve reductions in energy consumption of 10% - 15% through various capex initiatives, including an overarching "Energy Performance Contract" (EPC). Investing in the installation of energy efficient technologies and optimisation of all systems.
Contract negotiations and Trust approval should be completed in timescales which allow construction works to begin in 2018/19.

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, forms an integral component of the Trusts Sustainable Development Management Plan (SDMP).

Equality, diversity and inclusion

Building on the firm foundations laid in 2016-2017, the Trust has continued to develop its work around equality, diversity and inclusion for the benefit of our patients and service users, our staff and the communities we serve.

The Trust is proud to have achieved and demonstrated a good level of compliance with its statutory and mandatory equality obligations and the work continues to ensure we excel in relation to the equality agenda. The road map to inclusion below highlights some of the key achievements and milestones on our journey to move beyond compliance to excellence.

Equality, diversity and inclusion are central to the ethos and work of the Trust. Further information about some of the equality related work streams can be located on the Trust's website:

https://www.ulh.nhs.uk/about/equality-diversity/

As part of the Public Sector Equality Duty (section 149 of the Equality Act 2010), the Trust publishes a detailed annual report in relation to the equality, diversity and inclusion work being undertaken. The Equality, Diversity and Inclusion Annual Report 2017-2018 is published on the Trust's website:

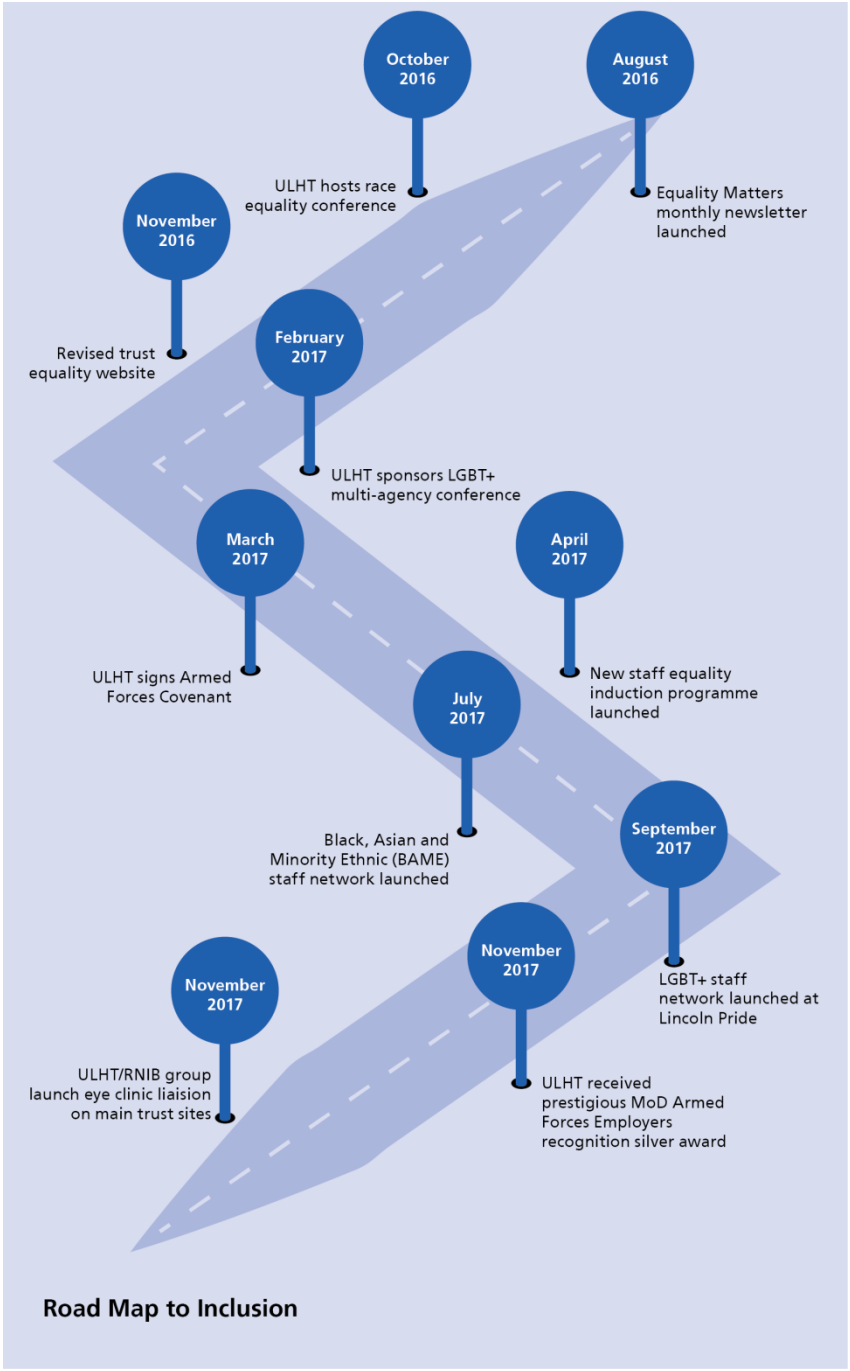
https://www.ulh.nhs.uk/about/equality-diversity/equality-diversity-and-inclusion-annual-report/

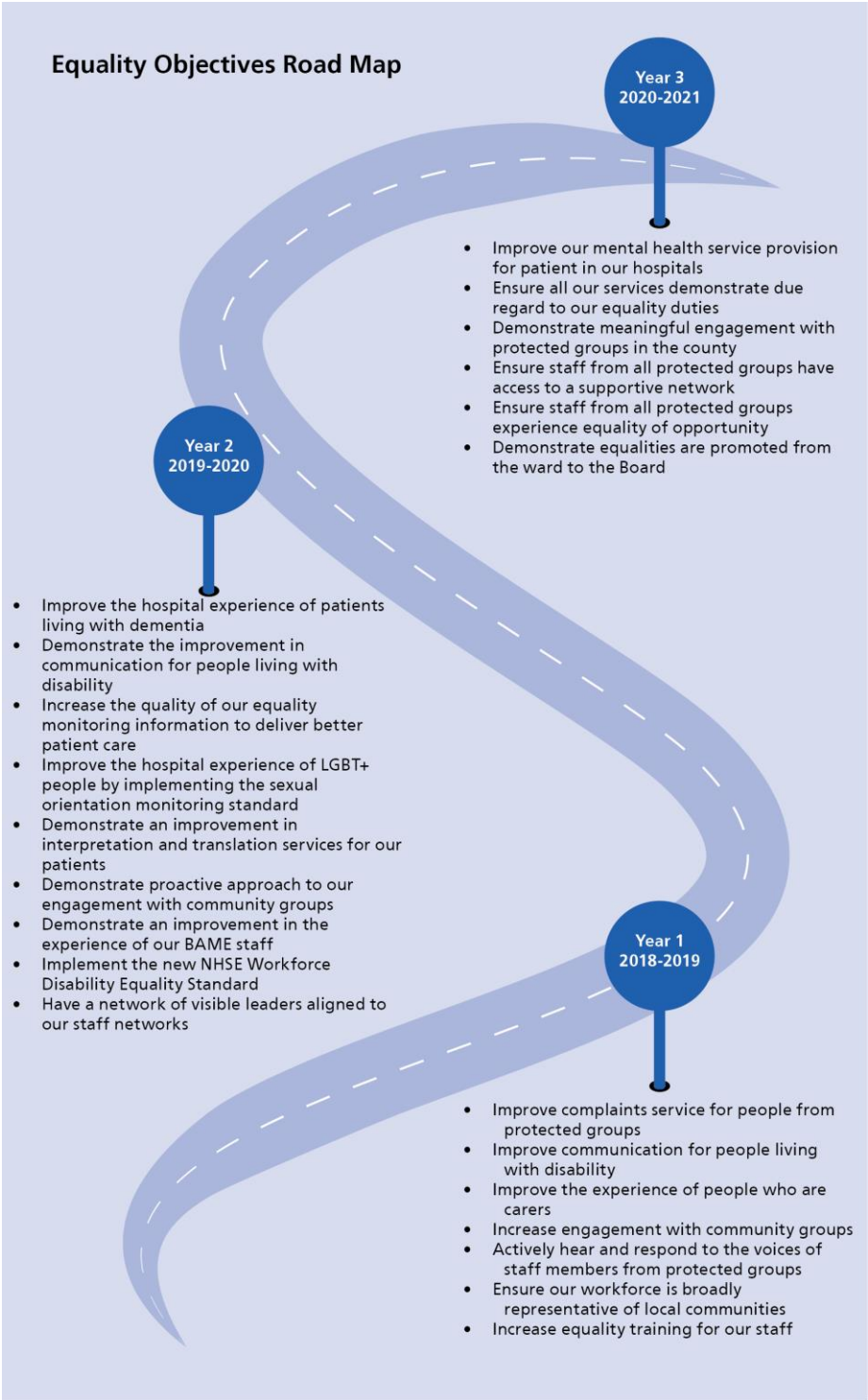
The Trust will publish its inclusion strategy in the first quarter of 2018-2019. The inclusion strategy will articulate the Trust's strategic approach to delivering and further developing its work around this important agenda.

The setting and delivery of equality objectives are an important part of the delivery of the Public Sector Equality Duty and these are contained within the inclusion strategy. An overview of the primary equality objectives can be seen in the equality objectives road map.

Once signed off by the Trust Board, the inclusion strategy will be placed on the Trust website.

As the financial year 2018-2019 commences, the Trust is confident that the important work around equality, diversity and inclusion will continue, as we strive to demonstrate we are an inclusive provider of healthcare services and employer.




Equality Objectives Road Map
Year 3
2020-2021
Improve our mental health service provision for patient in our hospitals
Ensure all our services demonstrate due regard to our equality duties
Demonstrate meaningful engagement with protected groups in the county
Ensure staff from all protected groups have access to a supportive network
Ensure staff from all protected groups experience equality of opportunity
Demonstrate equalities are promoted from the ward to the Board
Year 2
2019-2020
Improve the hospital experience of patients living with dementia
Demonstrate the improvement in communication for people living with disability
Increase the quality of our equality monitoring information to deliver better patient care
Improve the hospital experience of LGBT+ people by implementing the sexual orientation monitoring standard
Demonstrate an improvement in interpretation and translation services for our patients
Demonstrate proactive approach to our engagement with community groups
Demonstrate an improvement in the experience of our BAME staff
Implement the new NHSE Workforce Disability Equality Standard
Have a network of visible leaders aligned to our staff networks
Year 1
2018-2019
Improve complaints service for people from protected groups
Improve communication for people living with disability
Improve the experience of people who are carers
Increase engagement with community groups
Actively hear and respond to the voices of staff members from protected groups
Ensure our workforce is broadly representative of local communities
Increase equality training for our staff

Looking ahead to 2018/19

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

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

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

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

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

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

Accountable Officer: Mr Jan Sobieraj, Chief Executive
Organisation: United Lincolnshire Hospitals NHS Trust
Signature:
Date:

The Accountability Report

The purpose of the accountability section of the Annual Report is to meet key accountability requirements to Parliament. The requirements are based upon those dealt with in a Directors' Report, under the Companies Act 2006 and adapted for the public sector context.
The Trust Auditors have reviewed the Accountability Report for consistency with other information in the financial statements. Specific items which have been audited are marked as such.

The Accountability Report contains two sections;

- The Corporate Governance Report
- The Remuneration and Staff Report

Corporate Governance

Overview
The Board is collectively responsible for the long term success of the Trust. Executive and Non-Executive Directors provide an appropriate level of scrutiny, challenge and support. In this way proposals relating to strategy, performance, responsibility and accountability are constructively challenged and the Board ensures that all decisions are well considered, justified and of the highest quality. In addition, Board processes are set up to ensure adequate oversight of the implementation of those decisions.

This section details the structure and composition of the Board and its committees, how responsibilities are divided amongst the Board, its committees and individual Directors.

Annual Governance Statement 2017/18

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of United Lincolnshire Hospitals NHS Trust, to 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 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive, as the Accountable Officer (AO) for the Trust, is responsible for:

- The establishment and maintenance of effective corporate governance and internal control arrangements; and
- Being open and communicating effectively about the Trust's management of risks, both internally and externally.

The Medical Director, as the Executive lead for risk management is responsible for:

- Monitoring the consistent application of the Risk Management Policy throughout the Trust; and
- Retaining a suitable level of professional risk management expertise to support the effective implementation of the Policy.

Members of directorate management teams are responsible for:

- The consistent application of the Policy within their areas of accountability;
- The management of specific risks that have been assigned to them and are recorded in the risk register, in accordance with the criteria set out in the policy; and
- Reporting on risk management matters as required to ensure that risk management performance can be monitored, assurance provided and risks escalated to a more senior level of management where appropriate.

All members of staff are responsible for:

- Applying the Policy to any relevant risk management undertaken in the course of their duties; and
- The completion of any risk management related mandatory core learning.

The risk and control framework

The basic principle at the heart of the Trust's risk management approach is that an awareness and understanding of risk should be used to inform decision making at all levels. This requires not only the active engagement of all staff with risk management activity in practice, but also the integration of risk management principles and techniques within the formal governance arrangements of the organisation. This approach will enable major strategic, policy and investment decisions to be made with a full and reliable appreciation of the risks associated with them as well as any existing risks that those decisions may serve to mitigate.

During 2017/18 following internal audit review and an external governance review the Trust identified significant weaknesses in it risk and control framework. The Trust appointed a new risk manager in early 2018 who has progressed improvements to the framework since appointment. These are now in the early stages of being embedded.

The Board Assurance Framework (BAF) is an important document that enables the Trust Board to maintain effective oversight of strategic risk management within the organisation. The Trust Board identifies and defines strategic risks to its objectives and assigns each of those risks to a lead non-executive assurance committee for routine review and evaluation.

