Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Annual Report and Accounts for the year ended 31 March 2019

Contents

Accessibility

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

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Chief Executive and Chair's Foreword

We are really pleased to be able to share with you our Annual Report for the year 2018/19.

It is a great opportunity to reflect on all the work that has been taking place in the Trust over the last year, resulting in some significant achievements and improvements to the quality of care provided for the benefit of our patients.

At the same time, we must acknowledge that we have faced a very challenging 12 months, with continually increasing demand on our urgent care services, staffing shortages across some key areas and financial challenges.

To our disappointment, though as expected, the Trust has remained in special measures for both quality and finance throughout this year, but we feel that great strides are being made to improve this position.

A CQC inspection in March 2018, with reports released in July 2018, resulted in our position being improved from "inadequate" to "requires improvement" overall. We are immensely proud of the commitment and perseverance shown by staff over the past year, and feel this improvement reflects the hard work that has taken place. These improvements are also in evidence when you see the number of our wards achieving success in our new ward accreditation programme.

However, we know that we still have many challenges to face in order to make our services safer and sustainable, and repeat CQC inspections to the emergency department at Pilgrim Hospital, Boston later in the year reflected the work that is still to do.

It is regrettable that the Trust remains with a significant financial deficit, and we have 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. This includes changes to the way we treat our orthopaedic patients by carrying out the majority of inpatient procedures at Grantham hospital, which has enabled us to reduce cancellations and standardise care to a higher level.

Staffing challenges have been a real issue during the year, most notably for our paediatric service where we had to make the difficult decision to change the service model at Pilgrim hospital on a temporary basis due to a shortage of doctors to safely staff it.

However, the interim model has been up and running since August 2018, and we are pleased with the level of service we have been able to retain at Pilgrim in spite of the challenges faced, which has been backed up by an independent review by the Royal College of

Paediatrics and Child Health. More importantly, we have had regular constructive dialogue with the families most affected and have used their feedback to make improvements.

An enormous effort has gone in over the year to address many of the concerns raised in fire enforcement notices, which have been in place for both Lincoln and Boston hospitals since 2017. We have spent over £24 million on a whole raft of improvements to make our hospitals safer, and more pleasant, environments in which to work and be cared for. This has included moving many wards at Pilgrim hospital and creating a new integrated assessment centre, one of only a few in the country, to improve the way we care for patients.

We hope this annual report will give a clear perspective on the challenges we face as well as highlighting a number of significant successes.

The launch of the NHS long term plan, and the Lincolnshire NHS Healthy Conversation 2019 on the future of NHS services in the county, are catalysts in a new approach to the provision of healthcare in Lincolnshire and we look forward to our conversations with local people to inform our developments. This means we will be in a position to really progress with transforming our services over the next few years.

We see 2019/20 as an exciting year for us, where we really start to see significant change as a result of our new Trust Operating Model (TOM), which is designed with patients at the centre of what we do. This will enable us to begin implementing our plans to improve our services, making them safer and more sustainable for the future.

On a final note from Jan, who retires this year, he would like to thank all the wonderful staff who have made his work an absolute pleasure and for the great support from colleagues and partners. Jan would like to wish the Trust every success as it builds on the progress made in very challenging circumstances.

Chief Executive Jan Sobieraj and Chair Elaine Baylis

Performance Report (subject to audit)

Overview

The purpose of this overview is 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.

Whilst we are required by law to include technical and financial detail, we have tried to make this overview of the information about our Trust, the services we provide and what we do as easy as possible to read and understand. The Performance Report is a summary of who we are, what we do, what we achieved in 2018/19, what your money was spent on, and other summary information.

The Accountability Report and the Financial Statements contain a range of other technical details, statements and financial information, which we are required to produce by Parliament and our legal regulators, NHS Improvement.

About us

United Lincolnshire Hospitals Trust (ULHT) serves one of the largest geographical areas in England with a population of around 751,200 (Office of National Statistics).

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 £447.5 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 1,304:

- Lincoln County Hospital (679 beds)
- Pilgrim Hospital, Boston (497 beds)
- Grantham and District Hospital (128 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 140,000 accident and emergency patients, over 600,000 outpatients and over 130,000 inpatients, and deliver around 5,000 babies.

For 2018/19 vs 2017/18 our attendances were as follows:

	2018/19	**2017/18**
Outpatient attendances	642,085	664,505
A&E attendances	147,722	154,888
Inpatients	145,273	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 largest 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.

Vision, ambitions and strategies

We have been continuing to develop our 2021 strategy since its launch in November 2017, where we outlined our vision and our ambitions together, with the changes we need to make to achieve them. We are clear that we are striving for excellence in everything we do in caring for our patients.

2021 is a marker in time on our journey to excellence- outlining how our ambitions are for our services to be consistently safe, responsive and give great care to our patients. Our 2021 programme outlines the affordability and sustainability of transformational changes. It sets out how we will put our people (our staff and volunteers) at the heart of how change is managed and how we will equip and empower them to make improvements.

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

Our ambitions for our patients, our services and our people for 2018/19 are described below:

Ambitions	
Our patients	• Will receive consistently compassionate, safe high quality care • Will be listened to and be involved in shaping their care around their needs to achieve successful health outcomes • Will be involved in shaping our 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 value our patients time and get things right first time • Will develop centres of excellence across all of our hospitals • Will deliver financially sustainable services
Our People	• 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

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.

The 2021 strategy is being delivered through five improvement programmes, each of which have comprehensive programmes of work and objectives each year. They are:

- Improving quality and safety.
- Saving money and improving our environment.
- Redesigning our clinical services.
- Delivering productive services.
- Developing the workforce to meet future needs.

Our key risks and issues

We continue to face serious challenges. These cover the spectrum of performance, staffing, finance and quality.

The Trust is working hard to address these issues, many of which are causing difficulties across the whole NHS, and will continue to do so in 2019/20. The Trust has a corporate risk register outlining what it perceives its key challenges to be.

Workforce

The Trust has identified that two of its biggest risks relate to our workforce. Our ability to recruit staff and the levels of staff engagement/morale impact on the financial stability of the Trust and the fragility of some of our services. These issues are covered in more detail in the staff report.

During 2018/19 our vacancy rates have declined. However, as they remain high in some key areas, this has resulted in planned increases in capacity costing more than they otherwise would due to the impact of temporary staffing.

Due to our staffing difficulties a number of our services remain fragile. The services this affects include urgent care, paediatrics and breast services.

The A&E department unfortunately remains closed at Grantham overnight (6.30pm to 8am) due to a shortage of staff. Significant efforts have been made to recruit additional staff, but despite this sufficient staff have not been recruited to populate three rotas. Work remains in progress with partners to secure the long-term model for urgent care across Lincolnshire.

In addition, the paediatric service at Pilgrim hospital has been temporarily reduced as a result of staffing shortages (see below).

The key focus of our workforce plan for 2019/20 is improving the balance of substantive and temporary staffing, thus reducing the cost of our workforce whilst improving the quality of patient care.

We have set out an ambitious recruitment improvement programme for medical and clinical roles whilst at the same time taking steps to reduce attrition through a number of retention interventions. We plan to optimise domestic recruitment, capitalise on the opportunity of newly qualifying professionals and continue to develop roles within our staff groups, as well as further developing our international recruitment programmes.

Paediatrics

A shortage of middle grade paediatric doctors and children's nurses resulted in the Trust having to take temporary action to change the paediatric service model at Pilgrim Hospital, Boston from August 2018.

For all of Pilgrim's children's and maternity services to run 24/7, there should be eight middle grade paediatric doctors at the hospital. It was predicted that there would only be only one substantive middle grade doctor available and there was a risk that some services may need to temporarily close to maintain patient safety.

The team developed an interim arrangement to enable services to be maintained at Pilgrim hospital, which sees over 98% of women and children who present to Pilgrim continuing to be seen and assessed there. This was done through developing a new paediatric assessment unit (PAU) with a recommended 12 hour length of stay for observation, and increasing the gestational age for neonates to 34 weeks from 30 weeks. This model also involved us investing in private ambulances to enable swift transfers of children and pregnant ladies to other sites if they required further treatment.

In the first six months, the interim service has seen, assessed and treated 1,869 children, of whom 203 have been transferred to other hospitals using one of our dedicated ambulances. Whilst these transfers were mainly to Rainforest Ward at Lincoln County Hospital, 53 children were transferred to other hospitals, and of those 21 were transferred elsewhere for further specialist care. This is far fewer transfers than was originally estimated and the model is working well.

Recruitment efforts continue, to improve the staffing position of the service.

Finance

We remained in Financial Special Measures throughout 2018/19 with a planned deficit of £74.7m and submitted an 18-month financial recovery plan in October 2018, with a revised forecast outturn of £89.4m deficit. We ended the year with a deficit of £87.9m.

As part of our financial recovery plan the realistic and deliverable financial efficiency programme for the year was revised down from £25m to £15.1m. The actual efficiency delivered in the year was £16.2m of which over 80% was on a recurrent basis and we delivered our financial plan for the last six months of the year.

Workforce costs continue to be the Trust's largest financial challenge due to the level of vacancies and difficulty in recruiting.

We face a significant challenge in 2019/20 in reducing our deficit to a control total of £70.3m deficit. A full financial recovery plan has been submitted to NHSI which will support the reduction of the Trust's deficit.

The financial recovery plan is supported by a range of financial efficiency plans which will enable the new clinical divisions to achieve significant reductions in operating costs.

Quality special measures

The Trust remains in quality special measures, and in 2018 we were re-inspected by the Care Quality Commission (CQC) and received an improvement in our rating from 'inadequate' to 'requires improvement'. It is our ambition to improve that rating further to 'good', and a quality improvement plan is being implemented to that end.

One success as part of this programme has been the introduction of our ward accreditation programme, which sees our wards inspected and rated against a set of 13 rigorous quality standards, then supported to make improvements. So far 21 of the Trust's 40 adult inpatient wards have achieved a 'green' rating in the programme.

We have also kept our focus on infection control, and during the year compliance with infection control practices has significantly improved. From a rating of 'red' in early 2017 the Trust was re-assessed in November 2017 as 'amber' and more recently in May 2018 received a 'green' rating.

The Trust continues to have some fragile services which lack capacity to meet demand and impact upon our quality of care, and we are working both internally and with the wider system to resolve these issues in 2019/20.

Performance challenges

The Trust's A&E services continue to operate under pressure with more attendances and emergency admissions. A number of schemes have been put in place to support the known times of pressure but unfortunately these have not been able to meet the underlying demand and additional growth. Staffing levels continued to be of concern but emergency department recruitment has shown an improving position.

In a year when the Trust experienced a 10% increase in referrals under the two week cancer pathway, the services still achieved some of the best individual month's performances against the 62 day cancer treatment standard and treated 13% more patients.

On 1 April 2018, there were 39,300 patients on the Trust's waiting lists. We met the NHS target to have a smaller waiting list size at 31 March 2019, with a waiting list size of 36,657. This shift reflects increased productivity across most ULHT services.

As of 31 March 2019, the Trust had no patients waiting over 52 weeks for treatment.

The achievements in elective care have come following significant work within the hospital increasing outpatient and theatre productivity but also through joint work with our partners resulting in innovative alternatives to hospital attendance, e.g. community based dermatology 'spot' clinics and GP-delivered specialist headache clinics.

Pilgrim A&E

During the year, the Care Quality Commission (CQC) carried out three inspections to the emergency department at Pilgrim Hospital, Boston. These highlighted concerns around triage, care of children in the department and staffing.

We are now undertaking a comprehensive improvement programme in our emergency departments, which is really starting to make a difference both for our patients and the teams working in these areas.

The future

The Trust is working with the whole Lincolnshire system on the 'Healthy Conversation 2019' – engaging with the whole community on proposals for improvements to services. This includes current thinking around the centralisation of some services to provide centres of excellence. The public's top health concerns include self-care, prevention, cancer and mental health and the Trust will look at how it can work with the wider system to support these concerns.

Following a review of the Trust's operating structure, we have implemented a new Trust Operating Model (TOM) which has restructured the Trust's services to operate across all sites via a four-division structure: surgery, medicine, women's and children's and clinical support services. This change has been successful in standardising services across the Trust's sites and will become permanent from 1 April 2019. A recruitment and redeployment programme is ongoing to fill all of the new management posts associated with this restructure.

Going concern

In preparing the financial statements for 2018/19, NHS organisations are required to consider the adoption of the 'going concern' basis. It is appropriate to prepare the financial statements 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.

The Trust Audit and Risk Committee reviewed and discussed this at its meeting held in April 2019.

Note 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 ongoing cash support in 2019/20 significantly mitigates this.

The Board of Directors is therefore satisfied and considers it appropriate that the accounts for the year ended 31 March 2019 should be prepared on a 'going concern' basis.

Performance analysis

Performance measurement and achievement

Overview

Performance has remained below our expectations during 2018/19. However in spite of our challenges, there have been developments and some improvements across the Trust this year.

The Trust produces a monthly Integrated performance report which is considered at the Board committees covering finance, performance, quality and workforce. The report is then presented to Trust Board with relevant matters for escalation.

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 2017 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, A&E waiting times, and diagnostics 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 a growth in demand for services has increased at a greater rate than we have been able to increase capacity due to difficulties with recruiting sufficient numbers of staff across all parts of the urgent and elective care pathways, including radiology and pathology. As a result of an increasing amount of emergency admissions and patients referred with potential cancer elective patients have continued to be displaced.

Performance Indicator	Target	Quarter 1 April to June	Quarter 2 July to Sept	Quarter 3 Oct to Dec	Quarter 4 Jan to March	2018/19
A&E: Proportion of patients spending less than 4 hours in A&E	95%	73.34%	71.33%	67.25%	66.95%	69.71%
A&E: 12 hour trolley waits	0	0	1	1	1	3
Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>99%	97.82%	98.31%	97.18%	96.95%	97.63%

Performance Indicator	Target	Quarter 1 April to June	Quarter 2 July to Sept	Quarter 3 Oct to Dec	Quarter 4 Jan to March	2018/19
Cancer: % of 2 week GP referral to 1st outpatient appointment	93%	78.0%	84.8%	80.8%	74.0%	79.4%
Cancer: % of 2 week GP referral to 1st outpatient- breast symptoms	93%	17.8%	50.7%	70.1%	18.8%	36.1%
Cancer: % of patients treated within 62 days of referral from screening	90%	87.5%	87.8%	81.8%	92.1%	87.3%
Cancer: % of patients treated within 62 days of referral from hospital specialist	85%	87.7%	87.4%	86.7%	84.1%	86.2%
Cancer: % of patients treated within 62 days of referral to treatment of all cancers	85%	75.6%	78.1%	72.8%	67.0%	73.3%
Cancer: % of patients treated within 31 days	96%	98.7%	97.6%	97.0%	95.8%	97.3%
Cancer: % of patients for second or subsequent treatment treated within 31 days – surgery	94%	83.9%	87.0%	95.3%	92.7%	89.7%
Cancer: % of patients for second or subsequent treatment treated within 31 days – drug	98%	100%	99.3%	98.6%	98.6%	99.1%
Cancer: % of patients for second or subsequent treatment treated within 31 days – radiotherapy	94%	98.0%	97.4%	95.5%	91.4%	95.6%
Referral To Treatment (RTT) waiting times incomplete pathways (18 weeks)	92%	84.49%	83.04%	83.21%	84.74%	83.86%
RTT over 52 weeks	0	40	53	61	17	171

Challenges do remain as we move into 2019/20, with a strong improvement focus on A&E and cancer standards whilst maintaining elective waiting lists. 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.