The role of the lead assurance committee is to consider evidence provided by members of the Executive Team in relation to relevant corporate risks, to enable the committee to make an informed judgement as to the level of assurance that can be provided to the Trust Board and assess the overall extent of strategic risk exposure at that time.

The role of the audit committee is to consider the appropriateness and effectiveness of the BAF as a key component of the Trust's internal control arrangements.

A strategic risk is defined as a risk that is Trust-wide in scope and extreme in terms of its potential severity. These are the risks that would fundamentally destabilise the organisation if they were to materialise.

The BAF has been identified as an area of particular weakness, and was not fit for purpose in 2017/18.

There are 4 key strategic risks defined within the BAF. Strategic risks are owned by the Trust Board, with responsibility for regular oversight being delegated to appropriate assurance committees. Relevant Key Risk Indicators (KRIs) were identified in relation to each strategic risk in the BAF. Reporting against these KRIs was included in regular management reports that provide the lead committees with evidence that associated corporate risks are being managed effectively. Lead assurance committees reviewed and challenged each corporate risk that is included in the BAF, to provide guidance and set expectations to support Trust management teams in developing and delivering their risk treatment strategies.

The Trust's risk appetite was not Board approved, therefore effective use was limited.

Quality governance arrangements have been reviewed following an external governance review and progress is being made to implement a new quality governance structure and improvement plans.

The Integrated performance report is also under review in response to challenge from the Board about its adequacy to meet the Board's needs. Compliance with the CQC registration requirements are considered both by the Trust Board and quality governance committee through reporting from the quality and safety improvement board.

Risks to data security are specifically highlighted within the revised 2018/19 BAF. The treatment of these risks is through a cyber security plan and digital strategy which are reviewed at Audit Committee and Finance Service Improvement and Delivery Assurance Committee.

During 2017/18, the Trust, in common with many areas of the NHS experienced a cyber-attack. The WannaCry world-wide cyber-attack infected 230k computers in 150 countries within a day. It exploited weakness in Windows operating systems sharing and affected 23 PCs and 14 servers mainly at Lincoln.
The impact of this was that the majority of ICT services and networks across the Lincolnshire community were shut down to allow the Trust to clean-up the limited infection and ensure that there was no risk to our data. This resulted in some disruption to patient services in particular those that depend on the use of supporting functions that are heavily reliant on ICT systems such as diagnostics and pathology, with departments having to enact local business continuity plans. The cost of the cyber-attack in lost income to the Trust was £0.3m.
The Trust has subsequently prioritised the following actions to reduce the risk and potential impact of future attacks:

- Successfully bid for external central capital funding of £0.9m as well as prioritising cyber investment locally, resulting in a total of investment of over £1.2m
- Commenced a number of major ICT infrastructure projects
- Planned and prioritised further investment in 2018/19
- Completed two external assessments to help prioritise resources

The four key strategic risks to the organisation during 2017/18 that were the focus of consideration by the Trust Board and Executive were:

- The Trust financial position;
- The ability of the Trust to attract and retain staff;
- The condition of the Trust estate, including the fire enforcement issues; and
- Maintenance and replacement of equipment.

Significant clinical risks are also highlighted within the Trust Board Assurance Framework specifically:

- A significant, widespread deterioration in the quality and safety of nursing care impacting on a large number of patients across directorates;

- A significant, widespread deterioration in the effectiveness of safeguarding practice impacting on the care of vulnerable people across directorates;
- A significant, widespread deterioration in safe medicines management practice impacting on a large number of patients across directorates; and
- An uncontrolled outbreak of serious infectious disease affecting a large number of patients, staff and visitors across directorates.

Managed and mitigated through:

- Clinical service structures & resources;
- Clinical governance arrangements at Trust, directorate & service levels;
- Clinical policies, procedures, guidelines, pathways, supporting documentation, audit programme & training;
- Clinical staff recruitment, induction, mandatory training, registration & re-validation;
- Quality & safety improvement planning process & plans;
- Defined safe staffing levels;
- Ward accreditation programme;
- Health, safety & security policies, guidance, monitoring and training;
- Patient experience policies, procedures, training and services; and
- Infection, prevention & control management framework.

The Trust was subject to an external governance review and in response to this appointed an Interim Director of Clinical Governance who commenced work revising the processes for the management of clinical risk. This has included strengthening of specialty governance arrangements and greater Executive oversight through performance review processes.

And outcomes assessed through:

- Number and severity of patient safety incidents;
- Number of Serious Incidents / Never Events;
- Number and severity of Healthcare Acquired Infections (HCAIs);
- Number and severity of safeguarding incidents;
- Number and severity of medication safety incidents;
- Harm free care rate;
- Hospital Standardised Mortality Ratio (HSMR);
- Number and type of complaints;
- Number and& severity of health and safety incidents;
- Friends and Family Test and patient feedback data;
- Delivery of constitutional standards;

The Trust self-assessed through a board development process in 2017/18 against the well led framework and has an action plan to deliver improvements. The Trust will also use the output from the CQC well led assessment when published (expected June 2018) to further support this assessment and identify actions.

The Trust had identified non-compliance with governance regulations and standards as a key risk within the Board Assurance Framework. The Board continue to focus on accessing support and strengthening the arrangements in place.

The Trust has been subject to a number of external reviews which led to the Board leading a review of its governance arrangements during 2017/18. The quality governance review has led to a new streamlined integrated approach being implemented under the leadership of the Medical Director.

Reporting to the Audit Committee has been improved by the Director of Finance, Procurement and Corporate Affairs with regular assurance given in relation to compliance of internal control weaknesses, Board Assurance Framework and the Risk Management Improvement Plans. This process is in its early stages and continues to be embedded.

The Trust Board charges its assurance committees with providing upward reports highlighting areas of assurance in relation to risks to achievement of the strategic objectives. The Interim Chair has encouraged challenge and rigour at Board meetings around the reports presented and assurances given.

The primary objective of Risk Management policy is to establish the foundations for consistent and effective risk management to become embedded in routine management activity throughout the Trust. It sets out clear definitions, responsibilities, and essential management requirements that enable risks to be managed in a consistent manner throughout the organisation to support the delivery of safer, more efficient, more effective and more resilient services. The policy aims to support the Trust in delivering against corporate governance requirements for maintaining an effective internal control environment, as reviewed by internal and external audit.

Every directorate within the Trust is expected to make active use of the Datix risk register to support their management of risks. In addition, directorates provide a regular report on the content of their risk registers as part of the Trust's performance management arrangements.

The Trust is not fully compliant with the registration requirements of the Care Quality Commission. The Trust had conditions placed on its licence in February 2018 in relation to A&E services at Pilgrim Hospital.

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This includes equality impact assessments being required on all new Trust business cases, strategies and policy developments.

The Trust has undertaken risk assessments and carbon deduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Modern Slavery and Human Trafficking Act 2015

The Trust's approach in meeting the requirements of the above Act has been to develop a statement in conjunction with the Trust's Head of Procurement.
The provision of the statement is considered to be an element of the Trust's commitment and demonstration of the need to be aware of this requirement, and associated values relating to equality, diversity and community relations.

Review of economy, efficiency and effectiveness of the use of resources

The Trust was placed in financial special measures during 2017/18 and the Board has received assurance reports from the Finance, Service Improvement and Delivery Committee following its monthly review of Trust financial and operational performance. The Trust has appointed an external organisation to support in its delivery of an efficiency programme during 2017/18 and has been subject to regular review of this process by NHS Improvement and NHS England.

The Trust planning process ensured the annual plan incorporated the 2021 strategy, key strategic objectives prioritisation aligned with the Trust key risks and national performance standards, as well as financial planning and management.

The external organisation CHKS were engaged by the Trust to undertake a Data Quality and Income Review, and their report was provided in December 2017.

They concluded that:
'Based on our review of data quality and contractual arrangements at United Lincolnshire Hospitals NHS Trust we have identified £14,932,352 undercharge at the Trust if activity was billed appropriately to commissioners under national payment rules.

The main challenges identified through the risk assessment were:

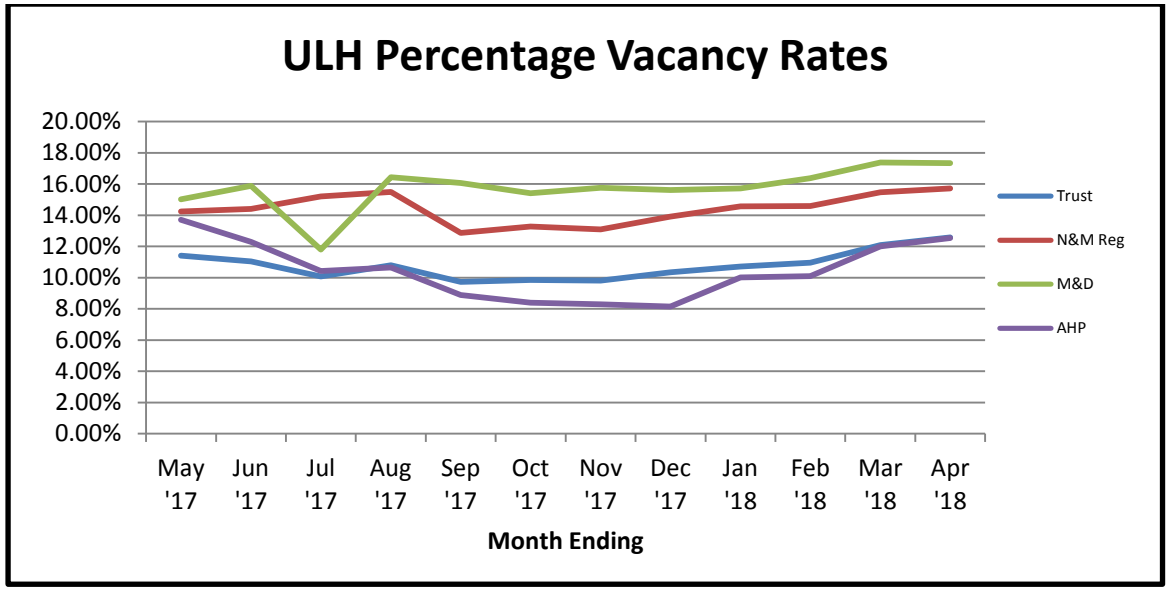
- addressing data quality issues impacting on income, in particular the clinical coding of admitted patient care, and
- agreeing changes to local tariffs and classification of non-consultant led activity with commissioners.'

The Action plan arising out of this piece of work is being monitored by the Finance, Service Improvement and Delivery Committee and the Audit Committee.

The National Health Service Act 2006 requires that 'in auditing the accounts of any NHS trust an auditor must by examination of the accounts and otherwise satisfy himself that... (d) the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources'. External audit planning work involved an assessment against a number of criteria, including those issued by the National Audit Office, to identify any significant risks to the above conclusion. External Audit present to the Audit Committee any significant risks identified and the planned audit response for consideration by the Committee.

The Board receive reports from External Audit and Internal Audit through the Audit Committee and the Assurance Committees.

Recruitment and retention has become an increasing area for concern. The chart below shows vacancy rates for the Trust overall and separately for Medical staff (M&D), Registered Nurses (N&M Reg) and Allied Health Professionals (AHP) in the last 12 months. What this shows is an increasing vacancy rate from September 2017. This is in part driven by an increasing turnover rate, which has increased from 8.7% to 9.76% in the same period.



The recruitment market for many medical staff, some AHPs and Registered Nurses is challenging, as is recognised in the Draft NHS Workforce Strategy. This is exacerbated by the difficulty of recruiting to Lincolnshire. The Trust has invested in additional staff to support recruitment activity to traditional roles and is using agencies to recruit from both the UK and overseas.

Alongside this, we are looking at our overall workforce model and establishment and the introduction of new roles, to reduce the need for roles to which we find it hard to recruit. We are also focused on increasing retention levels. Whilst our overall turnover rate remains lower than equivalent Trusts, we will explore ways to improve the morale of our staff and retain them for longer.

Stakeholder engagement

We commenced a programme of engagement events with patients, members of the public, staff and other key stakeholders in year to help inform and develop the clinical and financial strategies as part of the 2021 programme, to support aspirations of moving out of both quality and financial special measures.

Information governance

The Trust had one level 3 information governance incident which was reported to the Information Commissioners Office in January 2018. The ICO were satisfied with action taken by the Trust.

Annual Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

Steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data include the following:

- The Medical Director is the Executive lead for the Quality Account with designated personal responsibility for patient safety and quality on behalf of the Trust Board.

- The Annual Quality Account Report 2017/18 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Trust Board.

- The Trust has a robust process for scrutinising and revising local policies and monitoring compliance with NICE and other best practice guidelines. Annual audit programmes include the assessment of compliance with best practice guidance at both local and national level. This provides assurances to the Board that the quality of clinical care is based on the best clinical practice recognised nationally and that policies are up to date, appropriate and meet legislative obligations.

- The Quality Account is compiled following internal and external consultation, in order to inform the improvement indicators. Data are provided by nominated Trust leads. These leads are responsible for scrutinising the data they provide to ensure accuracy. The Medical Director is ultimately accountable to the Trust Board and its committees for the accuracy of the Quality Account Report.

- The Quality Account is subject to challenge at the Quality Governance Committee on both substantive issues and data quality. Where variance against targets is identified, the leads for individual measures are held to account. Following scrutiny

at this Committee, the Quality Account is reported to the Audit Committee and the Trust Board. The Board is required both to attest to the accuracy of the data and ensure that improvements against the targets are maintained.

- The Quality Account Report has been prepared in accordance with NHS Improvement's annual reporting guidance, as well as the standards to support data quality for the preparation of the Quality Report;

- Internal and external data audits are undertaken, focusing on data quality and associated process and procedures.

The quality reporting process is led by the Medical Director. The Quality Governance Committee reports directly to the Board on quality issues. It is working to ensure that appropriate assurance on quality governance is provided, in order to enable the Board and the Audit Committee to be satisfied on this area of internal control. The Quality Governance Committee is chaired by a Non-Executive Director.

The Quality Governance Assurance Committee has, on behalf of the Board, sought assurances relating to the Quality Account. The independent auditors present an assurance report to the Trust Board following their review.

The Trust assures itself of the quality and accuracy of elective waiting time data through specific training for staff, the use of electronic solutions to improve accuracy, validation processes linked to systems and inclusion in the internal and external audit work programmes.

The risks associated with elective waiting times and specifically those attached to the Patient Administration System (PAS) have been reviewed and assurance sought at the Finance, Service Improvement and Delivery Assurance Committee throughout the year and within the outpatient improvement programme plan.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports including:

• Internal Audit Reports

• Head of Internal Audit Opinion

• External Audit Reports

• Internal and External Peer Reviews

• Clinical Audit Reports

• Patient Surveys

• Staff Survey

• Care Quality Commission Intelligent Monitoring

• Senior Leadership Walk-rounds

• Care Quality Commission – registration and reports

• Equality and Diversity Reports

• General Medical Council Reports

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board

The Board have received assurance reports from the Audit Committee, Quality Governance Assurance Committee, Finance, Service Improvement and Delivery Assurance Committee and Workforce and OD Assurance Committee as well as considering the Trust Integrated Performance Report and Board Assurance Framework. The Board continue to direct their work to improve the identified weaknesses in the control framework and governance arrangements.

The Audit Committee

The Audit Committee have advised the Board on the effectiveness of the systems of control through their upward report to the Trust Board. The Committee have considered the Board Assurance Framework and the risk improvement plans and have monitored the delivery of internal and external audit plans.

Clinical Audit

During 2017/18 the Trust participated in 91% of possible national clinical audits and all of the national confidential enquiries in which it was eligible. The Trust benefitted from participating in gaining assurance that the services delivered are safe and effective, and outcomes were good based on evidenced based practice and standards of care.

Internal Audit

The Head of Internal Audit provided an opinion of Limited Assurance for the Trust and reported that there were weaknesses in the design and / or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives. The Opinion was based on a review of the systems of internal control, primarily through the operation of the Board Assurance Framework in the year to date, the outcome of individual assignments completed and the Trust response to recommendations made. A moderate assurance was given in terms of follow up actions and outturn internal audit plan, but only limited assurance in respect of design and operation of the BAF

The opinion acknowledged that the senior management team has taken steps to establish a stronger framework for the Trust to operate within. Specifically action was being taken to strengthen focus on areas of governance and risk management. This represented some of the fundamental control arrangements required if the Trust was to establish a strong position from which to achieve its strategic objectives. Progress was starting to show through in improved implementation rate of audit actions at follow

up. However, at this point in time although the Trust was establishing a sound base to set a positive path to improvement and had people in place to take this forward, this had yet to become embedded and achieve improved outcomes. The audit plan for 2018/19 continues to have focus in key areas that assist the Trust in establishing a robust second line of defence.

The Trust remains in special measures for quality following a CQC inspection in October 2016.

Conclusion

During the year the Trust identified the following significant control issues:

The Trust remained in special measures following a CQC inspection in October 2016 which assessed the Trust as inadequate and highlighted a range of issues which it needed to tackle.
Following the 2016 inspection the Trust implemented a quality and safety improvement programme, a further well led inspection was carried out by the CQC in April 2018, the result of this review is still awaited.

The Trust has continued to face significant financial challenges which are expected to continue during 2018/19. In September 2017 the Trust was placed in Financial Special Measures.

The Lincolnshire health system faces a significant financial challenge, both now and in the longer term. Local health and social care organisations continue to work together to identify ways in which we can collaborate to meet this challenge. The Local Health Economy work continues to deliver the Sustainability and Transformation Partnership (STP). Partners across the local health and care system have agreed to work together to deliver the STP.

The plan for Lincolnshire covers hospital services, community healthcare, mental health, social care and GP services. It has been developed by all local NHS organisations, including ours, and addresses the issues highlighted in the Lincolnshire Sustainability and Transformation Partnership (October 2016) which showed that local needs are growing and changing, demand on health services is increasing, the current system does not meet the standards of care we aspire to as a health system and our collective financial challenge is significant and growing.

The Trust also faces operational pressures with increasing demand. The organisation saw growth in A&E attends of 2%, urgent 2 week wait referrals 5.5% and increased GP referrals 3.8%. This is particularly difficult to deliver when many services have workforce or infrastructure challenges. As a result constitutional standards have not been met.

The Trust has significant recruitment and retention challenges, partly due to being in a large rural health system. The additional impact of working in a challenged organisation leads to an increasing reliance on agency staff to maintain services, this in turn increasing the challenge to improve quality.

The Trust has been subject to fire enforcement notices for its Lincoln County Hospital and Pilgrim Hospital Boston sites.

Overall, the Trust is clear on the issues and good progress has been made in developing and implementing improvement plans, however it is recognised that there is significant weakness in the current governance arrangements. The reason behind many of the issues is historical and there are many reasons for this - most notable are: the difficulty in attracting staff resulting in some difficult decisions for some services (notably Emergency Department), demand and acuity, geographical dispersement of sites, poor condition of the historical estate, and effective partnership working. 17/18 was a year of building foundations and 18/19 will make further progress in improving governance through several vehicles, e.g. 2021 strategy development and working actively in partnership with the STP on an Acute Services Review.
Of particular note, governance arrangements will be strengthened. The Board Assurance Framework is being refreshed for both format and content to ensure it is fit for purpose. The Committee and organisation structure will be reviewed to make necessary changes to effectively provide assurance and drive improvements. The Trust has adopted an Enterprise Risk Management (ERM) framework as the basis for the structure of its risk registers.

It is expected these actions will support the aspirations and ambition into the new year.

Signed……..
Chief Executive Date: 25th May 2018

Modern slavery statement 2017-18
This statement is to be accepted as United Lincolnshire Hospitals NHS Trust's (ULHT) response to the requirements of the Modern Slavery Act 2015.

Definition of Offences
Slavery, servitude and forced and/or compulsory labour.
A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows, or ought to know, that the other person is held in slavery or servitude, or;
- The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows, or ought to know, that the other person is being required to perform forced or compulsory labour.

Human Trafficking
A person commits an offence if:

- The person arranges or facilitates the travel of another person (victim) with a view to being exploited.
- It is irrelevant whether the victim consents to travel and whether or not the victim is an adult or a child.

Exploitation
A person is exploited if one or more of the following issues are identified in relation to the victim;

- Slavery, servitude, forced or compulsory labour.
- Sexual exploitation
- Removal of organs
- Securing services by force, threats and deception
- Securing services from children, young people and vulnerable persons.

Statement of response
In accordance with the Modern Slavery Act 2015, the Trust offers the following statement regarding the measures in place during 2017/18 to ensure that modern slavery and human trafficking does not occur within any part of its supply chain.

The Trust is committed to fulfilling our responsibility to ensure that there is a zero-tolerance approach to modern slavery and/or human trafficking within our supply chains or within any part of our business. Any identified concerns regarding modern slavery and human trafficking will be escalated in line with the organisation's safeguarding processes; working in conjunction with our partner agencies.

As such:

- The Trust adheres to the national NHS employment checks/standards (including employees' UK address; their right to work in the UK and obtaining suitable references).
- The Trust has systems in place to encourage the reporting of concerns and for the protection of those who do raise concerns.
- The Trust's safeguarding policies, training packages and Intranet site contain information relating to the indicators of human trafficking/modern slavery, for staff awareness and usage.
- The referral process for adults/children at risk, along with links to both the Lincolnshire safeguarding adult and Lincolnshire safeguarding children boards are located on the safeguarding section of the Trust's intranet site.
- NHS employment checks and payroll systems (i.e. people bought into the country illegally will not have a national insurance number).
- Contractors/suppliers employed by the Trust conform to the Trust's section 11 safeguarding requirements.

During 2017-18

The Trust aimed to be as effective as possible in ensuring that modern slavery and human trafficking was not taking place in any part of its business or supply chains. In addition to the above actions, the Trust will measure its performance against the following indicators:

- The Trust endeavoured to build long-standing relationships with our suppliers and make clear our expectations of business behaviour. Where national or international supply chains are used, we expected these suppliers to have suitable anti-slavery and human trafficking policies and procedures and, where there is a risk of slavery and human trafficking taking place, steps have been taken to assess and manage that risk.
- Developed a level of communication with the next link in the supply chain and their understanding of, and compliance with, our expectations in relation to the NHS terms and conditions. These conditions relate to issues such as bribery, slavery and other ethical considerations.
- Worked in partnership with multi-agency partners who are leading on this agenda within Lincolnshire, the Trust is represented on the modern slavery sub-committee.

- Modern slavery and human trafficking training is available to all Trust staff as part of their core safeguarding training. Additional training is available via the local safeguarding adults and children boards.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our organisation's modern slavery and human trafficking statement for the financial year 2017/18.

Trust Board and committees

Board changes

During the year we have seen some changes to the Trust Board membership.

- Dr Neill Hepburn was appointed as Medical Director in May 2017.
- Karen Brown joined the Trust as Director of Finance, Procurement and Corporate Affairs in August 2017 following a 3 month period as Interim Director in this role.
- The Trust Chair, Dean Fathers, resigned and left the Trust in December 2017 and the current Interim Chair, Elaine Baylis was appointed for a 12 month period from January 2018.Dr Chris Gibson and Professor Mala Rao were appointed to the Trust as Non-Executive Directors.
- Elizabeth Libiszewski was appointed as an Interim Non-Executive from March 2018
- Non-Executive Directors, Penny Owston, Kate Truscott and Professor Mala Rao left the Trust.

A full list of Directors who have served during the year is shown within the Remuneration Report on page 73.

Audit Committee

Audit Committee membership should comprise three Non-Executive Directors, one of whom should possess considerable financial expertise.

For 2017/18, Audit Committee membership was as follows:

- Geoffrey Hayward, Chair (April 17 - September 17).
- Sarah Dunnett, Chair (October 2017 – ongoing).
- Kate Truscott, (April 17 - February 18).
- Gill Ponder, (April 17 - ongoing).
- Penny Owston (April 17 - February 18).
- Elizabeth Libiszewski (March 2018 – ongoing).

Declarations of interest for each member of the Trust Board are shown in the table below:

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

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

	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care or any connection with a voluntary or other organisation contracting for NHS services	Research funding / grants that may be received by an individual or their department	Interests in pooled funds that are under separate management	To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust including, but not limited to,	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
Dr Chris Gibson Non-Executive Director	None	None	None	None	None	None	None	None	None
Mr Geoff Hayward Non-Executive Director	None	None	None	None	None	None	None	None	Spouse - volunteer for Butterfly Hospice Boston
Dr Neill Hepburn Medical Director	None	None	None	None	None	None	None	Private Medical Practice at BMI Lincoln and IOM Hospital	None
Mrs Gill Ponder Non-Executive Director	Non	None	None	None	None	None	None	Employed by Openreach	None
Mrs Michelle Rhodes Director of Nursing	None	None	None	None	None	None	None	None	Sister employed by Park Hospital Nottingham
Prof Mala Rao Non-Executive Director	None	None	None	Honorary Public Health Consultant	None			Professor and Senior Clinical	

	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care or any connection with a voluntary or other organisation contracting for NHS services	Research funding / grants that may be received by an individual or their department	Interests in pooled funds that are under separate management	To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust including, but not limited to,	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
				Public Health England Vice Chair, NHS WRES Advisory Group Member Health Equity Board, Public Health England				Fellow Imperial College London	
Mr Martin Rayson Director of Human Resources and Organisational Development	None	None	None	None	None	None	None	None	None
Ms Karen Brown Director of Finance	None	None	None	None	None	None	None	None	None
Mrs Elizabeth Libiszewski Interim Non-Executive Director	None	Elizabeth Libiszewski Sole Trader	None	Non-Executive Director Lincolnshire Community Health Services NHS Trust	None	None	None	None	Husband – Trustee St Barnabas Hospice

Remuneration and Staff Report

Overview
The Remuneration and Staff Report sets out the organisation's remuneration policy for Directors and Senior Managers, reports on how that policy has been implemented and sets out the amounts awarded.

The report also includes a series of tables providing information on:

- staff numbers and composition
- expenditure on consultancy
- off-payroll engagements
- exit packages
- sickness absence

Remuneration of Senior Managers (audited)
The Chief Executive has confirmed that the key decision makers within the Trust for the purposes of the remuneration and staff report are Board executive and non-executive members.

The tables and notes below detail the salaries and allowances paid during the year to each senior Executive along with a table showing pension benefits at 31 March 2018.

There were no payments made to former Directors in 2017/18.