Delivery of financial plan

The Trust plan for the year was a deficit of £74.7m. There were a number of significant pressures which challenged the delivery of this plan including the risks to the paediatric service, quality concerns in A&E at Pilgrim and the continued pressures around recruitment and resulted in the Trust being adverse to plan. The Trust agreed a revised forecast deficit with NHS Improvement of £89.4m and subsequently delivered an actual deficit of £87.9m. The financial performance of the Trust is scrutinised on a monthly basis by the Finance, Performance and Estates Committee to gain assurance on the mitigating actions being taken.

The Trust's overall borrowing to provide the required cash support has increased to a total of £302.5m as at 31 March 2019.

Performance against national targets

A&E performance

The Trust's performance for urgent care has been below our improvement trajectory and significantly below the national average throughout the last year. Our performance trajectory for 2018/19 is outlined below:

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 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 2018/19 which have included:

- Redesign of the ambulance handover process.
- Increase to the number of cubicles at Lincoln to support minors.
- Introduction of primary care streaming at Lincoln and Pilgrim.
- Investment in the nursing and medical rotas to right size the staffing to meet demand (recruitment continues).
- Re-invigoration of 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)’.
- Reconfiguration of the Pilgrim Hospital bed base including a redesign of how patients flow through the hospital.

Ongoing plans are in place for improvement in 2019/20. These include:

- Ambulance handovers and conveyance.
- Streaming 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.

Diagnostic performance

Performance against this standard has been difficult throughout the year due to a mixture of staffing and physical capacity issues. Endoscopy and cardiology have particularly struggled with physical capacity constraints. Business cases for all areas have been approved, with expansion expected during 2019/20.

Staffing remains challenging within urodynamic and echocardiography. Pathway and role redesign have been completed during 2018/19. Following these actions recovery of this standard is expected in June 2019.

Cancer

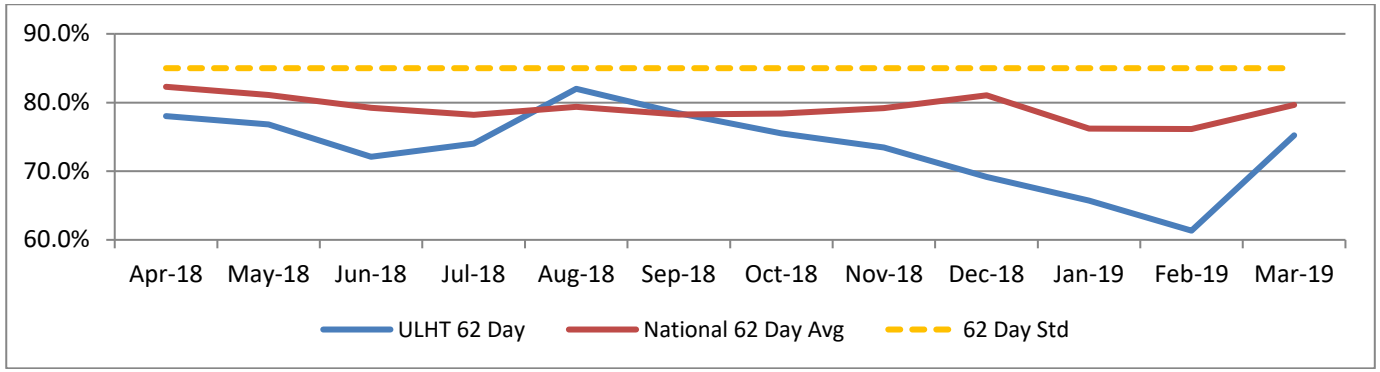
Cancer performance within the Trust was below the national standard for 14-day and 62-day during 2018/19. 31-day, first treatment and subsequent chemotherapy and radiotherapy were achieved during 10 of the 11 months. However, 31-day subsequent surgery performance has been less successful, achieving the standard only three times during this period..

During 2018/19 there was a 10% increase in referrals on the suspected cancer pathway compared with the previous year.

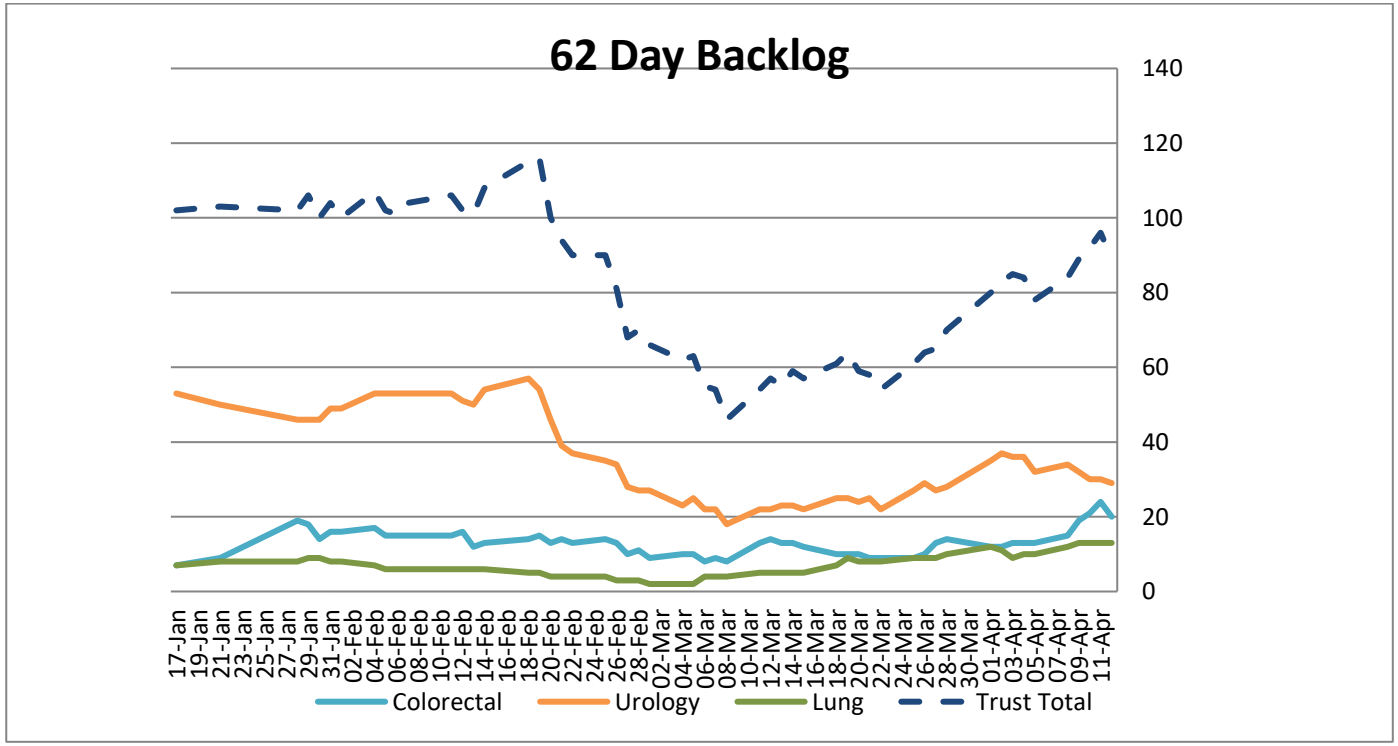
For the first two quarters we saw some of the best performance against the 62 day standard in recent years, maintaining a level consistently above 70%, and with performance in August 2018 peaking at 82%.

The winter months saw a rapid deterioration of our performance, partly due to challenges with recruiting to pathology, radiology and oncology consultant posts. These are largely resolved except for ongoing difficulties with an externally provided pathology service that are being managed at director level with support from NHS Improvement.

March 2019 performance is forecast to be back on track at approximately 74% and a trajectory has been agreed that will see us delivering the standard by November 2019.



The Trust focused on reducing the backlog of patients over 62-days with significant success. However due to the pathway challenges this remains difficult to sustain.



Actions undertaken to improve performance

During the course of 2018/19 a programme of improvement has been undertaken within the Trust, with support from CCG colleagues, in order to improve the timeliness of assessment, diagnosis and treatment of patients on cancer pathways. This improvement programme is overseen at a corporate level via the fortnightly cancer recovery and delivery group chaired by the deputy director of operations for planned care and divisional managing director for clinical support services.

18 weeks referral to treatment (RTT)

The Trust's performance in March 2018 was 84.7%, in March 2019 it was 84.5%. Whilst the Trust had planned to improve the RTT performance, a stabilised position through the year gives a reasonable performance and offers a good base from which to work towards compliance of the standard by the end of 2019/20

The Trust has had particular issues in a mix of specialities with regard to RTT performance, for example:
• ENT – consultant shortages and a large historical backlog coming into the year led to ongoing challenges. Locum appointments were secured into the autumn and the service has worked hard to secure treatment dates for its' longest waiting patients. Improved performance against the standard is expected in the early period of 2019/20.
• Orthopaedics – the impacts of cancellations in winter of 2017/18 had a significant impact in the early part of 2018/19. The speciality developed a new pilot model that established Grantham Hospital as an elective hub and we have seen reductions in waiting list size and significant improvements in throughput and RTT performance.
• Neurology – demand has significantly exceeded service capacity for the second half of 2018/19 leading to a deterioration in RTT performance as waiting times for routine referrals have grown. Work is on-going with primary care to establish specialist community based services, whilst the service explores opportunities to work with neighbouring Trusts to flex services to meet demand.

Sustainability report

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

The Trust's 2021 strategy 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 of work within the 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.

ULHT is committed to reduce its CO_2 emissions at least in line with NHS guidelines. Between 2009 and 2015 we reduced our carbon footprint by 13% against the national target of 10%. The Trust is committed to reduce its CO_2 emissions by a further 15% to 28% by 2021. By investing our it's infrastructure, increasing staff awareness, and by encouraging and embedding sustainable behaviours into the organisation, we seek to continue to be among leading NHS Trusts for its environmental and sustainability track record.

The Trust Board has approved a 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 the Trust's commitment and enhance its reputation, we are working our 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.

iiE 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 capital expenditure initiatives, including an overarching “energy performance contract” (EPC). Investing in the installation of energy efficient technologies and optimisation of all systems.

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

Adaptation planning is an opportunity to ensure a cohesive approach to current and future planning. The process of developing these plans should integrate with the development and refinement of emergency preparedness and business continuity plans. Adaptation, in harmony with NHS national guidelines, forms an integral component of the Trust’s sustainable development management plan (SDMP).

Emergency preparedness

In 2018/19 the Trust was fully compliant with 62 of the 64 EPRR core standards, evidenced by a self-assessment that has been approved by NHS England. Core standard 21 relating to lockdown was not compliant as the Trust was undergoing a complete fire door replacement across all sites which would result in changes to the existing lockdown plans. A full site lockdown cannot be tested until this replacement programme is complete.

Core standard 55, relating to assurance of commissioned providers/ suppliers business continuity plans, was partially compliant as the Trust had no system in place to assess the BCPs of commissioned providers. There are plans in place to include this within contracting arrangements for 2019/20.

Evidence of compliance with the core standards has been considered by both the emergency planning group, the finance, performance and estates committee and the Trust Board.

Social matters, anti- corruption and anti-bribery and human rights

The Trust has in place a counter fraud, bribery and corruption policy that protects the Trust, its staff and users. The policy is reviewed by the Trust's Audit and Risk Committee and the Counter- Fraud Specialist reports quarterly to the Audit and Risk Committee on preventative and proactive measures that are in place. No material incidents have been detected in 2018/19.

Human rights, specifically the right to life in regard to detentions under the Mental Health Act are addressed by the Mental Capacity Act and Deprivation of Liberty Safeguards Policy which are kept under regular review by the Trust's quality governance committee. No infringements of human rights have been reported in 2018/19.

Robust human resources policies and procedures are in place to ensure compliance with employment and equality legislation.

Jan Sobieraj Chief Executive
Date 23 May 2019

Accountability report (subject to audit)

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.

Directors' report

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.

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.

Further background on Board members can be found at https://www.ulh.nhs.uk/about/trust-board/

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 2018/19, this committee consisted of the chair and the non-executive directors.

Board changes

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

- Chair Elaine Baylis was appointed substantively from January 2019.
- Director of Finance Karen Brown was seconded from the Board between October 2018 – February 2019, retiring from the Trust in February 2019.
- Acting Director of Finance Paul Matthew was appointed in November 2018.
- Non-Executive Director Elizabeth Libiszewski was appointed substantively from November 2018.
- Interim Non-Executive Director Alan Lockwood left the Trust in March 2019.

A full list of directors who have served during the year is shown within the remuneration report on page 33.

Audit and Risk Committee

Audit and Risk Committee membership should comprise four non-executive directors, one of whom should possess considerable financial expertise.

For 2018/19, Audit and Risk Committee membership was as follows:
Sarah Dunnett, Chair (October 2017 – ongoing)
Geoffrey Hayward (July 2013 - ongoing)
Gill Ponder (April 2017 - ongoing)
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	Any other commercial interest in matters of relevance to the Trust.	Any close* family members in any of the above.
Elaine Baylis Chair (substantive from January 2019)	None	None	None	Chair – Lincolnshire Community Health Services NHS Trust Vice Chair – Lincolnshire Action Trust	None	None	None	None	None
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 DeMontfort University Hon Professor Plymouth University Advisory Board	None	Spouse – Nurse Lecturer University of Lincoln

							Member Kings Fund		
Kevin Turner Deputy Chief Executive	None	None	None	None	None	None	None	None	None
Paul Boocock Director of Estates and Facilities	None	None	None	None	None	None	None	None	None
Mark Brassington Chief Operating Officer	None	None	None	None	None	None	None	None	None
Dr Neill Hepburn Medical Director	None	None	None	None	None	None	None	Private Medical Practice at BMI Lincoln and IOM Hospital	None
Michelle Rhodes Director of Nursing	None	None	None	None	None	None	None	None	Sister employed by Park Hospital Nottingham
Martin Rayson Director of Human Resources and Organisational Development	None	None	None	None	None	None	None	None	None
Paul Matthew Acting Director of Finance and Procurement (from November 2018)	None	None	None	None	None	None	None	None	None
Geoff Hayward Non-Executive Director	None	None	None	None	None	None	None	None	Spouse - volunteer for Butterfly

									Hospice Boston
Gill Ponder Non-Executive Director	Non	None	None	None	None	None	None	Employed by Openreach	None
Elizabeth Libiszewski Non-Executive Director (substantive from November 2018)	None	Elizabeth Libiszewski Sole Trader	None	Non-Executive Director Lincolnshire Community Health Services NHS Trust	None	None	None	None	Husband – Trustee St Barnabas Hospice
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
Dr Chris Gibson Non-Executive Director	None	None	None	None	None	None	None	None	None
Karen Brown Director of Finance, Procurement and Corporate Affairs (to November 2018)	None	None	None	None	None	None	None	None	None
Alan Lockwood Interim Non-Executive Director (to March 2019)	None	None	None	Non-Executive Director Lincolnshire Partnership NHS Foundation Trust	None	None	None	None	None

Data-related incidents

The Trust has had one reportable data breach in 2018/19.

A patient notified the complaints department that a disc that had been sent to her containing the recording of her meeting with health professionals also included a recording of another complaints meeting relating to another patient.

She stated that patient identifiable information was contained on the disc along with details of the complaint and the discussion held. The disc contained details of a hospital stay and details surrounding the death of a patient.

A new process for burning voice recordings to discs has been implemented alongside advice from information governance.

The patient who received this disc has had a full apology, the investigation explained and the actions that have been put in place to mitigate any further incidents of this nature. They have received this via letter and numerous phone calls.

The ICO were happy with our investigation and mitigating actions and closed the incident with no further actions.

Statement of accounting officer's responsibilities

The Secretary of State has directed the chief executive as accountable officer to prepare for each financial year a statement of accounts. The accounts are prepared on an accruals basis and give a true and fair view of United Lincolnshire Hospitals NHS Trust and of its net resource outturn, application of resources and cash flows for the financial year.

In preparing the accounts, the accountable officer is required to comply with the requirements of the DHSC Group Accounting Manual and in particular to:

- Observe the directions issued by the Department of Health, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out within the manual have been followed and disclose and explain any material departures in the financial statements; and
- Prepare the financial statements on a going concern basis.

The responsibilities of an accountable officer, including the responsibility for the propriety and regularity of the public finances for which the accountable officer is answerable, for keeping proper records and for safeguarding United Lincolnshire Hospitals NHS Trust's assets, are set out in 'managing public money' published by HM Treasury.

The Chief Executive of NHS Improvement 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.

I confirm that as far as I the accountable officer am aware there is no relevant audit information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and I have taken all the necessary steps to make myself aware of any 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 is fair, balanced and understandable and I take personal responsibility as the accountable officer for the annual report and accounts and the judgements required for determining that it is fair and balanced and understandable.

It is my considered judgement that this annual report and accounts for United Lincolnshire Hospitals NHS Trust are as a whole, fair, balanced and understandable.

Annual governance statement

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 2019 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 divisional 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 Trust's risk management policy provides staff with clear and unambiguous criteria for evaluating risks, and the essential requirements of the risk management process have been designed into the Datix risk management system to provide a supportive structure and guidance for those with responsibility for managing risks.

Practical risk management workshops are provided on all hospital sites, as part of the core management skills programme. Practical recent examples of the Trust using effective risk management in its decision making through appropriate and accountable governance arrangements include: preparations to ensure compliance with the introduction of the EU General Data Protection Regulations (GDPR), the management of patient safety and quality risks whilst an interim model for paediatric services at Pilgrim hospital has been in place and contingency planning in relation to the UK's exit from the EU, including the supply of medicines, medical devices and workforce.

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.

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.

During 2018/19 the Board saw the following changes. The interim chair and interim non executive director were made substantive appointments. The director of finance retired and that post is currently filled by the deputy director of finance, who is acting up into the role.

The role of the each Board 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 and Risk 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 Trustwide 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 had been identified as an area of particular weakness, and was not fit for purpose in 2017/18. During 2018/19 the BAF was reviewed and revised. The HOIA opinion still identifies this as an area of moderate assurance and the Trust needs to be able to demonstrate that it can now fully embed the agreed framework and that this is the basis of the Trust Board agenda moving forward.

There are three key strategic objectives defined within the 2018/19 BAF underpinned by deliverable outcomes. Strategic objectives are owned by the Trust Board, with responsibility for regular oversight of these and the risks to achievement 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 absence of a Trust Board agreed risk appetite was identified as a weakness in the control environment during 2018/19 and in March 2019 a facilitated Board development session was held to develop this. The risk appetite statement as part of the risk strategy is due to be considered at the Trust Board in May 2019.

Progress is being made to implement a new quality governance structure and improvement plans.

The integrated performance report has also been reviewed 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 and Risk Committee and finance performance and estates committee.

The key strategic risks to the organisation during 2018/19 that were the focus of consideration by the Trust Board and executive were:

- The Trust financial position and delivery of the financial recovery plan.
- The ability of the Trust to attract and retain staff.
- The condition of the Trust estate, including the fire enforcement issues.
- Management of emergency demand.

Significant clinical risks are also highlighted within the Trust BAF 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.
- 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 and resources.
- Clinical governance arrangements at Trust, directorate and service levels.
- Clinical policies, procedures, guidelines, pathways, supporting documentation, audit programme and training.
- Clinical staff recruitment, induction, mandatory training, registration and re-validation.
- Quality and safety improvement planning process and plans.
- Defined safe staffing levels.
- Ward accreditation programme.

- Health, safety and security policies, guidance, monitoring and training.
- Patient experience policies, procedures, training and services.
- Infection, prevention and control management framework.

During 2018 the Trust appointed an associate 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 (FFT) and patient feedback data.
- Delivery of constitutional standards.

The Trust remains at risk of non-compliance with condition G4 of the NHS Providers licence in relation to CQC registration conditions and financial special measures and had identified non-compliance with governance regulations and standards as a key risk within the BAF. The Board continues to focus on accessing support and strengthening the arrangements in place.

Reporting to the Audit and Risk Committee has been improved with regular assurance given in relation to compliance of internal control weaknesses, BAF and the risk management improvement plans.

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 chair has encouraged challenge and rigour at Board meetings around the reports presented and assurances given.

The Trust's risk management strategy is based on the establishment of a core set of corporate and operational risks, which are aligned to strategic objectives as defined in the BAF and routinely monitored through the assurance committees of the Trust Board. Lead management groups (such as the patient safety group, information governance group and health and safety group) are responsible for reviewing and updating corporate risks within their areas of responsibility. With this framework now established, that Trust is beginning to utilise data from reported incidents to better understand areas of significant risk, so that mitigating action can be taken. Divisional management groups are responsible for maintaining oversight of the management of operational risks by their clinical business units through the established performance review meeting (PRM) process.

The primary objective of the 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 CQC. The Trust had conditions placed on its licence in February 2018 under Section 31 of the Health and Social Care Act 2008 in relation to A&E services at Pilgrim Hospital, Boston.

The Trust has published on its website an up to date register of interests for decision making staff within the past twelve months, as required by the managing conflicts of interest in the NHS guidance

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.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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, performance and estates committee following its monthly review of Trust financial and operational performance. The Trust has had the support of a financial advisor and appointed an external organisation to support in its delivery of an efficiency programme during 2018/19 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 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 and Risk Committee any significant risks identified and the planned audit response for consideration by the committee. In April 2019 the Trust external audit providers highlighted the following significant risks:

- The level of forecast in year deficit which follows a number of previous year of financial deficit resulting in the Trust being in financial special measures.
- The Trust has been in quality special measures since April 2017. A CQC re-inspection highlighted improvement and the Trust moved to requires improvement but remained in special measures.

- The significant financial pressures faced by the Trust are resulting in a shortage of cash and impacting on backlog capital investment.
- The Lincolnshire STP will review the services provided by the Trust following public consultation.
- Agency expenditure continues to exceed the agency ceiling for 2018/19 reflecting the significant recruitment and retention issues faced by the Trust.

The Board receive reports from external audit and internal audit through the Audit and Risk Committee and the assurance committees.

Recruitment and retention remains a concern for the Trust. The recruitment market for many medical staff, some allied health professionals (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.

Developing workforce safeguards

In November 2018 the workforce and organisational development committee and subsequently the Trust Board (in December 2018) received a full nursing and midwifery establishment review. This establishment review was comprehensive and fully complied with the requirements set out in the newly published standards.

In accordance with the published requirements and given day-to-day operational challenges, the Trust has business-as-usual dynamic staffing risk assessments (supported by HealthRoster) including formal escalation processes to align staffing numbers to acuity, dependency and demand. The standards recognise that at times staff numbers may be insufficient to meet this demand or complexity. In this case, an organisation must have a process or standard operating procedure (SOP) to recognise the risks and co-ordinate a response on a shift-by-shift or daily basis. A staffing safeguards SOP should provide assurance from the front line to the board that safe staffing standards are being achieved and risks to quality and safety mitigated. The recent increase to nursing establishment in A&E at Pilgrim hospital is evidence of this in practice.

In accordance with CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, have a full quality impact assessment (QIA) review signed off by the nursing and medical director. It is clearly understood that the

redesign or introduction of new roles (including but not limited nursing associates and advanced clinical practitioners) would be considered a service change and must have a full QIA.

An annual workforce plan was developed as part of the annual Trust operational planning process and submitted to NHSI. Through the annual planning process it is triangulated with planned activity and finance, signed off by the executive team and formally reported to the Board.

An initial assessment of the maturity of workforce planning has been undertaken using the associated NHSI operational workforce planning toolkit and whilst an annual workforce plan is completed each year, and is informed by many of the points listed above (to varying degree), the current workforce planning process it at an emerging level and can be significantly improved for 2020/21.

The 2019/20 workforce plan is too top down heavy and driven by high level assumptions including the Trust's financial recovery plan, the link from clinical activity to establishment (and job planning) is weak and this is exacerbated by high vacancy rates in medical and clinical establishments.

Whilst the Trust's current approach to workforce planning is underdeveloped, the complexity should not be under-estimated and is multi-faceted. Greater engagement and ownership at divisional and speciality level is needed with stronger integration with the Trust's clinical transformation programme and STP service changes.

Proposed actions - in the early part of 2019/20 operational year, using the NHSI toolkit to inform its development, the focus will be on establishing a more robust workforce planning approach which starts to extend the horizon of workforce planning. This work will be a key part of the support from the newly forming strategic HR business partnering team.

Stakeholder engagement

The Trust has continued 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. The Trust is also engaging specifically in relation to paediatric services at Pilgrim hospital.

Information governance

The Trust had one information governance incident which was reported to the Information Commissioners Office in 2018/19. The incident involved a breach of confidentiality of patients data and the ICO were satisfied with action taken by the Trust and have closed the incident.

EU exit planning

The Trust has established an EU Exit Contingency Planning Group and the deputy chief executive was appointed as senior responsible officer. This is how the Trust has overseen contingency arrangements and compliance with national and regional planning action requirements. Trust risks and mitigating actions were considered at the relevant board committee and upwardly reported to the Trust Board.

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 responsibility for patient safety and quality on behalf of the Trust Board.
- The quality account 2018/19 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 is 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.
- 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 and Risk 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 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. The quality governance committee is working to ensure that appropriate assurance on quality governance is provided, in order to enable the Board and the Audit and Risk Committee to be satisfied on this area of internal control. The Quality Governance Committee is chaired by a non-executive director.

The Quality Governance 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 Trust has identified access to end user training and resource for refresher training and the inconsistent application of RTT codes to pathways despite training as potential areas of risk to the data.

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, performance and estates 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.
- CQC intelligent monitoring.
- Senior leadership walk-rounds.
- CQC 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 and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Maintenance and review of the effectiveness of the systems of internal control have been supported by:

The Board

The Board have received assurance reports from the Audit and Risk Committee, Quality Governance Assurance Committee, Finance, Performance and Estates Committee and Workforce, Organisational Development and Transformation Committee as well as considering the Trust integrated performance report and Board Assurance Framework (BAF). The Board continue to direct their work to improve the identified weaknesses in the control framework and governance arrangements.

The Audit and Risk Committee

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

Clinical audit

During 2018/19 the Trust participated in 95.1% of possible national clinical audits and 100% 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 provides an opinion for 2018/19 of limited assurance for the Trust and report 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 has been given in respect of design and operation of the BAF and risk management. Limited assurance was given in respect of the outcome of individual assignments reported within the 2018/19 Internal Audit Plan and the extent to which the Trust had responded to audit recommendations.

10 of the 18 reports issued by internal audit were issued with a limited assurance. Internal audit reported the following high risk issues

Governance – report reference 1819ULH15 issued February 2019
The design of the overall systems and process of governance is not sufficient to support the Trust in meeting its overall strategic objectives and to drive improvement. Three high risk actions were agreed:

- The Board to agree/approve one set of strategic objectives to which all supporting documents (e.g. BAF), strategies and plans are consistently aligned.
- Define the Trust structure for performance, assurance and governance, which is to be used consistently within all documents across the Trust.
- Define the reporting required by/to groups and committees and ensure each group/ committee has an up to date terms of reference and work plan that reflects the expectations.

Mental Health Act Compliance - report reference 1819ULH11 issued September 2018

Our Mental Health Compliance Act review identified two high risks.

- The required MHA documentation may not be completed correctly and/or may not be available to evidence completion as our sample testing identified gaps both with completion and locating the required documentation.
- Delegation of the hospital managers' responsibilities may be unclear, particularly who can accept detained patients on

behalf of the Trust as the functions of the hospital managers are not clearer documented.

As part of the follow up process, internal audit have confirmed with the Trust that the agreed actions have been implemented.

The opinion acknowledged that the senior management team had 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, 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 Trust remains in special measures for quality following a CQC inspection in April 2018 which rated the Trust as requires improvement.