Salaries & Allowances

					2016/17					2017/18				
Name	Position	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	£000's	£00's	£000's	£00's	£000's	£000's	£00's	£000's	£00's	£000's
Elaine Baylis	Trust Chair		Jan-17	Ongoing						10 -15	2		2	10 -15
Dean Fathers	Trust Chair		Mar-16	Dec-17	35 - 40	22		20	40 - 45	25 - 30	21		19	30 - 35
Sarah Dunnett	Non-Executive Director		Jul-16	Ongoing	0 - 5	-		-	0 - 5	5 - 10	23		10	5 - 10
Dr Chris Gibson	Non-Executive Director		Aug-17	Ongoing						0 - 5	-		-	0 - 5
Paul Grassby	Non-Executive Director (Associate Non Exec wef Aug 2017)		Jul-13	Mar-18	5 - 10	-		-	5 - 10	0 - 5	-		-	0 - 5
Geoff Hayward	Non-Executive Director		Jul-13	Ongoing	5 - 10	11		5	5 - 10	5 - 10	9		4	5 - 10
Elizabeth Libiszewski	Non-Executive Director		Mar-18	Ongoing						0 - 5	-			0 - 5
Penny Owston	Non-Executive Director		Apr-10	Mar-18	5 - 10	21		8	5 - 10	5 - 10	20		9	5 - 10
Gill Ponder	Non-Executive Director		May-15	Ongoing	5 - 10	7		6	5 - 10	5 - 10	11		10	5 - 10
Prof Mala Rao	Non-Executive Director		May-17	Mar-18						5 - 10	-		-	5 - 10
Kate Truscott	Non-Executive Director		Mar-14	Feb-18	5 - 10	6		-	5 - 10	5 - 10	6		3	5 - 10
Tim Staniland	Non-Executive Director		Mar-07	Mar-17	5 - 10	-		-	5 - 10					
Mr Keith Darwin	Associate Non-Executive Director		Jan-10	Aug-16	0 - 5	4		4	0 - 5					
Jan Sobieraj	Chief Executive		Dec-15	Ongoing	185 - 190	9	120-122.5	-	305 - 310	185 -190	4	-	-	185 - 190
Kevin Turner	Deputy Chief Executive		Jan-11	Ongoing	140 - 145	4	-	-	140 - 145	140 - 145	1	-	-	140 - 145
Karen Brown	Director of Finance & Corporate Affairs	1	May-17	Ongoing						125 - 130	8	27.5 - 30	-	155 - 160
Peter Hollinshead	Interim Director of Finance & Corporate Affairs		Jan-17	Ongoing	25 - 30	-	-	-	25 - 30	15 - 20	5	-	-	15 - 20
John Barber	Interim Director of Finance & Corporate Affairs		Jun-16	Jan-17	75 - 80	-	-	-	75 - 80					
Jason Burn	Interim Director of Finance & Corporate Affairs	2	Jan-16	Jun-16	see note 3									
David Pratt	Director of Finance & Corporate Affairs		Oct-13	Nov-16	85 - 90	109	30 - 32.5	-	125 - 130					
Mark Brassington	Chief Operating Officer		Mar-16	Ongoing	120 - 125	23	-	-	120 - 125	125 - 130	28	207.5 - 210	-	335 - 340
Michelle Rhodes	Director of Nursing		Oct-10	Ongoing	120 - 125	26	47.5 - 50	-	175 - 180	125 - 130	18	30 - 32.5	-	155 - 160
Dr Neil Hepburn	Medical Director	3	May-17	Ongoing						165 - 170	27	105 - 107.5	-	270 - 275
Dr Sunil Kapadia	Medical Director		Jul-13	Apr-17	180 - 185	47	5 - 7.5	-	190 - 195	15 - 20	1	-	-	15 - 20
Martin Rayson	Director of Human Resources & Organisational Devt		Sep-16	Ongoing	45 - 50	2	10 - 12.5	-	60 - 65	95 - 100	11	22.5 - 25	-	115 - 120
Louise Ludgrove	Interim Director of Human Resources & Organisational Devt	4	Jul-16	Sep-16	see note 3									
Ian Warren	Director of Human Resources & Organisational Devt		Feb-13	Jul-16	35 - 40	-	12.5 - 15	-	50 - 55					
Paul Boocock	Director of Estates and Facilities		Oct-13	Ongoing	85 - 90	14	32.5-35	-	120 - 125	90 - 95	18	37.5 - 40	-	130 - 135

Notes:

1. Karen Brown was seconded from Lincolnshire Partnership Foundation Trust in May 2017 before being appointed to the substantive position of Director of Finance and Corporate Affairs in August 2017. Salary costs from May were initially paid by Lincolnshire Partnership before being recharged. The full salary details from May are reported in the above table.
2. Jason Burn was employed during 2016/17 through interim recruitment specialists Allen Lane Ltd at a cost of £64567.99
3. The salary for Dr Hepburn incorporates remuneration for his role as Medical Director and also for clinical duties as a Dermatology Consultant. The latter role is carried out for half a day each week.
4. Louise Ludgrove was employed through recruitment specialists IRG Advisors LLP at a cost of £45309.6

Definitions:

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

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

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

Pension related benefits in kind

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

No performance related pay or bonus payments have been made in 2016/17 or 2017/18.

Pension Benefits 2017/18

Name	Position	Notes	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Jan Sobieraj	Chief Executive	1	-	-	80 - 85	240 - 245	1,872	0	1,890	
Kevin Turner	Deputy Chief Executive		0 - 2.5	0 - 2.5	65 - 70	200 - 205	1,391	73	1,478	
Karen Brown	Director of Finance & Corporate Affairs		0 - 2.5	5 - 7.5	30 - 35	95 - 100	585	74	671	
Peter Hollinshead	Interim Director of Finance & Corporate Affairs	1	-	-	10 - 15	30 - 35	0	0	0	
Mark Brassington	Chief Operating Officer		10 - 12.5	22.5 - 25	30 - 35	80 - 85	319	139	461	
Michelle Rhodes	Director of Nursing		0 - 2.5	5 - 7.5	35 - 40	115 - 120	652	81	739	
Dr Neil Hepburn	Medical Director		5 - 7.5	17.5 - 20	60 - 65	180 - 185	1,166	169	1,361	
Dr Sunil Kapadia	Medical Director	1	-	-	80 - 85	255 - 260	1,823	0	1,841	
Martin Rayson	Director of Human Resources & Organisational Devt		0 - 2.5	-	0 - 5	-	11	24	35	
Paul Boocock	Director of Estates and Facilities		0 - 2.5	0 - 2.5	35 - 40	85 - 90	522	45	573	

Notes:

1. These Board members have not contributed to the NHS Pension Scheme in 2017/18. No increase in pension, lump sum or CETV has therefore been reported for the year.
Each member has frozen benefits which will be due upon retirement. An inflationary uplift of 1% has been applied to the total accrued pension, lump sum and CETV reported at 31 March 2018.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Fair pay disclosure (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 the Trust in the financial year 2017/18 was £185000 (2016/17 £185000). This was 7.84 times (2016/17, 7.92) the median remuneration of the workforce, which was £23597 (2016/17 £23363).

In 2017/18, zero (2016/17, zero) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £185,000 to £6,157 (2016/17 £185,000 to £6,083).

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

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

The change in the ratio of the highest paid Director to the median employee is due to the 2017/18 pay award. Directors received no award; other employees received an award of 1%.

Staff numbers and cost
The following tables contain details of staff costs and numbers employed in 2017/18 alongside comparators for 2016/17.

Permanently employed staff are defined as: members of staff with a permanent (UK) employment contract directly with the Trust. Other staff are staff engaged on the objectives of the Trust that do not have a permanent (UK) employment contract with the Trust. It includes employees on short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities where the whole or majority of the employees' costs are met locally.

Staff costs

	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	226,770	15,532	242,302	238,936
Social security costs	20,932	1,433	22,365	22,018
Apprenticeship levy	1,223	-	1,223	-
Employer's contributions to NHS pensions	26,255	1,798	28,053	27,483
Pension cost - other	28	-	28	26
Termination benefits	69	-	69	9
Temporary staff		29,385	29,385	29,398
Total gross staff costs	275,277	48,148	323,425	315,870
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	275,277	48,148	323,425	315,870
Of which				
Costs capitalised as part of assets	667	21	688	739

Average number of employees (WTE basis)

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	791	166	957	942
Administration and estates	1,210	48	1,258	1,195
Healthcare assistants and other support staff	775	73	848	814
Nursing, midwifery and health visiting staff	2,824	347	3,171	3,112
Nursing, midwifery and health visiting learners	6	-	6	6
Scientific, therapeutic and technical staff	762	31	793	777
Healthcare science staff	147	6	153	158
Social care staff	1	-	1	1
Total average numbers	6,516	671	7,187	7,005
Of which:				
Number of employees (WTE) engaged on capital projects	22	1	23	24

Expenditure on consultancy

Consultancy is defined as the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. 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.

Consultancy may include the identification of options with recommendations, or assistance with (but not delivery of) the implementation of solutions.

Under this definition Trust consultancy expenditure in 2017/18 was £3.07m. The majority of this related to work undertaken by KPMG in supporting the Trust to develop its financial recovery plan.

Off-payroll engagements

Following the review of the tax arrangements of public sector appointees published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arm's length bodies must 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) using the format set out in the tables below.

Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months.

No. of existing engagements as of 31 March 2018	8
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one & two years at time of reporting.	3
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	1
No. that have existed for four or more years at time of reporting.	3

New off-payroll engagements
For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months.

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	23
No. of engagements reassessed for consistency / assurance purposes during the year.	36
No. of engagements that saw a change to IR35 status following the consistency review	23

Table 3: off-payroll board member/senior official engagements
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year.	10

Exit packages (audited)

NHS organisations are required to disclose details of any exit packages agreed in the year. The tables below are subject to audit and set out the number and cost of exit packages agreed by the Trust in 2017/18.

The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost and expenditure notes in the Trust accounts.

Table 1:

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	31	**31**
£10,001 - £25,000	-	2	**2**
£25,001 - 50,000	-	2	**2**
£50,001 - £100,000	1	-	**1**
Total number of exit packages by type	**1**	**35**	**36**
Total resource cost (£)	£61,000	£187,000	**£248,000**

Reporting of compensation schemes - exit packages 2016/17

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	1	23	**24**
Total number of exit packages by type	**1**	**23**	**24**
Total resource cost (£)	£6,951	£53,062	**£60,013**

Redundancy and other departure costs in the above two tables have been paid in accordance with the provisions of the NHS Agenda for Change and medical and dental terms and conditions of service. Exit costs in this note are the full costs of departures agreed in the year.

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 tables.

Table 2:

Exit packages: other (non-compulsory) departure payments

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	2	69	-	-
Contractual payments in lieu of notice	33	118	23	53
Total	**35**	**187**	**23**	**53**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

As a single exit package can be made up of several components each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in Table 2 which will be the number of individuals.

In 2017/18 the Trust made zero non-contractual payments in lieu of notice.

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 following table shows the average number of days lost to sickness absence in 2016/17 and 2017/18.

The sickness absence figures are reported on a calendar year basis.

	2017/18 No.	2016/17 No.
Total days lost	69,164	67,643
Total staff years	6,401	6,302
Average working days lost (per WTE)	**11**	**11**

Statement of Accounting/Accountable Officer's responsibilities

I 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; have taken all the steps that he or she ought to have taken to make himself/herself aware of such information and to establish that the auditors are aware of it.

I understand my personal responsibility in the publication of the Annual Report and Accounts in determining what it fair, balanced and understandable.
It is my considered judgement that this Annual Report and Accounts for the United Lincolnshire Hospitals NHS Trust are as a whole, fair, balanced and understandable.

Accountable Officer: Mr Jan Sobieraj, Chief Executive

Organisation: United Lincolnshire Hospitals NHS Trust

Signature:

Date:

United Lincolnshire Hospitals NHS Trust

Annual Accounts for the year ended 31 March 2018

CONTENTS

FOREWORD TO THE ACCOUNTS

Financial Review - year ended 31 March 2018

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

Financial Target	**Actual Performance**		
	2017-18		2016-17
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)	**(97,081)**	**(Deficit)**	(56,798)
	17,527	**Impairments**	(509)
	178	**IFRIC 12 adjustments**	148
	(288)	**Other adjustments**	268
	(79,664)	**Reported Performance**	(56,891)
	(242,529)	**Cumulative position against breakeven duty (deficit)**	(162,865)
To achieve a capital cost absorption rate of 3.5%	**3.5%**		3.5%
To operate within an External Financing Limit set by the Department of Health and Social Care	**£9.19m**	**Undershoot**	£0.38m
To operate within a Capital Resource Limit set by the Department of Health and Social Care	**£1.08m**	**Underspent**	£1.12m
To pay 95% of creditor invoices within 30 days (by number of invoices)	**75%**	**Trade (Non-NHS)**	82%
	64%	**NHS**	72%

Karen Brown
Director of Finance, Procurement and Corporate Affairs
25 May 2018

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

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. 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 to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

Signed  **Chief Executive**

Date: **25 May 2018**

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 HM 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, the directors are required to:

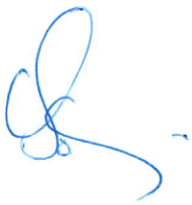
• apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

• 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  **Chief Executive**

Signed  **Director of Finance, Procurement and Corporate Affairs**

Date: **25 May 2018**

Independent Auditors' Report to the Directors of United Lincolnshire Hospitals NHS Trust

Report on the audit of the financial statements

Opinion

In our opinion, United Lincolnshire Hospitals NHS Trust's financial statements:

- give a true and fair view of the state of United Lincolnshire Hospitals NHS Trust's affairs as at 31 March 2018 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Final Accounts 2017-18, which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income, the Statement of Cash Flows and the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of United Lincolnshire Hospitals NHS Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.1.2 to the financial statements concerning United Lincolnshire Hospitals NHS Trust's ability to continue as a going concern.