Conclusion

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

The Trust remained in special measures following the CQC inspection in April 2018 however the Trust was assessed as having moved to requires improvement from inadequate. The Trust did not exit special measures at this point as NHS Improvement considered that the Trust still had weaknesses within its governance arrangements relating to safe care and well-led. The Trust continues to work to progress its quality and safety improvement programme, a further unannounced inspection was carried out by the CQC in December 2018 in the emergency department at Pilgrim Hospital, Boston. This review highlighted a number of significant safety concerns and the actions to address these have been incorporated within the quality and safety improvement programme. A CQC well led inspection re-visit is expected imminently.

In September 2017 the Trust was placed in financial special measures. The Trust has continued to face significant financial challenges which are expected to continue during 2019/20. The Trust has been supported by the wider system and has brought in the support of a financial advisor. The Trust agreed a financial recovery plan for 2018/19 with NHSI which it has successfully met in the last five months of the financial year.

The wider 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). 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 STP (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 attendances, urgent two week wait referrals and increased GP referrals. 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 was set a ceiling for agency expenditure of £21m but this was not met.

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

Overall, the Trust is clear on the issues and progress continues to be made in developing and implementing improvement plans, however it is recognised that there remain some weaknesses in the current governance arrangements. Governance arrangements continue to be strengthened. The Board Assurance Framework has been refreshed for both format and content to ensure it is fit for purpose. The Committees and organisation structure have also been reviewed to support better board assurance and drive improvements.

Signed……..
Chief Executive Date: 23rd May 2019

Remuneration report

Remuneration policy

Senior managers (executive directors) remuneration policy

We are committed to ensuring that the remuneration package for our executive directors or very senior managers (VSMs) enables us to recruit and retain individuals who provide the skills necessary to manage a large, complex organisation, facing significant challenges. The Trust remuneration committee reviews the pay package on an annual basis, to ensure that what is received by individuals is commensurate with market conditions, the responsibilities and duties of the role and provides value for money to the Trust.

We review salaries also when new appointments are made and where the proposed salary is above £150,500, approval is sought from NHSI and HM Treasury, in line with the policy for VSM appointments.

The remuneration package comprises:

- Base salary
- Benefits
- Pension

Base salary

In determining base salary, the committee takes account of the average for acute trusts of equivalent size. The table below shows comparison between current salary levels and the average, based on data provided by NHSE:

Job Title	ULHT Salary	Date Set	Lower Quartile Limit	Median	Upper Quartile Limit	% Compared With Median
Chief Executive	£185,000	7/12/15	£190,000	£197,500	£230,000	93.7
Deputy CEO	£142,814	6/12/15	£130,000	£155,000	£180,000	92.1

Director of Finance	£140,000	31/5/17	£126,000	£140,000	£155,000	100
Director of Estates/Facilities	£105,900	1/4/18 (backdated to 1st Jan)	£103,000	£126,000	£135,000	84
HR/Workforce Director	£110,000	1/8/18	£117,000	£128,000	£143,000	85.9
Medical Director	£185,000	1/5/17	£170,000	£182,000	£202,000	101.6
Nursing Director	£126,250	15/7/16	£115,000	£131,000	£137,500	96.4
Chief Operating Officer	£128,270	1/10/16	£117,000	£136,000	£152,000	94.3

Where salary exceeds £150k, new contracts must include an element of “earn-back” pay, where a proportion of salary is withheld unless agreed performance targets are met. At present this applies to the medical director only. The remuneration committee determine the level of earn-back payable on an annual basis.

Benefit

The primary benefit payable to VSM managers is annual leave, which is in line with Agenda for Change policy and increases with years of service.

Single total figures remuneration table (Audited)

					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)
			Start	Finish	£000's	£00's	£000's	£00's	£000's
Elaine Baylis	Trust Chair		Jan-17	Ongoing	10 -15	2		2	10 -15
Sarah Dunnett	Non-Executive Director		Jul-16	Ongoing	5 - 10	23		10	5 - 10
Dr Chris Gibson	Non-Executive Director		Aug-17	Ongoing	0 - 5	-		-	0 - 5
Alan Lockwood	Non-Executive Director		May-18	Ongoing					
Geoff Hayward	Non-Executive Director		Jul-13	Ongoing	5 - 10	9		4	5 - 10
Elizabeth Libiszewski	Non-Executive Director		Mar-18	Ongoing	0 - 5	-		-	0 - 5
Gill Ponder	Non-Executive Director		May-15	Ongoing	5 - 10	11		10	5 - 10
Jan Sobieraj	Chief Executive		Dec-15	Ongoing	185 -190	4	-	-	185 - 190
Kevin Turner	Deputy Chief Executive		Jan-11	Ongoing	140 - 145	1	-	-	140 - 145
Karen Brown	Director of Finance, Procurement & Corporate Affairs		May-17	Nov-18	125 - 130	8	27.5 - 30	-	155 - 160
Paul Matthew	Acting Director of Finance and Procurement		Nov-18	Ongoing					
Mark Brassington	Chief Operating Officer		Mar-16	Ongoing	125 - 130	28	207.5 - 210	-	335 - 340
Michelle Rhodes	Director of Nursing		Oct-10	Ongoing	125 - 130	18	30 - 32.5	-	155 - 160
Dr Neil Hepburn	Medical Director	1	May-17	Ongoing	165 - 170	27	105 - 107.5	-	270 - 275
Martin Rayson	Director of Human Resources & Organisational Devt		Sep-16	Ongoing	95 - 100	11	22.5 - 25	-	115 - 120
Paul Boocock	Director of Estates and Facilities		Oct-13	Ongoing	90 - 95	18	37.5 - 40	-	130 - 135

					2018/19				
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)
			Start	Finish	£000's	£00's	£000's	£00's	£000's
Elaine Baylis	Trust Chair		Jan-17	Ongoing	40 - 45	15		14	40 - 45
Sarah Dunnett	Non-Executive Director		Jul-16	Ongoing	5 - 10	20		8	5 - 10
Dr Chris Gibson	Non-Executive Director		Aug-17	Ongoing	5 - 10	-		-	5 - 10
Alan Lockwood	Non-Executive Director		May-18	Ongoing	0 - 5	-		-	0 - 5
Geoff Hayward	Non-Executive Director		Jul-13	Ongoing	5 - 10	13		13	5 - 10
Elizabeth Libiszewski	Non-Executive Director		Mar-18	Ongoing	5 - 10	4		4	5 - 10
Gill Ponder	Non-Executive Director		May-15	Ongoing	5 - 10	8		7	5 - 10
Jan Sobieraj	Chief Executive		Dec-15	Ongoing	185 - 190	-	-	-	185 - 190
Kevin Turner	Deputy Chief Executive		Jan-11	Ongoing	140 - 145	9	-	-	145 - 150
Karen Brown	Director of Finance, Procurement & Corporate Affairs		May-17	Nov-18	80 - 85	7	70 - 72.5	-	155 - 160
Paul Matthew	Director of Finance and Procurement		Nov-18	Ongoing	45 - 50	-	2.5 - 5	-	50 - 55
Mark Brassington	Chief Operating Officer		Mar-16	Ongoing	130 - 135	29	10 - 12.5	-	140 - 145
Michelle Rhodes	Director of Nursing		Oct-10	Ongoing	125 - 130	18	-	-	125 - 130
Dr Neill Hepburn	Medical Director	1	May-17	Ongoing	185 - 190	29	10 - 12.5	-	200 - 205
Martin Rayson	Director of Human Resources & Organisational Devt		Sep-16	Ongoing	105 - 110	7	30 - 32.5	-	135 - 140
Paul Boocock	Director of Estates and Facilities		Oct-13	Ongoing	105 - 110	19	87.5 - 90	-	195 - 200

Notes:

1. 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.

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 2017/18 or 2018/19.

Pensions entitlement table (Audited)

The Trust operates the standard NHS Pension Scheme.

Name	Position	Notes	Real increase in pension at pension age (bands of £2,500) £000's	Real increase in pension lump sum at pension age (bands of £2,500) £000's	Total accrued pension at pension age at 31 March 2019 (bands of £5,000) £000's	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000's	Cash Equivalent Transfer Value at 1 April 2018 £000's	Real increase in Cash Equivalent Transfer Value £000's	Cash Equivalent Transfer Value at 31 March 2019 £000's	Employer's contribution to stakeholder pension £000's
Jan Sobieraj	Chief Executive	1	-	-	80 - 85	250 - 255	1,890	0	1,947	
Kevin Turner	Deputy Chief Executive	1	-	-	65 - 70	205 - 210	1,478	0	1,522	
Karen Brown	Director of Finance & Corporate Affairs		5 - 7.5	17.5 - 20	40 - 45	125 - 130	671	179	990	
Paul Matthew	Acting Director of Finance & Procurement		0 - 2.5	0 - 2.5	20 - 25	10 - 15	155	24	221	
Mark Brassington	Chief Operating Officer		0 - 2.5	-	35 - 40	80 - 85	461	90	566	
Michelle Rhodes	Director of Nursing		0 - 2.5	0 - 2.5	40 - 45	120 - 125	739	97	859	
Dr Neil Hepburn	Medical Director		0 - 2.5	5 - 7.5	60 - 65	190 - 195	1,361	165	1,567	
Martin Rayson	Director of Human Resources & Organisational Devt		0 - 2.5	-	0 - 5	-	35	33	69	
Paul Boocock	Director of Estates and Facilities		2.5 - 5	7.5 - 10	40-45	100 - 105	573	156	745	

Notes:

1. These Board members have not contributed to the NHS Pension Scheme in 2018/19. 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 3% has been applied to the total accrued pension, lump sum and CETV reported at 31 March 2019.

Lump sum
No lump sum will be shown for senior managers who only have membership in the 2015 Scheme or 2008 Section (unless they chose to move their 1995 Section benefits to the 2008 Section under the 'choice' exercise).

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.
No CETV will be shown for pensioners or senior managers over NPA. Age 60 in the 1995 Section, age 65 in the 2008 Section or SPA or age 65, whichever is the later, in the 2015 Scheme.

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).

The factors used to calculate a CETV increased on 29 October 2018. This will affect the calculation of the real increase in CETV.

Inflation
The inflation applied to the accrued pension, lump sum and CETV is the percentage by which the Consumer Prices Index (CPI) for the September before the start of the tax year is higher than it was for the previous September.
For 2017/18 the difference in CPI between September 2016 and September 2017 was 3%. Therefore for benefit and CETV calculation purposes CPI is 3%.

Fair pay disclosure

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

The banded remuneration of the highest paid director in United Lincolnshire Hospitals NHS Trust in the financial year 2018/19 was £185,000 -£190,000 (2017/18 £185,000- £190,000). This was 8.01 times (2017/18, 7.84) the median remuneration of the workforce, which was £23,363 (2017/18 £23,597).

In 2018/19, 27 (2017/18, 21) employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £187,075 to £8,212.52 (2017/18 £185,000 to £8,212.52)

The slight change to the median and ratio is pay award related as there is no general workforce composition change, highest paid individual change other remuneration or pay freeze impact. The change in the highest paid Director to the median employee is due to the 2018/19 pay award.

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)

Compensation for loss of office

In 2018/19 the Trust made zero non-contractual payments in lieu of notice.

Payments to past directors

There were no payments made to former directors in 2018/19.

Staff report

Staff numbers and costs

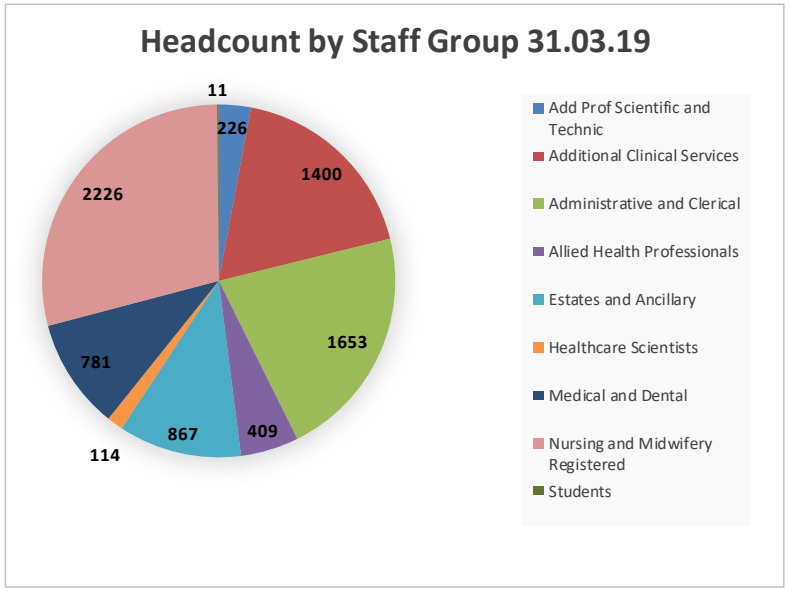
An analysis of staff numbers by type is shown in the tables below, by both full time equivalent (FTE), which is a translation of the number of hours worked by all staff into the number of equivalent full-time employees, and headcount, which numbers of individuals employed by the Trust.

FTEs as at Sunday 31 march 2019 (excludes bank staff)

Staff group	Permanent	Other	Total
Add professional scientific and technical	193.76	4.60	198.36
Additional clinical services	1126.39	51.85	1178.23
Administrative and clerical	1343.71	50.79	1394.50
Allied health professionals	364.96	2.40	367.36
Estates and ancillary	630.99	3.28	634.27
Healthcare scientists	102.10	1.40	103.50
Medical and dental	383.12	366.44	749.57
Nursing and midwifery registered	1875.81	31.44	1907.25
Students	9.65	0.96	10.61
Total	**6030.50**	**513.15**	**6543.65**

Headcount as at Sunday 31 march 2019 (excludes bank staff)

Staff group	Permanent	Other	Total
Add professional scientific and technical	221	5	226
Additional clinical services	1345	55	1400
Administrative and clerical	1596	57	1653
Allied health professionals	406	3	409
Estates and ancillary	863	4	867
Healthcare scientists	112	2	114
Medical and dental	404	377	781
Nursing and midwifery registered	2194	32	2226
Students	10	1	11
Total	**7151**	**536**	**7687**



Gender breakdown

As a large, public sector employer, ULHT is committed to promoting equality, diversity and inclusion and to tackling any inequalities that are identified in the workforce. An analysis of gender pay banding at the Trust is available on our website here: https://www.ulh.nhs.uk/about/equality-diversity/gender-pay-gap-reporting/
This report also contains information about how the organisation will respond to the data analysis.

A breakdown of staff by gender (as at 31/3/19) is shown in the table below:

	Gender (Numbers)	
Pay Band/Grade	Female	Male
Nursing Cadet	18.00	1.00
Trainee AHP	4.00	5.00
Band 1	319.14	50.87
Band 2	1207.92	270.15
Band 3	471.95	89.05
Band 4	310.58	86.99
Band 5	1162.13	194.82
Band 6	737.88	124.05
Band 7	381.87	93.51
Band 8A	119.03	36.39
Band 8B	36.34	14.75
Band 8C	18.60	17.20
Band 8D	7.00	5.85
Band 9	1.00	3.00
Director	1.00	6.00
Consultant	78.86	225.20
Associate Specialist	4.90	25.89
Staff Grade	0.30	0.73
Specialty Doctor	38.75	88.25
GPCA/Hospital Practitioner	1.14	0.59
Specialist Registrar	75.18	69.80
Foundation Year 2	38.00	32.00
Foundation Year 1	27.99	41.00
Total %	**77.35%**	**22.65%**

Staff costs				
			2018/19	2017/18
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	232,028	20,246	252,274	242,302
Social security costs	21,294	1,857	23,151	22,365
Apprenticeship levy	1,287	0	1,287	1,223
Employer's contributions to NHS pensions	26,145	2,280	28,425	28,053
Pension cost - other	67	0	67	28
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	58	0	58	69
Temporary staff	0	37,118	37,118	29,385
Total gross staff costs	280,879	61,501	342,380	323,425
Recoveries in respect of seconded staff	0	0	0	0
Total staff costs	280,879	61,501	342,380	323,425
Of which				
Costs capitalised as part of assets	684	0	684	688

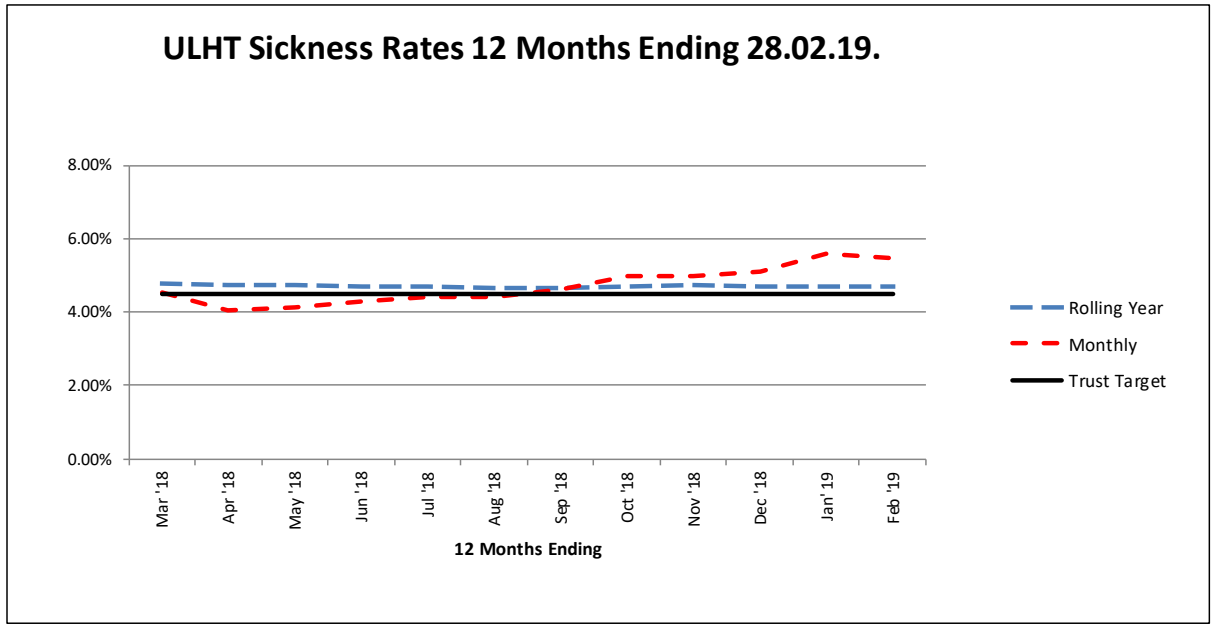
Average number of employees (WTE basis)				
			2018/19	2017/18
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	776	209	985	957
Ambulance staff	0	0	0	0
Administration and estates	1,249	64	1,313	1,258
Healthcare assistants and other support staff	747	62	809	848
Nursing, midwifery and health visiting staff	2,776	422	3,198	3,171
Nursing, midwifery and health visiting learners	4	0	4	6
Scientific, therapeutic and technical staff	770	37	807	793
Healthcare science staff	144	4	148	153
Social care staff	1	0	1	1
Other	0	0	0	0
Total average numbers	6,467	798	7,265	7,187
Of which:				
Number of employees (WTE) engaged on capital projects	23	0	23	23

Sickness absence

The chart below shows the sickness absence rate shown as a percentage (sick days as a % of total available working days.) The light blue line shows the month-by-month sickness rate for the 12 months up to and including January 2019. Sickness peaks during the winter months, when there is a prevalence of colds and flu and then declines through the summer.

The Trust offers flu vaccines to all of its frontline staff in order to minimise absence and protect patients. It is noteworthy that 88% of the target group of staff had the vaccine in 2018/19, and this is the third highest rate achieved by NHS trusts in the country and the highest uptake in the East Midlands.

Actions such as this are contributing to a slow downward trend in sickness absence. The dark blue line shows the 12 month rolling absence for sickness, which does remain slightly above our target of 4.5%. The largest cause of sickness is stress and we are working to tackle the causes of stress, as well as supporting staff who feel stressed through targeted health and wellbeing initiatives.



	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19
Rolling 12 months	4.76%	4.75%	4.73%	4.71%	4.69%	4.67%	4.67%	4.69%	4.72%	4.70%	4.69%	4.70%
Monthly Rate	4.54%	4.06%	4.14%	4.31%	4.43%	4.42%	4.61%	4.97%	5.00%	5.10%	5.61%	5.45%
Trust Target	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%

	31 March 2018 2017/18	31 March 2019 2018/19
Total days lost	69,164	68,577
Total staff years	6,401	6,325
Average working days lost (per WTE)	11	11

Vacancy rates

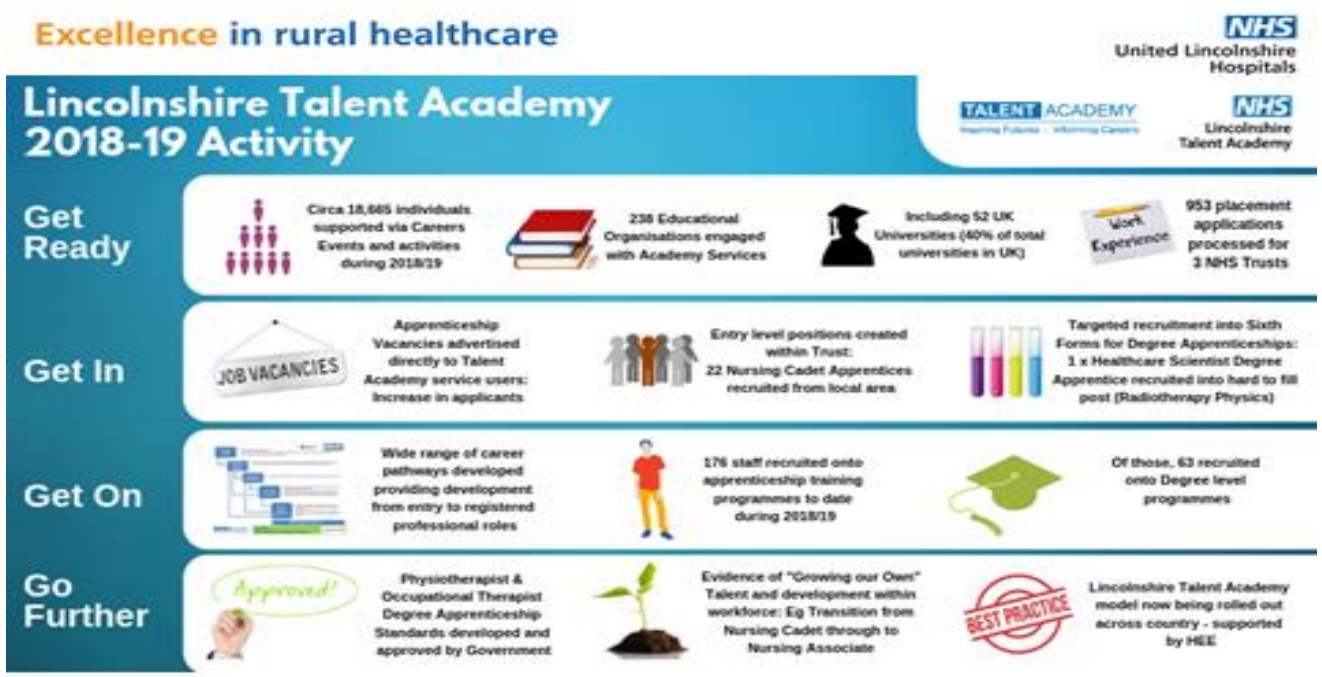
One of the biggest causes of stress is the significant vacancy rates, which does put pressure on the permanent workforce, particularly on wards. Fill rates remain high however, which means as a Trust we are very dependent on agency staff to fill gaps on nursing and medical rotas.

The high agency spend in the Trust is one of the main causes of the financial overspend. We have brought in additional agency staff too, where particular quality and service issues have been identified (such as in Pilgrim A&E), thereby increasing our agency spend.

The Trust has sought to tackle this challenge through recruitment and an emphasis on introducing new roles into clinical areas. The Talent Academy, which is managed by ULHT on behalf of the Lincolnshire healthcare system, is recognised as a best practice approach to supporting our talent. The graphic below shows the activities of the academy on behalf of ULHT in 2018/19, under the headings:

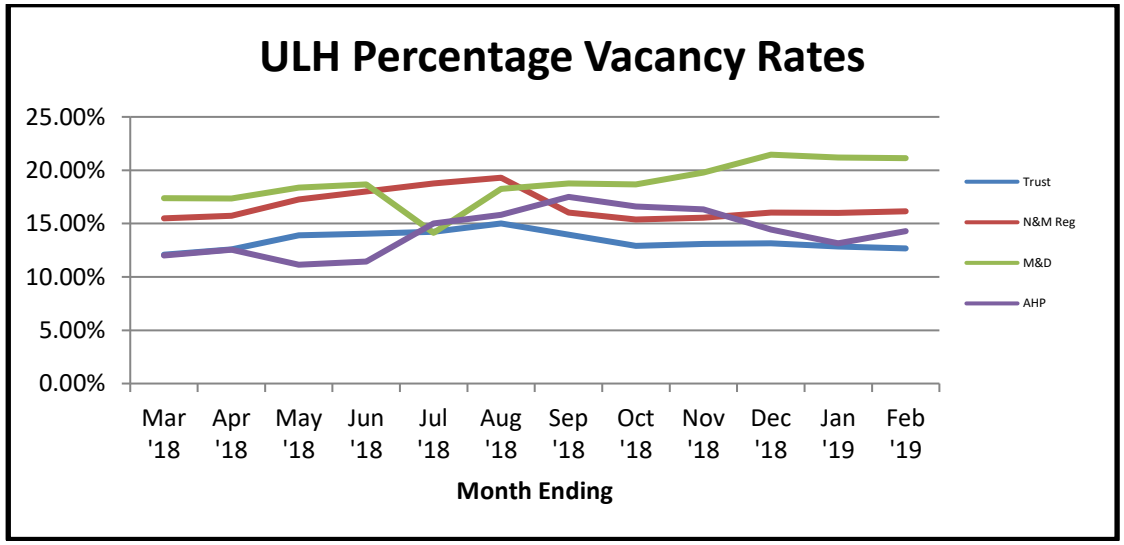
- Get Ready
- Get In
- Get On
- Get Further

Notable achievements are the appointment to permanent positions of 22 nurse cadets (apprentices) and the agreement of degree apprenticeship pathways for physiotherapists and occupational therapists.



Patient centred . Excellence . Respect . Compassion . Safety

Despite these efforts, the vacancy rate for key groups (nursing and midwifery, medical and dental and allied health professionals) has continued to grow, as the chart below shows:



Within the overall rates there are hotspots at Pilgrim hospital in particular and in professions where there are national staff shortages (e.g. medical specialties and radiographers).

Staff morale/engagement

After several years of some improvement, scores relating to staff engagement and morale in the 2017 staff survey declined significantly. This coincided with the Trust going into special measures for finance and quality, concerns about the staffing position and uncertainty about the future.

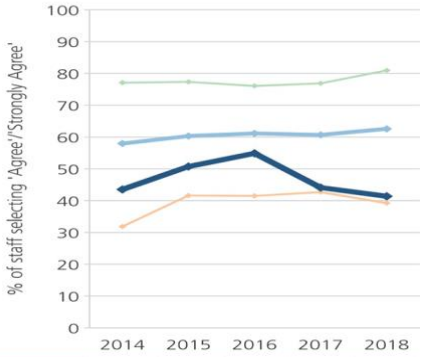
In response, the Trust took steps to create more opportunities to have a two-way dialogue with staff, both through their trade union representatives and directly, via a series of “Big Conversations” related to our 2021 change programme.

We also invested in additional health and wellbeing initiatives, such as mental health first aid and resilience, launched a new leadership programme and had a dialogue to improve the experience of staff when they are moved between wards to ensure patient safety.

Despite a “you said, we did” campaign, the results of the 2018 National Staff Survey are again disappointing. There have been some improvements, but largely there is evidence of continued issues around morale and engagement.

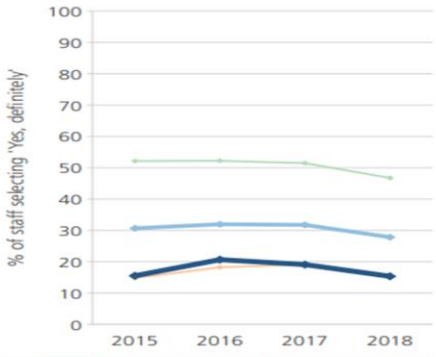
The charts below show the performance of ULHT (“your trust”) against the best and worst performing acute Trusts and the overall average. Clearly the Trust is performing less well than the majority of Trusts and the graphs evidence the sharp decline since 2016.