The Trust has been reliant on external cash support to meet its liabilities as they have fallen due during 2017/18. It has drawn down a cumulative total of £191.5 million in revenue related loans, and £9.5 million in capital loans, as at 31 March 2018. Of the revenue support loans, £35.6 million is repayable in November 2018 and no formal agreement has yet been reached on either an extension for the repayment or additional loan support. Additionally the Trust has submitted a deficit plan for 2018/19 of £79.4 million, which will require additional revenue cash support of £82 million. Furthermore, the plan assumes the delivery in full of new financial efficiencies of £19.7 million. These conditions, along with the other matters explained in note 1.1.2 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about United Lincolnshire Hospitals NHS Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if United Lincolnshire Hospitals NHS Trust were unable to continue as a going concern.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability report, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Reporting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing United Lincolnshire Hospitals NHS Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate United Lincolnshire Hospitals NHS Trust or to cease operations, or have no realistic alternative but to do so.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

Use of this report

This report, including the opinions, has been prepared for and only for the Directors of United Lincolnshire Hospitals NHS Trust as a body in accordance with the Code of Audit Practice and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the Department of Health and Social Care Group Accounting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of United Lincolnshire Hospitals NHS Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that United Lincolnshire Hospitals NHS Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

The Trust's outturn position for 2017/18 was a deficit of £79.7 million, which exceeds the planned deficit of £48.6 million. This included the delivery of £16.2 million of efficiencies of which only £5.0 million was achieved on a recurrent basis, and spending on agency staff of £29.4 million which is £8.4 million above the cap. The Trust's financial plan for 2018/19 is a deficit position of £79.4 million and the Trust has not accepted the control total set by NHS Improvement. The Trust was placed in financial special measures in September 2017. These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

During the year the Trust has reported that it has failed to meet the national priority targets in relation to A&E four hour waits, 18 week Referral to Treatment times and 62 day cancer waits. Action plans have been put in place although these are yet to result in evidence of sustained improvements in performance. This issue is evidence of weakness in proper

arrangements for understanding and using appropriate performance information to support informed decision making and performance management.

The Care Quality Commission (CQC) inspected the Trust in October 2016 and issued a report in April 2017 with an overall rating of inadequate. The report highlighted concerns in respect of safety, effectiveness, responsiveness and leadership. The Trust was placed in clinical special measures in April 2017 and has not yet been subject to re-inspection by the CQC. This is evidence of weaknesses in arrangements for planning and deploying workforce to deliver the Trust's priorities effectively.

In respect of the matters referred to above, we are not satisfied that United Lincolnshire Hospitals NHS Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2018.

Other matters on which we report by exception

Under the Code of Audit Practice, we are required to report to you if:

- We have referred a matter to Secretary of State for Health under Section 30 of the Act because we had reason to believe that the Trust, or a director or officer of United Lincolnshire Hospitals NHS Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- We have issued a report in the public interest under section 24 of the Act.
- We have made written recommendations to United Lincolnshire Hospitals NHS Trust under section 24 of the Act in the course of, or at the conclusion of the audit.
- We have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility except in relation to the referral of a matter to the Secretary of State for Health under section 30 of the Act on 21 May 2018 because we have reason to believe that the Trust has, taking into account the guidance issued by NHS Improvement in April 2018 entitled 'Statutory breakeven duty: a guide for NHS trusts', breached its statutory 'breakeven duty' as set out in paragraph 2 (1) of Schedule 5 to the National Health Service Act 2006. The Trust reported in its draft financial statements for 2017/18 an in-year breakeven duty financial performance deficit of £79.7 million, and a cumulative deficit as at 31 March 2018 of £242.5 million.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Alison Breadon (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Donington Court
Pegasus Business Park
Castle Donington
East Midlands
DE74 2UZ

Date: 29 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	394,512	392,427
Other operating income	4	38,649	44,897
Operating expenses	6.1, 8	(527,203)	(489,001)
Operating surplus/(deficit) from continuing operations		**(94,042)**	**(51,677)**
Finance income	11	41	47
Finance expenses	12	(2,752)	(1,963)
PDC dividends payable		(437)	(3,154)
Net finance costs		**(3,148)**	**(5,070)**
Other gains / (losses)	13	109	(51)
Surplus / (deficit) for the year		**(97,081)**	**(56,798)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(15,043)	571
Revaluations	17	7,483	1,380
Other reserve movements		-	1
Total comprehensive income / (expense) for the period		**(104,641)**	**(54,846)**

Financial performance for the year

Retained surplus/(deficit) for the year	**(97,081)**	(56,798)
Prior period adjustment to correct errors and other performance adjustments		
IFRIC 12 adjustment	**178**	148
Impairments	**17,527**	(509)
Adjustments in respect of donated gov't grant asset reserve elimination	**(288)**	268
Adjustment re absorption accounting		
Adjusted retained surplus/(deficit)	**(79,664)**	(56,891)

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	6,148	6,052
Property, plant and equipment	15	207,551	221,161
Trade and other receivables	19	1,828	1,211
Total non-current assets		**215,527**	**228,424**
Current assets			
Inventories	18	6,799	7,769
Trade and other receivables	19.1	25,393	24,280
Non-current assets held for sale / assets in disposal groups	20	1,225	1,251
Cash and cash equivalents	21.1	10,533	1,675
Total current assets		**43,950**	**34,975**
Current liabilities			
Trade and other payables	22	(53,481)	(43,265)
Borrowings	24	(36,157)	(284)
Provisions	26	(735)	(1,516)
Other liabilities	23	(3,210)	(3,578)
Total current liabilities		**(93,583)**	**(48,643)**
Total assets less current liabilities		**165,894**	**214,756**
Non-current liabilities			
Borrowings	24	(165,075)	(110,760)
Provisions	26.1	(2,994)	(2,926)
Other liabilities	23	(13,584)	(14,088)
Total non-current liabilities		**(181,653)**	**(127,774)**
Total assets employed		**(15,759)**	**86,982**
Financed by			
Public dividend capital		257,563	255,663
Revaluation reserve		35,283	44,003
Other reserves		190	190
Income and expenditure reserve		(308,795)	(212,874)
Total taxpayers' equity		**(15,759)**	**86,982**

The notes on pages 15 to 68 form part of these accounts.

The financial statements on pages 10 to 68 were approved by the Board on 25 May 2018 and signed on its behalf by:

Chief Executive: Date: **25 May 2018**

Director of Finance, Procurement and Corporate Affairs Date: **25 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**255,663**	**44,003**	**190**	**(212,874)**	**86,982**
Surplus/(deficit) for the year	-	-	-	(97,081)	**(97,081)**
Other transfers between reserves	-	(1,145)	-	1,145	**-**
Impairments	-	(15,043)	-	-	**(15,043)**
Revaluations	-	7,483	-	-	**7,483**
Transfer to retained earnings on disposal of assets	-	(15)	-	15	**-**
Public dividend capital received	1,900	-	-	-	**1,900**
Taxpayers' equity at 31 March 2018	**257,563**	**35,283**	**190**	**(308,795)**	**(15,759)**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**251,746**	**43,004**	**190**	**(157,029)**	**137,911**
Surplus/(deficit) for the year	-	-	-	(56,798)	**(56,798)**
Other transfers between reserves	-	(952)	-	952	**-**
Impairments	-	571	-	-	**571**
Revaluations	-	1,380	-	-	**1,380**
Public dividend capital received	6,735	-	-	-	**6,735**
Public dividend capital repaid	(2,818)	-	-	-	**(2,818)**
Other reserve movements	-	-	-	1	**1**
Taxpayers' equity at 31 March 2017	**255,663**	**44,003**	**190**	**(212,874)**	**86,982**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the PDC dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

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

Income and expenditure reserve
The balance of this reserve is the net accumulated deficit of the Trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(94,042)	(51,677)
Non-cash income and expense:			
Depreciation and amortisation	6.1	11,723	11,733
Net impairments	7	17,527	(509)
Income recognised in respect of capital donations	4	(464)	(35)
Amortisation of PFI deferred credit		(503)	(503)
(Increase) / decrease in receivables and other assets		(1,227)	(2,887)
(Increase) / decrease in inventories		970	(639)
Increase / (decrease) in payables and other liabilties		2,699	3,247
Increase / (decrease) in provisions		(720)	242
Net cash generated from / (used in) operating activities		**(64,037)**	**(41,028)**
Cash flows from investing activities			
Interest received		41	48
Purchase of intangible assets		(1,626)	(1,460)
Purchase of property, plant, equipment and investment property		(14,985)	(13,215)
Sales of property, plant, equipment and investment property		322	24
Net cash generated from / (used in) investing activities		**(16,248)**	**(14,603)**
Cash flows from financing activities			
Public dividend capital received		1,900	6,735
Public dividend capital repaid		-	(2,818)
Movement on loans from the Department of Health and Social Care		90,473	56,548
Movement on other loans		(119)	(118)
Capital element of finance lease rental payments		(167)	137
Interest paid on finance lease liabilities		(17)	(28)
Other interest paid		(1,987)	(1,396)
PDC dividend (paid) / refunded		(940)	(2,920)
Net cash generated from / (used in) financing activities		**89,143**	**56,140**
Increase / (decrease) in cash and cash equivalents		**8,858**	**509**
Cash and cash equivalents at 1 April - brought forward		**1,675**	**1,166**
Cash and cash equivalents at 31 March	21.1	**10,533**	**1,675**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM 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 GAM permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 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.

Note 1.1.2 Going concern
The Trust's Annual Report and Accounts have been prepared on a going concern basis.

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

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

Continuity of Service
The Trust recorded a deficit of £79.7 million which was £31.1 million above the planned deficit of £48.6 million in 2017/18.
The Trust failed to achieve core operational and financial trajectories and therefore did not qualify for receipt of Sustainability and Transformation Funding (STF).
The Trust delivered £16.2 million, of which £5.0 million was recurrent, of its Financial Efficiency Programme (FEP). This was against a plan agreed with NHSI to deliver £16.0m, the recurrent full year effect was £14.1m.

At the start of 2017/18 the Board of Directors and NHS Improvement approved the Trust's two-year plan of £48.6 million deficit in 2017/18 and £41.1m deficit in 2018/19. Taking account of the 2017/18 performance and the challenging external environment and transformation programme which the Trust is facing, the plans for 2018/19 have subsequently been refreshed to include a deficit of £79.4 million.
The plans include FEP programme delivery in full of new financial efficiencies of £19.7 million in 2018/19.
The Trust continues to receive the majority (95%) of its patient care income through two main contracts, Lincolnshire Clinical Commissioning Groups plus Associates and NHS England. Contracts for 2018/19 were agreed and signed with each in advance of 31 March 2018. No contracts have yet been signed for the period after this date.
The signing of these contracts at levels consistent with those anticipated within the financial plan provides a degree of comfort around the income and planning assumptions for the next 12 months. Within this the Trust acknowledges the heightened risk of contract penalties being applied for non-delivery of quality standards as a consequence of not signing off the 2018/19 NHSI control total. Discussions have been taking place with CCG partners which will mitigate this risk, estimated to be circa £15-17m.

The Sustainability and Transformation Plan (STP) for Lincolnshire has the objective of bringing the whole health system back into financial balance by 2021.
The STP key aim is to assess the county wide strategic provision of services across all health and social care bodies, identifying and delivering the potential for large scale service reconfiguration and rationalisation. This should deliver improved patient outcomes and reduced costs through improved efficiency and a reduction in duplication.

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

The approved plans supported by the publication of the STP and Trust plans offer a clear signal and constitute reasonable evidence that the NHS intends on-going provision of acute healthcare services to the people of Lincolnshire be that through the Trust or via an alternative delivery model.

Financing
The Board of Directors has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health and Social Care (DHSC) (NHS Act 2006,s42a) to continue to deliver the full range of mandatory services for the foreseeable future. The Trust has been reliant on external cash support to meet its liabilities as they have fallen due during 2017/18, being reliant on cash support from the DHSC in meeting its payment obligations. It has drawn down a cumulative total of £191.52 million in revenue related loans and £9.5 million in capital loans, at 31 March 2018.

Of the revenue support loans, £35.62 million is repayable in November 2018 and no formal agreement has yet been reached with the DHSC on either an extension for the repayment or additional loan support. However the uncertainty about the refinancing does not of itself affect the Trust's going concern basis.

The 2018/19 financial plan incorporates further revenue cash support of £82.0 million alongside an agreed capital loan of £26.6 million.

The Trust recognises that there is material uncertainty which may cast significant doubt about the Trust’s ability to continue as a Going Concern, however the assurance provided by the immediate continuing provision of healthcare services and cash support significantly mitigates this.

The Board of Directors is therefore satisfied and considers it appropriate that the accounts for the year ended 31 March 2018 should be prepared on a Going Concern basis.

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust 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 2018 will be paid in full.

Note 1.2.1 Sources of estimation uncertainty
Management do not consider that there are any estimates which create a significant risk of causing a material uncertainty. However, the following are areas of estimation or judgement which have a major effect on the amounts recognised in the financial statements:

Property Plant and Equipment Valuations:
An annual revaluation of Trust Property, Plant and Equipment is conducted by Cushman & Wakefield (formerly DTZ Debenham Tie Leung Ltd (DTZ)). As part of this revaluation process the Trust reviews the remaining useful life of its buildings in accordance with advice received from the valuer. This estimation of remaining useful life is in accordance with the Royal Institute of Chartered Surveyors (RICS) appraisal and valuation manual. The value of land, buildings and dwellings post revaluation was £178.4m and is detailed at Note 15.

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 2018. The assets associated with this 'onerous' contract are impaired based upon this assessment.

Pension Costs:
Details of the actuarial assumptions used in calculating the Trust's pension liabilities are provided in Note 9.

Income estimates:
Included in the income figure is an estimate for partially completed spells, i.e. treatment for admitted patients which is ongoing at the 31 March each year. This income is estimated based on the average speciality tariff applicable to each spell and adjusted for the portion of work completed at the end of the financial year.
For patients occupying a bed as at 31 March 2018, the estimated income from partially completed spells was £4.4m (31 March 2017: £3.6m). Similarly income received for the period of antenatal care has been deferred where this provision has not been completed, this totalled £2.1m (31 March 2017: £2.2m).

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

Provisions recognised by the Trust at 31 March 2018 include legal actions against the Trust in relation to employers and public liability claims as well as employment, 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 2018 were £3.7m (31 March 2017: £4.4m). See Note 26.1.

Contingent Liabilities:
Reports from the Trust solicitor are utilised to assess potential outcome and costs. Where the potential for the claim succeeding is less than 50% but considered not to be remote, a contingent liability is recorded. These total £0.5m at 31 March 2018 (31 March 2017: £3.0m). See Note 27.