Q21c
I would recommend my organisation as a place to work



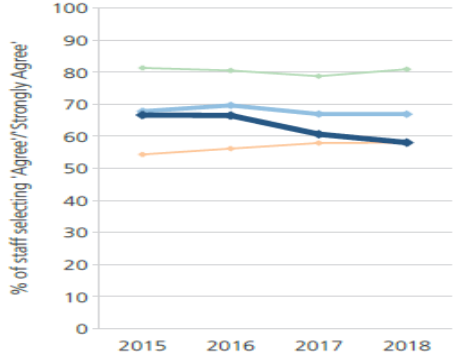
	2014	2015	2016	2017	2018
Best	77.1%	77.4%	76.1%	76.9%	81.0%
Your org	43.5%	50.7%	54.9%	44.1%	41.4%
Average	58.0%	60.3%	61.1%	60.7%	62.6%
Worst	31.9%	41.6%	41.5%	42.7%	39.2%

Q11a
Does your organisation take positive action on health and well-being?



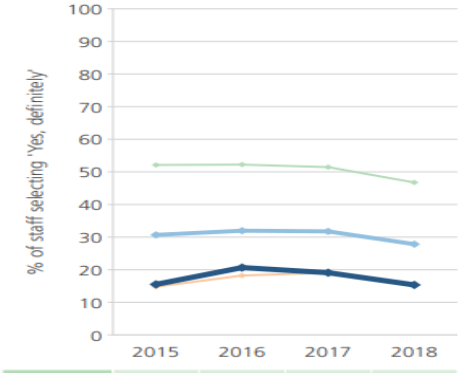
	2015	2016	2017	2018
Best	52.1%	52.2%	51.5%	46.7%
Your org	15.5%	20.7%	19.1%	15.3%
Average	30.7%	32.0%	31.7%	27.8%
Worst	14.8%	18.2%	19.1%	15.3%

Q7c
I am able to deliver the care I aspire to



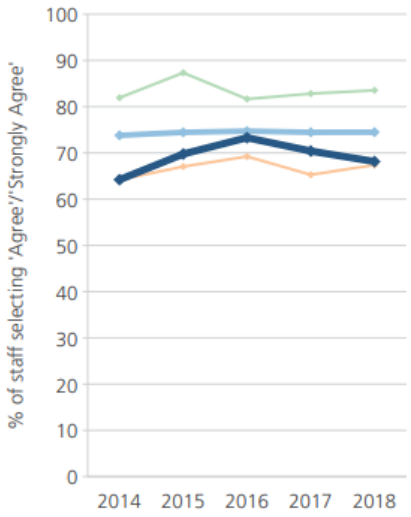
	2015	2016	2017	2018
Best	81.3%	80.5%	78.7%	80.9%
Your org	66.6%	66.5%	60.6%	58.0%
Average	67.8%	69.6%	66.9%	66.9%
Worst	54.3%	56.1%	57.9%	58.0%

Q11a
Does your organisation take positive action on health and well-being?



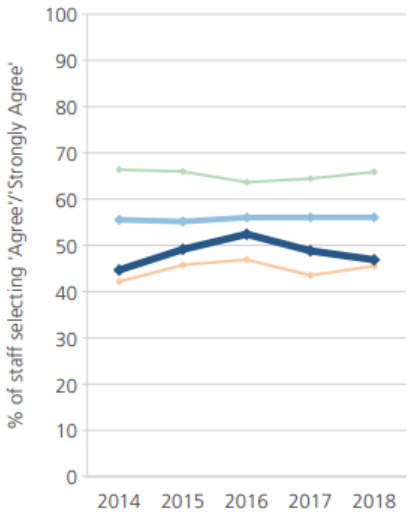
	2015	2016	2017	2018
Best	52.1%	52.2%	51.5%	46.7%
Your org	15.5%	20.7%	19.1%	15.3%
Average	30.7%	32.0%	31.7%	27.8%
Worst	14.8%	18.2%	19.1%	15.3%

Q4b
I am able to make suggestions to improve the work of my team / department



	2014	2015	2016	2017	2018
Best	81.9%	87.3%	81.6%	82.8%	83.5%
Your org	64.2%	69.8%	73.3%	70.4%	68.1%
Average	73.8%	74.4%	74.7%	74.5%	74.5%
Worst	64.2%	67.0%	69.2%	65.3%	67.4%

Q4d
I am able to make improvements happen in my area of work



	2014	2015	2016	2017	2018
Best	66.4%	66.0%	63.7%	64.4%	65.9%
Your org	44.7%	49.1%	52.4%	48.8%	46.9%
Average	55.5%	55.2%	56.0%	56.1%	56.1%
Worst	42.2%	45.8%	46.9%	43.5%	45.5%

There is a relationship between the staffing position and overall morale, and we know that an integrated workforce strategy is required to tackle the workforce issues which are at the heart of ULHT's challenges, and identify solutions.

Staff policies

The ULHT people strategy has two core themes reflecting the challenges we face:

- **Workforce skills and numbers:**
  A future workforce that is fit for purpose, reflects our clinical strategy and the needs of the system.

- **Engagement through change:**

A workforce which has patient safety at its heart is engaged with the Trust's vision and values and embraces a learning and safety culture.

The Trust has invested heavily to increase the resources focused on recruitment, with the ambition to make significant in-roads into its vacancy rates in 2019/20. Already in the first few months of 2019 there have been some important appointments to medical roles.

Policies in relation to disabled employees and equal opportunities

The Trust is committed to ensuring that all current and potential staff are able to achieve what they want at ULHT. During 2018/19 we agreed our first inclusion strategy, which has the following vision for our staff:

1. Feel valued and fairly treated in a Trust that really cares.
2. Know the Trust as a Trust that people want to come and work for, stay with and thrive in, because of its commitment to equality, diversity and inclusion.
3. Are proud to work in an open and inclusive Trust.

During the course of the year, among a number of actions taken as part of the strategy we have established networks for our LGBT and BAME staff, as well as ex-armed forces personnel. We are in the process of setting up MAPLE - a group for staff with disabilities.

We still believe reporting of disabled staff in the organisation is under-reported, as we rely on self-disclosure, but hope that the new network will assist with this. We have this year also become a disability confident employer, thereby demonstrating that our policies around recruitment and employment support disabled employees to thrive at ULHT.

In 2019/20 the Workforce Disability Equality Standard (WDES) comes into effect. It is a set of ten specific measures that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality. We will be contracted to respond to the WDES, but ULHT will embrace it, as we do the Workforce Race Equality Standard, not because of an obligation to do so, but because they provide frameworks through which we can embrace inclusion and compare ourselves to others.

The staff survey results from 2018 show that we have some way to go in terms of our staff feeling that the organisation is inclusive. The tables below show the scores in the last five years against two of the questions in the survey related to inclusivity, and makes comparison with the best acute trust, the worst and the average across all acute trusts:

- Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (% responding positively):

	2014	2015	2016	2017	2018
Best	95.7%	96.1%	95.5%	94.2%	94.3%
ULHT	84.8%	89.4%	86.7%	82.6%	77.6%
Average	86.9%	86.9%	86.4%	84.5%	83.9%
Worst	70.6%	69.4%	66.8%	68.6%	69.2%

- In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues? (% responding yes):

	2014	2015	2016	2017	2018
Best	4.1%	3.1%	2.8%	5.0%	3.4%
ULHT	8.8%	4.9%	6.6%	7.8%	9.7%
Average	7.9%	7.2%	7.3%	8.2%	7.7%
Worst	15.1%	14.8%	16.0%	15.8%	15.1%

We will be working with our staff networks to understand the experiences that lie behind this data and understand what actions we can take to tackle the issues and actions that cause those experiences.

Trade union facility time

The Trade Union (Facility Time Publication Requirement) Regulations 2017 took effect on 1 April 2017, and this means that NHS employers are now required to publish certain information on trade union officials and facility time on their website. Here is an extract of the information we have published for the 2018/19 financial year:

Number of staff who are trade union Officials FTE Employees Total cost of facility time	 10 6462.87 £106,930
Total pay bill	£322.7million
Percentage of the total pay bill spent on facility time, calculated as:	0.33%

(total cost of facility time ÷ total pay bill) x 100	

Rewarding and recognising our staff

The Trust pay and reward policies are based around nationally negotiated frameworks for medical and AfC staff and the guidance provided on VSM appointments. We recognise the importance of offering an attractive benefits package for the purposes of recruitment and retention and this is consistently under review to ensure its attractiveness. Recognising the achievements of our staff is a key element of this and we have a number of mechanisms in place to do so:

Current arrangement	Details
ULHT Staff Awards	Held annually, attracting around 700 nominations for individuals and team in 13 categories. Everyone nominated receives a personal letter from the Trust Chair thanking them for their efforts. Between 200/250 people are then invited to attend an annual award ceremony. Shortlisted entries receive a certificate, winners receive a certificate and trophy.
Examples of Excellence	Certificates that individuals can fill out and send to people to recognise where they have done something 'excellent'. These are sent by email, but can also be printed out and given in person. There is the option to tick a box to share the entry with the Trust executive- these nominations are also automatically forwarded to the Staff Awards.
Daisy Awards	Awards for nursing to recognise good practice, launched at the end of September. Anyone who wins is automatically put through to ULHT Staff Awards
FAB academy	A "repository of inspirational ideas" .We have a number of staff and projects featured on here, and also use it as inspiration for further work

Engaging with our staff

We also understand that to maximise the morale and productivity of our people, we need to ensure that they have a stake and a voice in our future. We have developed our 2021 strategy and the vision and values that underpin it with our staff. We have held, in the course of the year, a number of 'big conversations' around key issues, notably our clinical strategy and provide a variety of other mechanisms to ensure the staff voice is heard.

Where there are specific changes impacting upon our staff, we fully consult with them in line with our managing change policy.

Framework of employment policies

We have an agreed set of people policies, which provide a framework for the management and development of our staff at ULHT. These cover the full employment lifecycle, from recruitment through to retirement and embrace how we support our staff to be successful and how we attend to their health and safety. Those policies are regularly reviewed with staff representatives to ensure they reflect employment law and best practice. All are assessed from a diversity perspective to ensure there can be no detriment to any group of staff through their application.

Freedom to speak up (FTSU)

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust. ULHT is committed to ensuring that speaking up is part of the culture of the organisation. We want to support senior leaders to make the connection between speaking up and improving patient safety and staff experience, and will use this to inform the actions that are needed to continuously improve.

Speaking up cases raised with the Trust freedom to speak up guardian in 2018/19:

	Total cases	Cases received anonymously	Cases with element of patient safety	Cases with element of bullying/ harassment	Cases where detriment reported for raising concerns
Q1	8	1	0	5	0
Q2	13	0	0	13	0
Q3	11	0	3	2	0
Q4	10	0	2	6	0

The Trust has conducted a self-assessment of its speaking up arrangements in 2018/19 and identified areas where progress could be made in respect of the FTSU vision and strategy. The Trust has a freedom to speak up policy in place and a freedom to speak up guardian, who has completed the national training programme.

The NHS staff survey for 2018 showed that our staff confidence and security in reporting unsafe clinical practice is average for our benchmark group of Trusts.

The percentage of staff experiencing bullying and harassment or abuse from staff increased in 2018 and was worse than our benchmark group of trusts.

The CQC inspection report published early in 2018/19 highlighted that there were still weaknesses and that many staff were not aware of the process through which they could speak up. In March 2019 the Trust began a process to identify a network of FTSU champions to promote and increase awareness of speaking up.

Consultancy expenditure

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 2018/19 was £3.7m (2017/18 £3.1m).

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 2019, for more than £245 per day and that last for longer than six months.

No of existing engagements as of 31 March 2019	**7**
Of which	
No that have existed for less than one year at time of reporting	**0**
No that have existed for between one and two years at time of reporting	**2**
No that have existed for between two and three years at time of reporting	**2**
No that have existed for between three and four years at time of reporting	**0**
No that have existed fo four years or more 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 2018 and 31 March 2019, 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 2018 and 31 March 2019	49
Of Which	
No assessed as caught by IR35	42
No assessed as not caught by IR35	7
No engaged directly and are on the departmental payroll	0
No of engagements reassessed for consistmency assurance purposes during the year	0
No of engagements that saw a change in IR35 status following the consistency review	0

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 2018 and 31 March 2019

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.	9

Exit packages

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 2018/19.

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 2018/19

	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	-	-	**-**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**-**	**-**
Total cost (£)	£0	£0	**£0**

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**
£10,000 - £25,000	-	2	**2**
£25,001 - 50,000	-	2	**2**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**35**	**36**
Total cost (£)	£61,000	£187,000	**£248,000**

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							
	2018/19				**2017/18**		
	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
Mutually agreed resignations (MARS) contractual costs	-		-		-		-
Early retirements in the efficiency of the service contractual costs	-		-		-		-
Contractual payments in lieu of notice	-		-		33		118
Exit payments following Employment Tribunals or court orders	-		-		-		-
Non-contractual payments requiring HMT approval	-		-		-		-
Total	**-**		**-**		**35**		**187**
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 2018/19 the Trust made nil non-contractual payments in lieu of notice.
In 2017/18 the payments made did not relate to compensation payments.

Jan Sobieraj Chief Executive
Date 23 May 2019

Gifts

In line with the guidance in Managing Public Money, DHSC group bodies are required to report on the total value of gifts made, if this exceeds £300k, and provide details of any individual gifts over £300k.
United Lincolnshire Hospitals NHS Trust has made no payments which could be deemed as gifts in 2018/19.

Audit opinion

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 ("the Trust") financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of the Trust's 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 2018/19.

We have audited the financial statements, included within the Annual Report and Accounts for the year ended 31 March 2019 (the "Annual Report"), which comprise: the Statement of Financial Position; the Statement of Comprehensive Income; the Statement of Cashflows; the Statement of Changes in Taxpayer's Equity for the year ended 31 March 2019; 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 Local Audit and Accountability Act 2014, 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 the 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 1.2 to the financial statements concerning the Trust's ability to continue as a going concern.

The Trust has been reliant on external cash support from the Department of Health and Social Care to meet its liabilities as they have fallen due during 2018/19. It has drawn down a cumulative total of £274.4 million in revenue related loans, and £26.2 million in capital loans, as at 31 March 2019. Of the revenue support loans, £35.6 million was due to be repaid in 2018/19 and £110.5 million is repayable in 2019/20, and no formal agreement has yet been reached with the Department of Health and Social Care on either an extension for the repayment or additional loan support in either case. Additionally the Trust has submitted a deficit plan for 2019/20 of £41.4 million, which will require additional revenue cash support of £59.8 million. Furthermore, the plan assumes the delivery in full of new financial efficiencies of £25.6 million.

These conditions, along with the other matters explained in note 1.2 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the 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.

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 2018/19 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 2019 is consistent with the financial statements and has been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

In light of the knowledge and understanding of the 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 reports to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 27, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, 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 the 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 the Trust or to cease operations, or have no realistic alternative but to do so.
The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

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 the 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.
We are required under section 21 of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

Our audit did not consider any impact that the United Kingdom's withdrawal from the European Union may have on the Trust as the terms of withdrawal are not clear, and it is difficult to evaluate all of the potential implications on the Trust's activities, patients, suppliers and the wider economy.

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 paragraph 24 of Schedule 7 of the National Health Service Act 2006 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

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 the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Adverse opinion

As a result of the matters set out in the basis for adverse opinion below, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2019.

Basis for adverse opinion

The Trust's outturn position for 2018/19 was an adjusted financial performance deficit of £87.9 million, which compares to a revised planned deficit of £74.7 million. This included the delivery of £18.8 million of efficiencies of which £3.2 million was achieved on a non-recurrent basis, and spending on agency staff of £37 million which is significantly above the cap of £21 million. The Trust's financial plan for 2019/20 is a control total deficit position of £70.3 million, which requires achieving £25.6 million of efficiencies. If the control total is met, the Trust will receive Provider Sustainability Fund ('PSF'), Financial Recovery Fund ('FRF') and Marginal Rate Emergency Tariff ('MRET') income of £28.9 million and deliver a deficit of £41.4 million. The Trust has struggled to reduce its underlying deficit without the use of additional funding. These matters are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

There is a capital expenditure backlog of £236 million. This includes £102 million which is either required to meet statutory obligations or mandatory to be compliant with relevant laws and regulations. The financial plan for 2019/20 is for £32.1 million of capital spend, and the Trust is reliant on external funding to undertake its capital programme. These matters 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 4 hour waits, 18 week Referral to Treatment 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 matter is evidence of weakness in proper arrangements for understanding and using appropriate cost and 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. A re-inspection in 2018 identified an improvement in clinical performance resulting in the overall Trust rating moving to requires improvement. However, the Pilgrim Hospital site remained inadequate. This is evidence of weaknesses in arrangements for planning and deploying workforce to deliver the Trust's priorities effectively.

Other matters on which we report by exception

We are required to report to you if:

- we have referred a matter to the Secretary of State for Health under section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or a director or officer of the 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 Local Audit and Accountability Act 2014.
- we have made written recommendations to the Trust under section 24 of the Local Audit and Accountability Act 2014 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 24 May 2019 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 2018/19 an in-year breakeven duty financial performance deficit of £87.945 million, and a cumulative deficit as at 31 March 2019 of £330.474 million. The Trust's income in 2018/19 was £447.492 million.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of section 21 of the Local Audit and Accountability Act 2014 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

28 May 2019

Financial statements (subject to audit)

Foreword to the accounts

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		
	2018-19		2017-18
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)	**(104,501)**	**(Deficit)**	(97,081)
	16,245	**Impairments**	17,527
	233	**IFRIC 12 adjustments**	178
	78	**Other adjustments**	(288)
	(87,945)	**Reported Performance**	(79,664)
	(330,474)	**Cumulative position against breakeven duty (deficit)**	(242,529)
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	**£1.23m**	**Undershoot**	£9.19m
To operate within a Capital Resource Limit set by the Department of Health and Social Care	**£0.76m**	**Underspent**	£1.08m
To pay 95% of creditor invoices within 30 days (by number of invoices)	83%	**Trade (Non-NHS)**	75%
	63%	**NHS**	64%

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.
- 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 Jan Sobieraj Chief Executive
Date: 23 May 2019

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Jan Sobieraj Chief Executive

Paul Matthew Interim Director of Finance and Procurement

Date: 23 May 2019

Statement of comprehensive income for the year ending 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	413,754	394,512
Other operating income	4	33,738	38,649
Operating expenses	7, 9	(546,418)	(527,203)
Operating deficit from continuing operations		**(98,926)**	**(94,042)**
Finance income	12	122	41
Finance expenses	13	(6,317)	(2,752)
PDC dividends payable		-	(437)
Net finance costs		**(6,195)**	**(3,148)**
Other gains	14	620	109
Deficit for the year from continuing operations		**(104,501)**	**(97,081)**
Deficit for the year		**(104,501)**	**(97,081)**
Other comprehensive Expense			
Will not be reclassified to income and expenditure:			
Impairments	8	(5,939)	(15,043)
Revaluations	19	4,020	7,483
Total comprehensive income expense for the period		**(106,420)**	**(104,641)**
Financial performance for the year			
Deficit for the period		(104,501)	(97,081)
Remove net impairments not scoring to the Departmental expenditure limit		16,245	17,527
Remove I&E impact of capital grants and donations		78	(288)
IFRIC 12 Adjustment		233	178
Adjusted financial performance Deficit		**(87,945)**	**(79,664)**

The notes on pages 93 to 172 form part of these accounts.

Statement of financial position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	16	6,341	6,148
Property, plant and equipment	17	208,749	207,551
Receivables	25	1,560	1,828
Total non-current assets		**216,650**	**215,527**
Current assets			
Inventories	24	7,440	6,799
Receivables	25	22,036	25,393
Non-current assets held for sale / assets in disposal groups	27	660	1,225
Cash and cash equivalents	28	7,386	10,533
Total current assets		**37,522**	**43,950**
Current liabilities			
Trade and other payables	29	(51,412)	(53,481)
Borrowings	32	(114,340)	(36,157)
Provisions	34	(608)	(735)
Other liabilities	31	(3,372)	(3,210)
Total current liabilities		**(169,732)**	**(93,583)**
Total assets less current liabilities		**84,440**	**165,894**
Non-current liabilities			
Borrowings	32	(188,196)	(165,075)
Provisions	34	(2,863)	(2,994)
Other liabilities	31	(13,081)	(13,584)
Total non-current liabilities		**(204,140)**	**(181,653)**
Total liabilities employed		**(119,700)**	**(15,759)**
Financed by			
Public dividend capital		260,042	257,563
Revaluation reserve		32,159	35,283
Other reserves		190	190
Income and expenditure reserve		(412,091)	(308,795)
Total taxpayers' equity		**(119,700)**	**(15,759)**

The financial statements on pages 87 to 92 were approved by the Board on 23rd May 2019 and signed on its behalf by;

Jan Sobieraj
Chief Executive Officer
Date: 23rd May 2019

Statement of changes in equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**257,563**	**35,283**	**190**	**(308,795)**	**(15,759)**
Deficit for the year	-	-	-	(104,501)	**(104,501)**
Other transfers between reserves	-	(827)	-	827	**-**
Impairments	-	(5,939)	-	-	**(5,939)**
Revaluations	-	4,020	-	-	**4,020**
Transfer to retained earnings on disposal of assets	-	(378)	-	378	**-**
Public dividend capital received	2,479	-	-	-	**2,479**
Taxpayers' equity at 31 March 2019	**260,042**	**32,159**	**190**	**(412,091)**	**(119,700)**

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**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**255,663**	**44,003**	**190**	**(212,874)**	**86,982**
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)**

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 organisation. 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 as the public dividend capital 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.

Income and expenditure reserve

The balance of this reserve is the accumulated deficits of the Trust.

Other reserves

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

Statement of cash flows for the year ending 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating deficit		(98,926)	(94,042)
Non-cash income and expense:			
Depreciation and amortisation	7.1	11,443	11,723
Net impairments	8	16,245	17,527
Income recognised in respect of capital donations	4	(157)	(464)
Amortisation of PFI deferred credit		(503)	(503)
Decrease/(increase) in receivables and other assets		2,948	(1,227)
(Increase) / decrease in inventories		(641)	970
Increase in payables and other liabilities		161	2,699
decrease in provisions		(261)	(720)
Net cash generated used in operating activities		**(69,691)**	**(64,037)**
Cash flows from investing activities			
Interest received		122	41
Purchase of intangible assets		(1,514)	(1,626)
Purchase of property, plant, equipment and investment property		(30,379)	(14,985)
Sales of property, plant, equipment and investment property		1,302	322
Net cash generated from used in investing activities		**(30,469)**	**(16,248)**
Cash flows from financing activities			
Public dividend capital received		2,479	1,900
Movement on loans from the Department of Health and Social Care		99,551	90,473
Movement on other loans		(59)	(119)
Capital element of finance lease rental payments		(152)	(167)
Interest on loans		(5,476)	(1,987)
Other interest		(2)	-
Interest paid on finance lease liabilities		(5)	(17)
PDC dividend refunded/(paid)		677	(940)
Net cash generated from used in financing activities		**97,013**	**89,143**
(decrease)/increase in cash and cash equivalents		**(3,147)**	**8,858**
Cash and cash equivalents at 1 April - brought forward		**10,533**	**1,675**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**10,533**	**1,675**
Cash and cash equivalents transferred under absorption accounting	46	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	28.1	**7,386**	**10,533**

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 2018/19 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 the 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 1.2 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 lAS1.

Continuity of service

The Trust recorded a deficit of £87.9m which was £13.2m above the planned deficit of £74.7m in 2018/19.

The Trust did not accept the 2018/19 control total allocated by the Department of Health and Social Care (DHSC) and therefore did not qualify for receipt of Provider Sustainability Funding (PSF)

Taking account of the 2018/19 performance and the challenging external environment and transformation programme which the Trust is facing, the Board approved a Financial Recovery Plan in January 2019 for a £75.2m deficit in 2019/20. Having updated the FRP to take planning guidance into account the Trust has revised its plan to accept the issued Control Total deficit of £70.3m for 2019/20. Having accepted the Control Total the Trust potentially gains access to £28.9m from the Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) & Marginal Rate Emergency Tariff (MRET) reducing the overall deficit to £41.4m. It is therefore reasonable to assume that the DHSC will continue to provide cash support in line with the Control Total deficit although this hasn't been formally agreed. The plan includes delivery of a financial efficiency programme which is planned to achieve annual cost savings of £25.6m.

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. The main patient contract for 2019/20 with the Lincolnshire Clinical Commissioning Groups for £338m has been signed, the second biggest patient care contract with NHSE is near completion and signing. 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

The NHS Long Term plan sets out to achieve that all NHS organisations are in financial balance by 2023/24.

The Lincolnshire Sustainability and Transformation Partnership 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 March 2019 the Lincolnshire health community launched a public consultation under the banner "Healthy Conversation 2019" seeking views on proposed service reconfigurations.

In parallel with the Lincolnshire Sustainability and Transformation Partnership STP the Trust has 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 2018/19, being reliant on cash support from the DHSC in meeting its payment obligations. It has drawn down a cumulative total of £274.4m in revenue related loans and £26.2m in capital loans, at 31 March 2019.

Of the revenue support loans, £35.6m was repayable in November 2018. This has been extended but with no formal agreement being made with the DHSC as to the revised repayment. A further £110.5m is due to be repaid in 2019/20. The uncertainty about the refinancing does not however, of itself affect the Trust's going concern basis.

The 2019/20 financial plan incorporates further revenue cash support of £59.8m alongside an agreed capital loan of £11.7m.

The Trust recognises that the lack of certainty regarding future funding (including extension of loans which were due for repayment) and its ability to achieve planned cost reductions indicate that there is a 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 2019 should be prepared on a Going Concern basis.

Note 1.3 Interests in other entities

The Trust does not hold interests in other entities.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by

the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

As the services provided by the Trust are distinct they have substantially the same pattern of transfer to the customer. Therefore when Healthcare is delivered by the Trust, the performance obligation for all services delivered, is satisfied over time.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Collection of income is dependent on the Trust delivering on its contract obligations. Commissioners can only choose not to pay when those obligations have not been met. This is transacted via the levy of fines and penalties. Performance monitoring arrangements within the Trust provides an early indication of the likelihood of fines and penalties allowing prompt resolution and ensure revenue is recognised appropriately.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made and forms part of the contract by reducing the contract value and is fully recognised within the year and there is no deferral of income.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

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, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 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 1.4.3 Other income

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.

Note 1.5 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 scheme.

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 1.6 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 1.7 Property, plant and equipment

Note 1.7.1 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 the Trust has not treated these components as separate assets and has depreciated all components over the useful live of the large asset.

In January 2019 The Royal Institute of Chartered Surveyors issued guidance clarifying that where a large asset includes a number of components with significantly different asset lives, then these components must be treated as separate assets and depreciated over their own useful lives.

The Trust’s asset valuation, undertaken as at 31 March 2019, treated components as separate assets which will, from 1 April 2019, be depreciated over their own useful lives.

Note 1.7.2 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 assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values 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 on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

The valuation using the alternative site basis takes into account that the modern equivalent replacement with the same service potential as the existing hospitals would be on smaller sites than the existing and whilst in appropriate locations within the existing towns/cities not necessarily in the same locations as the existing. The sites are Lincoln, Pilgrim and Grantham Hospitals.

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, borrowings costs. Assets are revalued and depreciation commences when the assets 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 lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 1.7.3 De-recognition

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 1.7.4 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 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT 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. The agreement reflects a contract entered into with Progress Living for the provision of accommodation, as part of this the Trust are not buying a service concession as this is funded by the tenants.

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 1.7.6 Useful lives of property, plant and equipment

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

	Min life	Max life
	Years	Years
Land	-	-
Buildings, excluding dwellings	3	46
Dwellings	60	78
Plant & machinery	2	15
Transport equipment	5	11
Information technology hardware	3	10
Furniture & fittings	5	10

Note 1.8 Intangible assets

Note 1.8.1 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.

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.

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, eg, 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.
- The Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset.

Note 1.8.2 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. 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 of 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Internally generated information technology software	5	5
Websites	5	5
Software licences	3	15

Note 1.9 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 1.10 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.11 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 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018. Details of the initial application of this standard are given in Note 44.1

Note 1.13.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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 described below.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

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

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially

measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired (A financial asset is credit-impaired when one or more events that have a detrimental impact on the estimated future cash flows of that financial asset have occurred.) since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

The Trust operates a "hold to collect" business model on it trade receivables and have applied the general expected credit loss model for borrowings held at amortised costs

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition

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

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

Note 1.14 Leases

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

Note 1.14.1 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 an item of property plant and equipment.