Inventories:
The Trust information systems are unable to accurately identify the figures for 'Inventories recognised as expenses' under Note 18. The Trust has therefore estimated this figure using data extracted from the pharmacy stock system for drugs (£42.3m) and purchases through NHS Supply Chain (£11.2m).

Trade and other payables:
Outstanding pay liabilities incorporate estimates for:
• Annual Leave - based upon authorised carry forward for staff in work and an estimate taking account of length of service and period of leave taken / remaining for staff on long term sickness or maternity leave.
• Overtime and enhancements relating to March 2018 - based upon actual payments for a 'similar' accounting period.
• Agency - based upon details of unclaimed 'booked' shifts going back 3 months.

Note 1.3 Income

Income 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 income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year.
Revenue relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the end of the reporting period multiplied by a historic average daily income rate; the resulting balance is accrued and agreed with the commissioner.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from Commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as Social Security costs and the Apprenticeship Levy are recognised in the period in which the service is received from employees.
The cost of annual leave entitlement 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.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:

• 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 be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• 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 cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.6.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs 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 property assets are measured subsequently at valuation.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.
Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site may 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 and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Freehold land, which is considered to have an infinite life is not depreciated.
Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the 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.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of :
(i) the impairment charged to operating expenses; and
(ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 Derecognition
Non-current assets intended for disposal are reclassified as 'held for sale' if their carrying amount will be recovered principally through a sale transaction rather than through continuing use and once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale'
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value (open market value including alternative uses) less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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 which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The nature of the PFI held by United Lincolnshire Hospitals NHS Trust means that no operating expenses are recorded.

PFI assets, liabilities and finance costs

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

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

Other assets contributed by the Trust to the operator

On initial recognition of the asset, the difference between the fair value of the asset and the initial value of the liability is recognised as deferred income, 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.

Note 1.6.6 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	80
Dwellings	60	78
Plant & machinery	2	15
Transport equipment	5	11
Information technology	3	10
Furniture & fittings	3	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, for example, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.
Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	5
Websites	5	5
Software licences	3	15

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.9 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. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure" or loans and receivables.
The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The exception to this being loans from Department of Health and Social Care, which are carried at historic cost.
The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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 the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

Note 1.11 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.

Note 1.11.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11.2 The Trust as lessor

Finance leases

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

Operating 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 as an expense on a straight-line basis over the lease term.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.
Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016-17: positive 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.42% (2016-17: negative 2.70%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.85% (2016-17: negative 1.95%) for expected cash flows over 5 .years up to and including 10 years
- A long term rate of negative 1.56% (2016-17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at Note 26.2 but is not recognised in the Trust's accounts.

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 NHS Resolution 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 when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in Note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Note 1.14 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (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.

Note 1.15 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.

Note 1.16 Corporation tax

The Trust has no corporation tax liability.

Note 1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot .exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.18 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. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

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

Note 1.21 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 1.23 Charitable Funds

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

Note 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 financial results for this segment are the same as in the primary statements.

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

Revenue from activities (medical treatment of patients) is analysed by customer type in Note 3 to the financial statements. Other operating revenue is analysed in Note 4 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.

	2017/18		2016/17	
	£000s	**%**	£000s	%
Revenue from HM Government sources	**421,019**	**97.2**	425,345	97.3
Revenue from non HM Government sources	**12,142**	**2.8**	11,979	2.7
Total	**433,161**	**100.0**	437,324	100.0

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	55,659	61,738
Non elective income	126,160	122,437
First outpatient income	37,859	31,366
Follow up outpatient income	32,240	42,135
A & E income	20,966	18,775
Other NHS clinical income	104,215	100,531
All services		
Private patient income	381	551
Other clinical income	17,032	14,894
Total income from activities	**394,512**	**392,427**

Note 3.2 Income from patient care activities (by source)		
Income from patient care activities received from:	**2017/18 £000**	**2016/17 £000**
NHS England	66,159	61,593
Clinical commissioning groups	324,400	326,804
Department of Health and Social Care	12	29
Other NHS providers	312	373
NHS other	175	188
Non-NHS: private patients	381	551
Non-NHS: overseas patients (chargeable to patient)	327	177
NHS injury scheme	1,557	1,542
Non NHS: other	1,189	1,170
Total income from activities	**394,512**	**392,427**
Of which:		
Related to continuing operations	394,512	392,427

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	327	177
Cash payments received in-year	84	78
Amounts added to provision for impairment of receivables	148	28
Amounts written off in-year	42	4

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	1,720	1,382
Education and training	16,826	17,148
Receipt of capital grants and donations	464	35
Non-patient care services to other bodies	6,813	5,204
Sustainability and transformation fund income	3,551	9,660
Rental revenue from operating leases	415	433
Rental revenue from finance leases	158	173
Income in respect of staff costs where accounted on gross basis	2,598	2,312
Other income	6,104	8,550
Total other operating income	**38,649**	**44,897**
Of which:		
Related to continuing operations	38,649	44,897

Other income includes £4.7m revenue from income generating activities as detailed in Note 5.

Note 5 Fees and charges

	2017/18	2016/17
	£000	£000
Income	4,670	4,740
Full cost	(2,667)	(2,591)
Surplus / (deficit)	**2,003**	**2,149**

This note addresses and aggregates schemes that , individually, have a cost exceeding £1m.
In 2017-18 and 2016-17 this comprises catering and car parking income from the public and staff.

Catering	2017/18	2016/17
	£000s	£000s
Income	**2,038**	2,111
Full cost	**(1,933)**	(1,936)
Surplus / (deficit)	**105**	175

Car Parking	2017/18	2016/17
	£000s	£000s
Income	**2,631**	2,629
Full cost	**(734)**	(655)
Surplus / (deficit)	**1,897**	1,974

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	2,046	1,342
Staff and executive directors costs	319,522	311,991
Remuneration of non-executive directors	88	87
Supplies and services - clinical (excluding drugs costs)	56,573	57,547
Supplies and services - general	8,053	6,946
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	51,916	47,785
Inventories written down	190	88
Consultancy costs	3,066	4
Establishment	4,461	4,436
Premises	17,601	14,874
Transport (including patient travel)	1,935	1,663
Depreciation on property, plant and equipment	10,286	10,328
Amortisation on intangible assets	1,437	1,405
Net impairments	17,527	(509)
Increase/(decrease) in provision for impairment of receivables	1,739	99
Change in provisions discount rate(s)	48	315
Audit fees payable to the external auditor		
audit services- statutory audit	101	110
other auditor remuneration (external auditor only)	10	12
Internal audit costs	158	171
Clinical negligence	21,884	19,959
Legal fees	588	460
Insurance	50	46
Research and development	1,742	1,868
Education and training	2,857	3,022
Rentals under operating leases	1,687	1,519
Redundancy	69	-
Car parking & security	90	90
Hospitality	8	8
Losses, ex gratia & special payments	748	460
Other services, e.g. external payroll	464	449
Other	259	2,426
Total	**527,203**	**489,001**
Of which:		
Related to continuing operations	527,203	489,001
Related to discontinued operations	-	-

Other auditor's remuneration relates to the assurance and audit work performed on the Trust's Quality Account.

Consultancy costs in 2017/18 include the additional costs associated with the Trust being in Financial Special Measures.

Note 6.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services - Quality Account	10	12
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**10**	**12**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5m (2016/17: £1m).

Note 7 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(1,206)	(446)
Other	18,733	(63)
Total net impairments charged to operating surplus / deficit	**17,527**	**(509)**
Impairments charged to the revaluation reserve	15,043	(571)
Total net impairments	**32,570**	**(1,080)**

Material Impairment losses / (reversals) charged to SOCI in 2017/18 resulting from changes in market price following valuation are summarised below:

	2017/18		2016/17	
	£000	£000	£000	£000
Reversals of impairments charged to SOCI in previous years				
Other - buildings	(1,206)		(846)	
		(1,206)		(846)
Impairments charged to SOCI in current year				
Other buildings	0		400	
		0		400
		(1,206)		(446)

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

	2017/18		2016/17	
	£000	£000	£000	£000
Reversal of impairments charged to SOCI in previous years				
Progress Care Housing Association Onerous Contract net reversal **		1,470		(1,584)
Impairments Charged to SOCI in current year*				
Tower Block, Boston	1,484		1,138	
Maternity Unit, Lincoln	3,300			
Plant Rooms, Grantham	2,591			
Other buildings impaired	9,888		383	
		17,263		1,521
		18,733		(63)

* As part of the Quinquenial on-site revaluation, the valuer, Cushman & Wakefield have undertaken a full review of the entire Trust estate. This takes account of numerous factors contributing to an overall assessment of each building asset on a modern equivalent basis; these include functional and external obsolescence, investment into the property since the previous valuation, and any change of use. As part of this specific valuation the Trust and valuer have also jointly re-assessed all the floor areas associated with each building. In some instances this has contributed to the movement in asset values between years.

**As set out in notes 1.2.1 and 30, 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) against this contract were:

	2017/18	2016/17
Site:	£000	£000
Lincoln		0
Boston	1,413	(2,220)
Grantham	57	636
Total	**1,470**	(1,584)

Property, Plant and Equipment impairments and reversals charged to the revaluation reserve

	2017/18	2016/17
	£000	£000
Other	17,077	104
Changes in market price	(2,034)	(675)
Total impairments for PPE charged to reserves	**15,043**	**(571)**

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	242,302	236,936
Social security costs	22,365	22,018
Apprenticeship levy	1,223	-
Employer's contributions to NHS pensions	28,053	27,483
Pension cost - other	28	26
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	69	9
Temporary staff (including agency)	29,385	29,398
Total gross staff costs	**323,425**	**315,870**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**323,425**	**315,870**
Of which		
Costs capitalised as part of assets	688	739

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

Note 8.1 Retirements due to ill-health

During 2017/18 there were 9 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £379k (£247k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 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 NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 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 employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision.
The Trust is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrols the employee into NEST.
NEST is a defined contribution scheme.

Note 10 Operating leases

Note 10.1 United Lincolnshire Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where United Lincolnshire Hospitals NHS Trust is the lessor.

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

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	198	191
Contingent rent	217	242
Total	**415**	**433**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	573	524
- later than one year and not later than five years;	915	968
- later than five years.	1,110	1,374
Total	**2,598**	**2,866**

Note 10.2 United Lincolnshire Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where United Lincolnshire Hospitals NHS Trust is the lessee.

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 then renegotiated an extension to July 2024 though either party can revoke with 6 months notice.

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

The Trust leases various items of medical equipment. These leases expire in the period to September 2021.

The Trust has numerous vehicles leased which expire before April 2021.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	1,687	1,519
Total	**1,687**	**1,519**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,313	1,569
- later than one year and not later than five years;	92	1,234
Total	**1,405**	**2,803**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	41	47
Total	**41**	**47**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,727	1,941
Finance leases	17	(15)
Interest on late payment of commercial debt	1	-
Total interest expense	**2,745**	**1,926**
Unwinding of discount on provisions	7	37
Total finance costs	**2,752**	**1,963**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	1,948	-
Amounts included within interest payable arising from claims made under this legislation	1	-

To comply with the Public Contract Regulations 2015 the Trust is required to disclose details relating to payment performance and liability to pay interest accrued.

The total liability under the Late Payment of Commercial Debts (Interest) Act 1998 which suppliers could potentially have levied upon the Trust for late payment (over 30 days) during 2017/18 is estimated to be £1.948m (Flat fee: £1.569m , Interest £0.379m).

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	140	20
Losses on disposal of assets	(31)	(71)
Total gains / (losses) on disposal of assets	109	(51)
Total other gains / (losses)	**109**	**(51)**

Note 14.1 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Websites	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**10,259**	**20**	**15**	**391**	**10,685**
Additions	1,093	-	-	329	**1,422**
Reclassifications	725	-	-	(607)	**118**
Disposals / derecognition	(301)	-	-	-	**(301)**
Gross cost at 31 March 2018	**11,776**	**20**	**15**	**113**	**11,924**
Amortisation at 1 April 2017 - brought forward	**4,607**	**20**	**6**	**-**	**4,633**
Provided during the year	1,434	-	3	-	**1,437**
Disposals / derecognition	**(294)**	**-**	**-**	**-**	**(294)**
Amortisation at 31 March 2018	**5,747**	**20**	**9**	**-**	**5,776**
Net book value at 31 March 2018	**6,029**	**-**	**6**	**113**	**6,148**
Net book value at 1 April 2017	**5,652**	**-**	**9**	**391**	**6,052**

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

IT - in-house & 3rd party software showing as fully depreciated relates to one internally developed asset which is still in use.

Other fully amoritised assets still in use and reported within Computer Licenses had an original purchase cost of £0.48m.

Note 14.2 Intangible assets - 2016/17

	Software licences	Internally generated information technology	Websites	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**9,947**	**20**	**15**	**-**	**9,982**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**9,947**	**20**	**15**	**-**	**9,982**
Additions	527	-	-	391	**918**
Reclassifications	932	-	-	-	**932**
Disposals / derecognition	(1,147)	-	-	-	**(1,147)**
Valuation / gross cost at 31 March 2017	**10,259**	**20**	**15**	**391**	**10,685**
Amortisation at 1 April 2016 - as previously stated	**4,352**	**20**	**3**	**-**	**4,375**
Provided during the year	1,402	-	3	**-**	**1,405**
Disposals / derecognition	(1,147)	-	-	-	**(1,147)**
Amortisation at 31 March 2017	**4,607**	**20**	**6**	**-**	**4,633**
Net book value at 31 March 2017	**5,652**	**-**	**9**	**391**	**6,052**
Net book value at 1 April 2016	**5,595**	**-**	**12**	**-**	**5,607**

Note 15.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - b'f	**12,125**	**153,345**	**24,394**	**6,486**	**58,345**	**751**	**8,619**	**363**	**264,428**
Additions	-	7,315	-	9,002	3,356	59	2,329	-	**22,061**
Impairments	(2,229)	(34,893)	(1,849)	-	-	-	-	-	**(38,971)**
Reversals of impairments	-	2,500	159	-	-	-	-	-	**2,659**
Revaluations	95	6,700	139	-	-	-	-	-	**6,934**
Reclassifications	-	10,707	-	(12,202)	736	-	641	-	**(118)**
Transfers to/ from assets held for sale	(150)	-	-	-	(1,797)	(75)	(20)	-	**(2,042)**
Disposals / derecognition	-	(7)	-	-	(3,259)	-	(998)	-	**(4,264)**
Valuation/gross cost at 31 March 2018	**9,841**	**145,667**	**22,843**	**3,286**	**57,381**	**735**	**10,571**	**363**	**250,687**
Accumulated depreciation at 1 April 2017 - b'f	**-**	**-**	**-**	**-**	**38,690**	**552**	**3,832**	**193**	**43,267**
Provided during the year	-	3,937	356	-	4,070	51	1,828	44	**10,286**
Impairments	-	(2,851)	(239)	-	-	-	-	-	**(3,090)**
Reversals of impairments	-	(648)	(4)	-	-	-	-	-	**(652)**
Revaluations	-	(436)	(113)	-	-	-	-	-	**(549)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	(1,791)	(75)	(20)	-	**(1,886)**
Disposals / derecognition	-	(2)	-	-	(3,240)	-	(998)	-	**(4,240)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**37,729**	**528**	**4,642**	**237**	**43,136**
Net book value at 31 March 2018	**9,841**	**145,667**	**22,843**	**3,286**	**19,652**	**207**	**5,929**	**126**	**207,551**
Net book value at 1 April 2017	**12,125**	**153,345**	**24,394**	**6,486**	**19,655**	**199**	**4,787**	**170**	**221,161**
Revaluation Reserve for Property, Plant & Equipment									
At 1 April 2017	**2,679**	**31,985**	**9,111**	**-**	**228**	**-**	**-**	**-**	**44,003**
Movements									
Disposals	**(13)**	**-**	**(2)**	**-**	**-**	**-**	**-**	**-**	**(15)**
Excess Depreciation	**-**	**(859)**	**(161)**	**-**	**(125)**	**-**	**-**	**-**	**(1,145)**
Revaluations / Impairments	**(1,095)**	**(6,740)**	**275**	**-**	**-**	**-**	**-**	**-**	**(7,560)**
At 31 March 2018	**1,571**	**24,386**	**9,223**	**-**	**103**	**-**	**-**	**-**	**35,283**
Additions to Assets Under Construction in 2017/18	**-**	**8,343**	**-**	**-**	**-**	**-**	**604**	**55**	**9,002**

Note 15.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**12,186**	**153,841**	**23,159**	**5,891**	**53,760**	**774**	**9,242**	**406**	**259,259**
Additions	-	1,548	-	5,435	6,017	-	1,415	29	**14,444**
Impairments	-	(5,923)	1,227	-	-	-	-	-	**(4,696)**
Reversals of impairments	-	2,603	-	-	-	-	-	-	**2,603**
Revaluations	-	326	8	-	227	-	-	-	**561**
Reclassifications	-	1,065	-	(4,804)	2,051	-	756	-	**(932)**
Transfers to / from assets held for sale	(61)	(115)	-	-	(672)	(23)	-	-	**(871)**
Disposals / derecognition	-	-	-	(36)	(3,038)	-	(2,794)	(72)	**(5,940)**
Valuation/gross cost at 31 March 2017	**12,125**	**153,345**	**24,394**	**6,486**	**58,345**	**751**	**8,619**	**363**	**264,428**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**-**	**37,630**	**528**	**5,131**	**202**	**43,491**
Provided during the year	**-**	**3,658**	**334**	**-**	**4,745**	**47**	**1,495**	**49**	**10,328**
Impairments	-	(1,186)	(334)	-	-	-	-	-	**(1,520)**
Reversals of impairments	-	(1,653)	-	-	-	-	-	-	**(1,653)**
Revaluations	-	(819)	-	-	-	-	-	-	**(819)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	(668)	(23)	-	-	**(691)**
Disposals/ derecognition	-	-	-	-	(3,017)	-	(2,794)	(58)	**(5,869)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**38,690**	**552**	**3,832**	**193**	**43,267**
Net book value at 31 March 2017	**12,125**	**153,345**	**24,394**	**6,486**	**19,655**	**199**	**4,787**	**170**	**221,161**
Net book value at 1 April 2016	**12,186**	**153,841**	**23,159**	**5,891**	**16,130**	**246**	**4,111**	**204**	**215,768**
Revaluation Reserve for Property, Plant & Equipment									
At 1 April 2016	**2,679**	**31,039**	**9,267**	**-**	**19**	**-**	**-**	**-**	**43,004**
Movements									
Excess Depreciation	**-**	**(794)**	**(172)**	**-**	**(18)**	**-**	**-**	**-**	**(984)**
Revaluations / Impairments	**-**	**1,740**	**16**	**-**	**227**				**1,983**
At 31 March 2017	**2,679**	**31,985**	**9,111**	**-**	**228**	**-**	**-**	**-**	**44,003**

Note 15.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	9,841	144,964	-	3,286	18,808	171	5,907	114	**183,091**
Finance leased	-	-	-	-	103	-	-	-	**103**
On-SoFP PFI contracts and other service concession arrangements	-	-	22,843	-	-	-	-	-	**22,843**
Owned - government granted	-	44	-	-	-	-	-	-	**44**
Owned - donated	-	659	-	-	741	36	22	12	**1,470**
NBV total at 31 March 2018	**9,841**	**145,667**	**22,843**	**3,286**	**19,652**	**207**	**5,929**	**126**	**207,551**

Note 15.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	12,125	152,858	-	6,486	18,986	152	4,748	155	**195,510**
Finance leased	-	-	-	-	227	-	-	-	**227**
On-SoFP PFI contracts and other service concession arrangements	-	-	24,394	-	-	-	-	-	**24,394**
Owned - government granted	-	69	-	-	-	-	-	-	**69**
Owned - donated	-	418	-	-	442	47	39	15	**961**
NBV total at 31 March 2017	**12,125**	**153,345**	**24,394**	**6,486**	**19,655**	**199**	**4,787**	**170**	**221,161**

Note 16 Donations of property, plant and equipment and Intangibles

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

Donor: United Lincolnshire Hospitals NHS Trust Charitable Fund

Asset Description - Donation of physical asset	Plant & machinery	Total Property, Plant and Equipment	Software licences	Total Intangibles	Fair value of asset
	£000	£000	£000	£000	£000
BK3000 Scanner	62	**62**	**-**	**-**	62
Aplio I800 Scanner x 2	136	**136**	**-**	**-**	136
Aplio I600 Scanner x 2	105	**105**	**-**	**-**	105
Upgrade to Volcano S5i Ultrasound	44	**44**	**-**	**-**	44
Scope Guide	36	**36**	**-**	**-**	36
VIVIDEO VNL9-CP Video E/scope	15	**15**	**-**	**-**	15
MPC225-873 Panel Computer	1	**1**	**-**	**-**	1
13-PSW-01 Slimline Workstation	3	**3**	**-**	**-**	3
VP-701XL Digital Scan Con	1	**1**	**-**	**-**	1
VIVIDEO CP-1000 Video Proc	9	**9**	**-**	**-**	9
Digital Reminiscence therapy Software	**-**	**-**	52	**52**	52
Total value of physical assets donated	**412**	**412**	**52**	**52**	**464**

Note 17 Revaluations of property, plant and equipment

The Trust commissioned a full quinquenial on site revaluation of land, buildings and dwellings in March 2018. This revaluation was conducted by Mr D.M. Wilson MRICS of Cushman & Wakefield formerly (DTZ Debenham Tie Leung Ltd (DTZ)).

The valuation has been undertaken on the following basis:

Assets in existing use:

For specialised properties (i.e. those for which no active market exists), depreciated replacement cost has been used and is considered to be a satisfactory approximation of current value in existing use. Within this methodology, the Modern Equivalent Asset (MEA) concept is applied: the “replacement cost” being based on the cost of a modern replacement asset that has the same productive capacity as the property being valued. An alternative site basis has been adopted.

Progress Care Housing Association Ltd accommodation units (non-specialised) 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 - Specialised: Current Value in existing use

Restrictions on sale - Non specialised: Current Value in existing use

No restrictions on sale - Fair Value

Assets held for sale - Fair value

The following table provides details of property valued on an open market valuation basis at 31 March 2018.

	2017/18	2016/17
	£000s	£000s
Land	700	755
Dwellings	22,844	24,394
Buildings	0	0
Total	**23,544**	25,149

Accounting policies Note 1.6 provides further information regarding the method of valuation.

The useful economic asset lives for intangibles and plant and equipment are initially assessed when an asset is first recognised. Thereafter an annual review is undertaken to identify and adjust for any assets impaired or where the useful economic life requires adjustment.

In 2017/18 an in depth review was carried out to re-assess the remaining useful economic lives of all Medical Equipment. This review was carried out with the assistance of the Trust's Clinical Engineering Dept. who oversee the on-going maintenance and replacement programme for Medical Equipment.

The impact of this has been to reduce the annual depreciation charge in 2017/18 by £0.8m.

The asset lives for individual buildings and dwellings are in accordance with the latest valuation report prepared by the external valuer.

The gross value of fully depreciated assets still in use is £7.37m (2016/17 £10.58m).

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 2018 was £4.5m as set out in the table below:

	2017/18	2016/17
	£000s	£000s
Net book value 1 April 2017	3,405	2,429
New leases	96	
Additions	88	52
Depreciation	(59)	(61)
Increase in valuation 31 March 2018	1,447	1,280
Impairments	(158)	(3)
Terminated Leases	(270)	(292)
Net book value 31 March 2018	**4,549**	**3,405**

Note 18 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	2,551	2,902
Consumables	4,246	4,850
Energy	2	17
Total inventories	**6,799**	**7,769**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £54,054k (2016/17: £50,323k). Write-down of inventories recognised as expenses for the year were £190k (2016/17: £132k).

Note 19.1 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	7,667	6,338
Accrued income	13,469	11,293
Provision for impaired receivables	(1,882)	(506)
Deposits and advances	5	10
Prepayments (non-PFI)	4,066	3,703
PDC dividend receivable	677	174
VAT receivable	414	1,062
Other receivables	977	2,206
Total current trade and other receivables	**25,393**	**24,280**
Non-current		
Provision for impaired receivables	(665)	(361)
Other receivables	2,493	1,572
Total non-current trade and other receivables	**1,828**	**1,211**
Of which receivables from NHS and DHSC group bodies:		
Current	20,413	16,421
Non-current	-	-

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 at 31 March 2018 includes £3.0m (of which £2.5m is non current) relating to the injury cost recovery scheme administered by the Department of Work and Pensions.

Note 19.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**867**	**797**
Increase in provision	1,810	132
Amounts utilised	(59)	(29)
Unused amounts reversed	(71)	(33)
At 31 March	**2,547**	**867**

The provision for impairment of receivables incorporates two elements:

(1) a specific provision against invoiced receivables where the Trust believes that it is unlikely to receive payment: £1.76m (2016-17 £0.15m)

This is based upon the respective age categorisation of each invoice. Non-NHS receivables between 0-90 days are deemed current and thus have no corresponding provision unless the Trust has specific reason to provide for it. Non-NHS receivables exceeding 90 days carry a 100% provision unless a repayment plan is in place.
NHS receivables are individually assessed taking account of the the level of activity data queries submitted by CCGs.

(2) a general provision of 22.84% (2016/17: 22.94%) against income receivable from the Compensation Recovery Unit (CRU): £0.78m (2016/17 £0.71m).

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

Note 19.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	55	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	18	-	13	-
Over 180 days	2,529	-	799	-
Total	**2,547**	**-**	**867**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,171	-	1,751	-
30-60 Days	(1,229)	-	126	-
60-90 days	424	-	186	-
90- 180 days	1,211	-	385	-
Over 180 days	2,218	-	446	-
Total	**3,795**	**-**	**2,894**	**-**

NHS receivables past their due date account for £3.45m of the total financial assets at 31 March 2018.
As CCGs are funded by Government the credit quality of these receivables is considered to be good.

Note 20 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,251**	**1,075**
Assets classified as available for sale in the year	156	**180**
Assets sold in year	(182)	**(4)**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**1,225**	**1,251**

The Trust is holding two properties for sale at 31 March 2018:

(1) Land at the site of the former Welland Hospital, Spalding is held at £1.075m. This was initially classified as 'held for sale in 2016/17. Contracts for sale have been signed and the sale is now expected in the first half of 2018/19.

(2) Land at Grantham Hospital Site, the site of the 'old main entrance' is held at £0.150m. The sale of this property is anticipated to conclude in the early part of 2018/19.

During 2017/18 the Trust sold Laundon House, Boston for £0.269m. This generated a profit of £0.093m against the net book value.

Equipment sold in 2017-18 related predominantly to various items of medical equipment, sold to external parties at a profit of £0.046m.

Note 21.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**1,675**	**1,166**
Net change in year	8,858	509
At 31 March	**10,533**	**1,675**
Broken down into:		
Cash at commercial banks and in hand	10	10
Cash with the Government Banking Service	10,523	1,665
Total cash and cash equivalents as in SoFP	**10,533**	**1,675**
Total cash and cash equivalents as in SoCF	**10,533**	**1,675**

Note 21.2 Third party assets held by the Trust

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

	31 March 2018	31 March 2017
	£000	£000
Bank balances	-	-
Monies on deposit	1	-
Total third party assets	**1**	**-**

Note 22.1 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	19,516	17,009
Capital payables	11,727	5,319
Accruals	10,221	10,416
Social security costs	3,732	3,412
Other taxes payable	3,052	2,674
Accrued interest on loans	1,127	386
Other payables	4,106	4,049
Total current trade and other payables	**53,481**	**43,265**
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	6,038	3,507
Non-current	-	-
Other payables' includes:		
Outstanding Pension contributions at the year end	3,814	3,767

Note 23 Other liabilities

	31 March 2018	31 March 2017
	£000	£000
Current		
Deferred income	2,707	3,075
PFI deferred income / credits	479	479
Lease incentives	24	24
Total other current liabilities	**3,210**	**3,578**
Non-current		
PFI deferred income / credits	12,929	13,409
Lease incentives	655	679
Total other non-current liabilities	**13,584**	**14,088**

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

Note 24 Borrowings

	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from the Department of Health and Social Care	35,946	-
Other loans	59	118
Obligations under finance leases	152	166
Total current borrowings	**36,157**	**284**
Non-current		
Loans from the Department of Health and Social Care	165,075	110,548
Other loans	-	60
Obligations under finance leases	-	152
Total non-current borrowings	**165,075**	**110,760**

Borrowings / Loans - repayment of principal falling due in:	**31 March 2018**		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 Years	35,946	211	**36,157**
1 - 2 Years	75,586	0	**75,586**
2 - 5 Years	82,285	0	**82,285**
Over 5 Years	7,204	0	**7,204**
TOTAL	**201,021**	**211**	**201,232**

Note 25 Finance leases

Note 25.1 United Lincolnshire Hospitals NHS Trust as a lessor

Future lease receipts due under finance lease agreements where United Lincolnshire Hospitals NHS Trust is the lessor:

The Trust owns 3 properties where it has granted long leases to other NHS bodies; each has an annual rent of 1 peppercorn.

	Term Years	Commencing
Ambulance Station at Boston Pilgrim Hospital	125	1992
Manthorpe Centre at Grantham Hospital	80	1997
Adult Mental Illness Unit at Boston Pilgrim Hospital	125	1993

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

	31 March 2018	31 March 2017
	£000	£000
Contingent rents recognised as income in the period	158	-

Note 25.2 United Lincolnshire Hospitals NHS Trust as a lessee

Obligations under finance leases where United Lincolnshire Hospitals NHS Trust is the lessee.

	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	**158**	**340**
of which liabilities are due:		
- not later than one year;	158	183
- later than one year and not later than five years;	-	157
- later than five years.	-	-
Finance charges allocated to future periods	(6)	(22)
Net lease liabilities	**152**	**318**
of which payable:		
- not later than one year;	152	166
- later than one year and not later than five years;	-	152
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

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

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

Note 26.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**3,121**	**1,288**	**33**	**4,442**
Change in the discount rate	48	-	-	**48**
Arising during the year	275	255	72	**602**
Utilised during the year	(199)	(850)	(5)	**(1,054)**
Reversed unused	(63)	(225)	(28)	**(316)**
Unwinding of discount	7	-	-	**7**
At 31 March 2018	**3,189**	**468**	**72**	**3,729**
Expected timing of cash flows:				
- not later than one year;	195	468	72	**735**
- later than one year and not later than five years;	780	-	-	**780**
- later than five years.	2,214	-	-	**2,214**
Total	**3,189**	**468**	**72**	**3,729**

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

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

The provision for legal claims are made up of two component elements:
(1) Third party liability and property expense claims as notified by NHS Resolution.
(2) Projected liabilities in relation to claims made against the Trust for employment, commercial and other litigation issues.
The Trust's legal advisors have provided details to support an assessment of the potential liability for those claims where they are representing the Trust. This takes account of the potential range of outcomes, the related probability and the expected settlement date.

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 27.

Other provisions relate to costs associated with relocation expenses.

Note 26.2 Clinical negligence liabilities

At 31 March 2018, £220,518k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of United Lincolnshire Hospitals NHS Trust (31 March 2017: £211,792k).

Note 27 Contingent assets and liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(40)	-
Employment tribunal and other employee related litigation	(431)	(380)
Other	-	(2,641)
Gross value of contingent liabilities	**(471)**	**(3,021)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(471)**	**(3,021)**
Net value of contingent assets	-	-

A provision for legal claims brought against the Trust in relation to Employment issues has been disclosed at Note 26. This provision is assessed based upon the most likely outcome. The contingent liability reported within this note takes account of the potential liability in the event the Trust assessment is underestimated.

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

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

Note 28 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	15,789	1,696
Intangible assets	14	106
Total	**15,803**	**1,802**

Note 29 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018	31 March 2017
	£000	£000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 30 On-SoFP PFI

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

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

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

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

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

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

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

The Trust has recorded the assets on its balance sheet in accordance with IAS 17, with the corresponding liability being shown as an ‘other liability’. This is amortised to the Statement of Comprehensive Income over 40 years with an end date of 31st March 2046.

Note 31 Financial instruments

Note 31.1 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

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

The Trust has borrowed from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken and it is fixed for the life of the loan.
Following the Trust being placed in financial special measures in September 2017, the Interest rates on new revenue borrowings were increased from 1.5% to 6%. These rates will continue to be applied to new revenue loans until such time as the Trust exits special measures. The rates on existing loans are unchanged.
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 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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.

Note 31.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	19,832	-	-	-	**19,832**
Cash and cash equivalents at bank and in hand	10,533	-	-	-	**10,533**
Total at 31 March 2018	**30,365**	**-**	**-**	**-**	**30,365**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	20,726	-	-	-	**20,726**
Cash and cash equivalents at bank and in hand	1,675	-	-	-	**1,675**
Total at 31 March 2017	**22,401**	**-**	**-**	**-**	**22,401**

Note 31.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	201,080	-	**201,080**
Obligations under finance leases	152	-	**152**
Trade and other payables excluding non financial liabilities	45,570	-	**45,570**
Provisions under contract	5,173	-	**5,173**
Total at 31 March 2018	**251,975**	**-**	**251,975**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	110,726	-	**110,726**
Obligations under finance leases	318	-	**318**
Trade and other payables excluding non financial liabilities	54,845	-	**54,845**
Provisions under contract	3,656	-	**3,656**
Total at 31 March 2017	**169,545**	**-**	**169,545**

Note 31.4 Fair values of financial assets and liabilities

Book value (carrying value) is considered to be a reasonable approximation of fair value in relation to the financial assets and liabilities held by the Trust.

Note 31.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	81,727	41,041
In more than one year but not more than two years	75,586	36,333
In more than two years but not more than five years	82,285	75,936
In more than five years	12,377	16,235
Total	**251,975**	**169,545**

Note 32 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	7	20	1	24
Bad debts and claims abandoned	90	69	25	30
Stores losses and damage to property	5	190	8	197
Total losses	**102**	**279**	**34**	**251**
Special payments				
Compensation under court order or legally binding arbitration award	25	1,292	154	250
Extra-contractual payments	1	185	1	80
Ex-gratia payments	70	10	121	30
Total special payments	**96**	**1,487**	**276**	**360**
Total losses and special payments	**198**	**1,766**	**310**	**611**
Compensation payments received		-		-

Special Payments incorporate:

- payments made to Progress Housing under occupancy guarantee £0.18m (2016/17: £0.08m)

- payments made through the NHSLA for Employer / Third Party Liability scheme claims and other compensation payments under legal obligation £1.292m (2016/17: £0.4m)

Following a Prosecution brought by the Health and Safety Executive for a breach of Section 3(1) of the Health and Safety at Work Act 1999 the Trust was ordered to make payments of £1.16m. This incorporated a fine of £1.0m and Prosecution costs £0.16m.

Note 33 Related parties

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 2017/18 between the Trust and Organisations with whom Trust Senior Executives / Management hold positions of influence.
The income / expenditure values quoted are those attributable to the named related party and do not represent earnings of the individual.

Details of related party transactions with individuals are as follows:	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Mrs E Baylis - Chairman ULHT / Chair - Lincolnshire Community Health Services NHS Trust	2,015,761	2,354,354	-	553,917
Mr D Fathers - Chairman ULHT / Chair - Nottinghamshire Healthcare NHS FT	61,975	3,381	14,000	-
Mr D Fathers - Chairman ULHT / Vice Chair - NHS Confederation Mental Health Network	5,890	-	5,735	-
Mrs E Libiszewski - Non Executive Director ULHT / Non-Executive - Lincolnshire Community Health Services NHS Trust	2,015,761	2,354,354	-	553,917
Mrs S Dunnett - Non Executive Director ULHT / Trustee / Hon Treasurer - Health Quality Improvement Partnership	46,339	-	-	-
Mrs S Dunnett - Non Executive Director ULHT / Non Executive Director - North West Anglia NHS Foundation Trust	378,391	5,358	197,135	4,816

The Department of Health and Social Care is the Trust's 'Parent body' and 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. These entities are listed below.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	**£000**	**£000**	**£000**
NHS England	17	70,183	328	6,479
NHS Lincolnshire East CCG	241	118,031	915	4,102
NHS Lincolnshire West CCG	-	110,177	840	3,163
NHS South West Lincolnshire CCG	28	61,593	402	3,331
NHS South Lincolnshire CCG	403	24,362	738	-
NHS Newark and Sherwood CCG	37	4,303	126	-
NHS North Lincolnshire CCG	-	860	22	16
NHS East Leicestershire and Rutland CCG	-	661	95	-
NHS Cambridgeshire and Peterborough CCG	-	365	-	163
NHS Bassetlaw CCG	-	435	10	-
NHS North East Lincolnshire CCG	-	349	1	-
NHS Sheffield CCG	-	207	19	-
NHS Rushcliffe CCG	-	209	11	-
NHS Resolution (formerly NHS Litigation Authority)	21,898	-	12	3
NHS Improvement (TDA legal entity)	-	564	-	-
NHS Business Services Authority (incl student bursaries)	-	-	72	-
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	10,820	1,027	906	327
Lincolnshire Partnership NHS Foundation Trust	839	1,774	248	248
North West Anglia NHS Foundation Trust	379	5	197	5
Sheffield Teaching Hospitals NHS Foundation Trust	157	6	41	1
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	88	-	85	-
Lincolnshire Community Health Services NHS Trust	2,016	2,354	-	554
University Hospitals of Leicester NHS Trust	207	1,694	98	401
Nottingham University Hospitals NHS Trust	937	274	408	113
Liverpool Community Health NHS Trust	-	-	815	-
Leeds Teaching Hospitals NHS Trust	235	-	64	-
Hull And East Yorkshire Hospitals NHS Trust	32	22	24	24
East Midlands Ambulance Service NHS Trust	-	76	11	4
Leicestershire Partnership NHS Trust	85	-	-	3
NHS Property Services	2,056	385	237	76
NHS Blood and Transplant	2,410	2	-	-
Care Quality Commission	289	-	-	-
Health Education England	15	17,009	-	146

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. The most significant of which are listed below.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	**£000**	**£000**	**£000**
NHS Pension Scheme	28,053	-	3,809	-
HM Revenue & Customs	23,588	-	6,783	414
Lincolnshire County Council	188	20	-	2

The Trust is the Corporate Trustee for the United Lincolnshire Hospitals Charity (Charity No:1058065). The Charity is therefore deemed to be a related party.

The purpose or objects of the fund are set out within the Charity Deed and state:
The Trustees shall hold the Trust fund upon Trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service.

The Charity has supported numerous initiatives during 2017/18 including the purchase / donation of various capital assets to the Trust. The value of these in 2017/18 was £0.46m (2016/17: £0.03m).

Direct transactions with the Charity are summarised below:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	**£000**	**£000**	**£000**
United Lincolnshire Hospitals Charity	0	123	0	0

Note 34 Events after the reporting date

There have been no significant events after the reporting date which require disclosure.

Note 35 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	125,963	166,841	136,595	171,085
Total non-NHS trade invoices paid within target	93,945	114,611	112,444	132,918
target	74.58%	68.69%	82.32%	77.69%
NHS Payables				
Total NHS trade invoices paid in the year	2,092	44,444	2,455	39,147
Total NHS trade invoices paid within target	1,336	33,943	1,768	29,462
Percentage of NHS trade invoices paid within target	63.86%	76.37%	72.02%	75.26%

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

Note 36 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	83,229	59,975
External financing requirement	**83,229**	**59,975**
External financing limit (EFL)	92,416	60,353
Under / (over) spend against EFL	9,187	378

Note 37 Capital Resource Limit

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

	2017/18 £000	2016/17 £000
Gross capital expenditure	23,483	15,362
Less: Disposals	(213)	(75)
Less: Donated and granted capital additions	(464)	(35)
Charge against Capital Resource Limit	22,806	15,252
Capital Resource Limit	23,886	16,429
Under / (over) spend against CRL	1,080	1,177

Note 38 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(81,253)
IFRIC 12 breakeven adjustment	178
CQUIN risk reserve adjustment	1,411
Breakeven duty financial performance surplus / (deficit)	(79,664)

Note 39 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,282	(13,880)	320	124	(25,813)	(15,161)	(56,917)	(56,891)	(79,664)
Breakeven duty cumulative position	4,071	5,353	(8,527)	(8,207)	(8,083)	(33,896)	(49,057)	(105,974)	(162,865)	(242,529)
Operating income		391,141	392,202	407,975	422,802	425,524	433,250	423,428	437,324	433,161
Cumulative breakeven position as a percentage of operating income		1.37%	(2.17)%	(2.01)%	(1.91)%	(7.97)%	(11.32)%	(25.03)%	(37.24)%	(55.99)%
Break-even in-year position as a percentage of turnover		0.33%	(3.54)%	0.08%	0.03%	(6.07)%	(3.50)%	(13.44)%	(13.01)%	(18.39)%

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.

Performance in respect of financial years prior to 2009/10 have not been restated to IFRS and remain on a UK GAAP basis.