The annual rental charge 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 1.14.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's 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 1.15 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 0.29% (2017/18: positive 0.10%) 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 0.76% (2017-18: negative 2.42%) for expected cash flows up to and including 5 years.
- A medium term rate of 1.14% (2017-18: negative 1.85%) for expected cash flows over 5 years up to and including 10 years.
- A long term rate of negative 1.19% (2017-18: negative 1.56%) 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 34.2 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 1.16 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 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, 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.

Note 1.17 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 organisation. 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 1.18 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 1.19 Corporation tax

The Trust has no Corporation tax liability.

Note 1.20 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 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 1.21 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 1.22 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 its 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 1.23 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 1.24 Transfers of functions [to / from] [other NHS bodies / local government bodies]

The Trust has not transferred any functions to, or from, other NHS or Local Government bodies.

Note 1.25 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 2019 will be paid in full. A settlement agreement has been reached with Lincolnshire CCG's in respect of their element of the contract (£312m). Therefore, the judgement does not need apply to this element of Contract income.

Note 1.25.1 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 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)). The value of land, buildings and dwellings post revaluation was £175.9m and is detailed at Note 17.

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. Details of the method of the recognition of asset lives are disclosed in Note 1.7.1

The Trust entered into a contract with a third party in 2006, Progress Living, 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 2019, the estimated income from partially completed spells was £4.4m (31 March 2018: £4.4m). 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 2018: £2.1m)."

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 2019 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 2019 were £3.5m (31 March 2018: £3.7m). See Note 26.1.

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 (£42.2m) and purchases through NHS Supply Chain (£11.5m).

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 2019 - based upon actual payments for a 'similar' accounting period.
- Agency - based upon details of unclaimed 'booked' shifts going back 3 months.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 14 Regulatory Deferral Accounts
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

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.

The Trust is working to quantify the likely impact, on its financial statements, of the adoption of IFRS 16 which has been deferred for the Public Sector until 1 April 2020.

IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2022, but not yet adopted by the FReM: early adoption is not therefore permitted.

As the Trust does not issue insurance contracts the adoption of this standard will have no impact on the Trust.

IFRIC 23 Uncertainty over Income Tax Treatments
Application required for accounting periods beginning on or after 1 January 2019.

Note 1.28 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.

	2018/19		2017/18	
	£000s	**%**	£000s	%
Revenue from HM Government sources	**435,558**	**97.3**	**421,019**	**97.2**
Revenue from non HM Government sources	**11,934**	**2.7**	**12,142**	**2.8**
Total	**447,492**	**100.0**	433,161	100.0

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19	2017/18
	£000	£000
Acute services		
Elective income	57,366	55,659
Non elective income	132,775	126,160
First outpatient income	38,470	37,859
Follow up outpatient income	32,385	32,240
A & E income	21,577	20,966
High cost drugs income from commissioners (excluding pass-through costs)	42,393	35,128
Other NHS clinical income	78,695	69,087
All services		
Private patient income	201	381
Agenda for Change pay award central funding	5,069	-
Other clinical income	4,823	17,032
Total income from activities	**413,754**	**394,512**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	67,928	66,159
Clinical commissioning groups	335,839	324,400
Department of Health and Social Care	5,079	12
Other NHS providers	1,230	312
NHS other	176	175
Local authorities	65	-
Non-NHS: private patients	201	381
Non-NHS: overseas patients (chargeable to patient)	197	327
Injury cost recovery scheme	1,702	1,557
Non NHS: other	1,337	1,189
Total income from activities	**413,754**	**394,512**
Of which:		
Related to continuing operations	413,754	394,512
Related to discontinued operations	-	-

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

	2018/19	2017/18
	£000	£000
Income recognised this year	197	327
Cash payments received in-year	92	84
Amounts added to provision for impairment of receivables	203	148
Amounts written off in-year	64	42

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	1,317	1,720
Education and training (excluding notional apprenticeship levy income)	16,433	16,797
Non-patient care services to other bodies	6,259	6,813
Provider sustainability / sustainability and transformation fund income (PSF / STF)	-	3,551
Income in respect of employee benefits accounted on a gross basis	2,627	2,598
Other contract income	5,657	5,601
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	262	29
Receipt of capital grants and donations	157	464
Rental revenue from finance leases	156	158
Rental revenue from operating leases	367	415
Amortisation of PFI deferred income / credits	503	503
Other non-contract income	-	-
Total other operating income	**33,738**	**38,649**
Of which:		
Related to continuing operations	33,738	38,649
Related to discontinued operations	-	-

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,636
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019
	£000
within one year	4,392
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	**4,392**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19	2017/18
	£000	£000
Income	4,055	4,670
Full cost	(1,943)	(2,667)
Surplus	**2,112**	**2,003**

This note addresses and aggregates schemes that, individually, have a cost exceeding £1m.
In 2018-19 and 2017-18 this comprises catering and car parking income from the public and staff.

Catering	**2018/19**	**2017/18**
	£000s	£000s
Income	**1,383**	**2,038**
Full cost	**(1,297)**	**(1,933)**
Surplus	**86**	105
Car Parking	**2018/19**	**2017/18**
	£000s	£000s
Income	**2,672**	**2,631**
Full cost	**(646)**	**(734)**
Surplus	**2,026**	1,897

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	2,237	2,046
Staff and executive directors costs	338,856	319,522
Remuneration of non-executive directors	86	88
Supplies and services - clinical (excluding drugs costs)	58,539	56,573
Supplies and services - general	8,239	8,053
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	53,049	51,916
Inventories written down	98	190
Consultancy costs	3,724	3,066
Establishment	5,213	4,461
Premises	16,601	17,601
Transport (including patient travel)	2,539	1,935
Depreciation on property, plant and equipment	9,841	10,286
Amortisation on intangible assets	1,602	1,437
Net impairments *	16,245	17,527
Movement in credit loss allowance: contract receivables / contract assets	261	
Movement in credit loss allowance: all other receivables and investments	-	1,739
Change in provisions discount rate(s)	(63)	48
Audit fees payable to the external auditors		
audit services- statutory audit	100	101
other auditors remuneration (external auditors only)	10	10
Internal audit costs	170	158
Clinical negligence	21,290	21,884
Legal fees	21	588
Insurance	46	50
Research and development	1,546	1,742
Education and training	2,760	2,857
Rentals under operating leases	1,590	1,687
Redundancy	58	69
Car parking & security	76	90
Hospitality	13	8
Losses, ex gratia & special payments	422	748
Other services, eg external payroll	432	464
Other	817	259
Total	**546,418**	**527,203**
Of which:		
Related to continuing operations	546,418	527,203
Related to discontinued operations	-	-

* Note 8 provides further detail relating to the Net Impairments expense

Note 7.2 Other auditors' remuneration

	2018/19	2017/18
	£000	£000
Other auditors remuneration paid to the external auditors:		
2. Audit-related assurance services	10	10
Total	**10**	**10**

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

Note 7.3 Limitation on auditors liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 8 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	19,894	(1,206)
Other	(3,649)	18,733
Total net impairments charged to operating surplus / deficit	**16,245**	**17,527**
Impairments charged to the revaluation reserve	5,939	15,043
Total net impairments	**22,184**	**32,570**

Material Impairment losses/(reversals) charged to SOCI in 2018/19 resulting from changes in market price following valuation are summarised below:

	2018/19	2017/18
	£000	£000
Reversals of impairments charged to SOCI in previous years		
Other - buildings	(1,411)	(1,206)
Impairments charged to SOCI in current year		
Other - buildings	21,305	0
	19,894	(1,206)

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

	2018/19	2017/18
	£000	£000
Reversal of impairments charged to SOCI in previous years		
Progress Care Housing Association Onerous Contract net reversal **	(3,649)	1,470
Impairments Charged to SOCI in prior year*		
Tower Block, Boston		1,484
Maternity Unit, Lincoln		3,300
Plant Rooms, Grantham		2,591
Other buildings impaired		9,888
	(3,649)	18,733

Cushman & Wakefield have undertaken a desktop review of the Trust estate as at 31 March 2019. 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 to ensure both parties are operating from a single robust baseline. In some instances this has contributed to the movement in asset values between years.

The Trust entered into a contract with a third party in 2006, Progress Living, 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 contract are reviewed and impaired annually as appropriate based upon an assessment of future occupancy levels.

Impairments charged / (reversed) against this contract were:

	2018/19	2017/18
	£000	£000
Boston	(3,200)	1,413
Grantham	(449)	57
	(3,649)	1,470

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

	2018/19	2017/18
	£000	£000
Other		17,077
Changes in market price	(1,919)	(2,034)
Total impairments for PPE charged to reserves	**(1,919)**	**15,043**

Note 9 Employee benefits

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	252,274	242,302
Social security costs	23,151	22,365
Apprenticeship levy	1,287	1,223
Employer's contributions to NHS pensions	28,425	28,053
Pension cost - other	67	28
Termination benefits	58	69
Temporary staff (including agency)	37,118	29,385
Total gross staff costs	**342,380**	**323,425**
Recoveries in respect of seconded staff	-	-
Total staff costs	**342,380**	**323,425**
Of which		
Costs capitalised as part of assets	684	688

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

Note 9.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (9 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £177k (£379k in 2017/18).

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

Note 10 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 for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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 11 Operating leases

Note 11.1 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.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	198	198
Contingent rent	169	217
Total	**367**	**415**
	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	273	573
- later than one year and not later than five years;	916	915
- later than five years.	922	1,110
Total	**2,111**	**2,598**

Note 11.2 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 Trusts lessee arrangements relate to the lease of plant and equipment supplied under normal commercial terms by non-NHS suppliers. There is no contingent rent associated with the arrangements.

Additionally 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.

The Trust also leases various items of medical equipment and vehicles. These leases expire in the period up to September 2021 (medical equipment) and January 2024 (Vehicles)

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	1,590	1,687
Contingent rents	-	-
Less sublease payments received	-	-
Total	**1,590**	**1,687**
	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	204	1,313
- later than one year and not later than five years;	145	92
- later than five years.	-	-
Total	**349**	**1,405**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	122	41
Total finance income	**122**	**41**

Note 13.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	6,312	2,727
Finance leases	-	17
Interest on late payment of commercial debt	2	1
Total interest expense	**6,314**	**2,745**
Unwinding of discount on provisions	3	7
Total finance costs	**6,317**	**2,752**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	1,334	1,948
legislation	2	1
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 14 Other gains		
	2018/19	2017/18
	£000	£000
Gains on disposal of assets	734	140
Losses on disposal of assets	(114)	(31)
Total gains on disposal of assets	**620**	**109**
Total other gains	**620**	**109**

Note 15 Discontinued operations

The Trust has had no operations discontinued within the reporting year.

Note 16.1 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Websites	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**11,776**	**20**	**15**	**113**	**11,924**
Additions	1,522	-	-	-	**1,522**
Reclassifications	386	-	-	-	**386**
Disposals / derecognition	(800)	-	-	(113)	**(913)**
Valuation / gross cost at 31 March 2019	**12,884**	**20**	**15**	**-**	**12,919**
Amortisation at 1 April 2018 - brought forward	**5,747**	**20**	**9**	**-**	**5,776**
Provided during the year	1,599	-	3	-	**1,602**
Disposals / derecognition	(800)	-	-	-	**(800)**
Amortisation at 31 March 2019	**6,546**	**20**	**12**	**-**	**6,578**
Net book value at 31 March 2019	**6,338**	**-**	**3**	**-**	**6,341**
Net book value at 1 April 2018	**6,029**	**-**	**6**	**113**	**6,148**

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

Note 16.2 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 - as previously stated	**10,259**	**20**	**15**	**391**	**10,685**
Prior period adjustments	-	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**10,259**	**20**	**15**	**391**	**10,685**
Additions	1,093	-	-	329	**1,422**
Reclassifications	725	-	-	(607)	**118**
Disposals / derecognition	(301)	-	-	-	**(301)**
Valuation / gross cost at 31 March 2018	**11,776**	**20**	**15**	**113**	**11,924**
Amortisation at 1 April 2017 - as previously stated	**4,607**	**20**	**6**	**-**	**4,633**
Prior period adjustments	-	-	-	-	**-**
Amortisation at 1 April 2017 - restated	**4,607**	**20**	**6**	**-**	**4,633**
Transfers by absorption	-	-	-	-	**-**
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**

Note 17.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**9,841**	**145,667**	**22,843**	**3,286**	**57,381**	**735**	**10,571**	**363**	**250,687**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	10,785	-	13,517	3,006	-	2,284	-	**29,592**
Impairments	-	(31,849)	-	-	-	-	-	-	**(31,849)**
Reversals of impairments	-	2,912	3,463	-	-	-	-	-	**6,375**
Revaluations	-	2,082	1,348	-	-	-	-	-	**3,430**
Reclassifications	-	8,815	-	(10,220)	54	-	965	-	**(386)**
Transfers to / from assets held for sale	-	-	-	-	(525)	-	-	-	**(525)**
Disposals / derecognition	-	-	-	-	(3,158)	-	(2,252)	(61)	**(5,471)**
Valuation/gross cost at 31 March 2019	**9,841**	**138,412**	**27,654**	**6,583**	**56,758**	**735**	**11,568**	**302**	**251,853**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**-**	**37,729**	**528**	**4,642**	**237**	**43,136**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,543	337	-	3,834	49	2,039	39	**9,841**
Impairments	-	(2,596)	-	-	-	-	-	-	**(2,596)**
Reversals of impairments	-	(508)	(186)	-	-	-	-	-	**(694)**
Revaluations	-	(439)	(151)	-	-	-	-	-	**(590)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	(523)	-	-	-	**(523)**
Disposals / derecognition	-	-	-	-	(3,157)	-	(2,252)	(61)	**(5,470)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**37,883**	**577**	**4,429**	**215**	**43,104**
Net book value at 31 March 2019	**9,841**	**138,412**	**27,654**	**6,583**	**18,875**	**158**	**7,139**	**87**	**208,749**
Net book value at 1 April 2018	**9,841**	**145,667**	**22,843**	**3,286**	**19,652**	**207**	**5,929**	**126**	**207,551**

Note 17.2 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 - as previously stated	**12,125**	**153,345**	**24,394**	**6,486**	**58,345**	**751**	**8,619**	**363**	**264,428**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**12,125**	**153,345**	**24,394**	**6,486**	**58,345**	**751**	**8,619**	**363**	**264,428**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
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 - as previously stated	**-**	**-**	**-**	**-**	**38,690**	**552**	**3,832**	**193**	**43,267**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2017 - restated	**-**	**-**	**-**	**-**	**38,690**	**552**	**3,832**	**193**	**43,267**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
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**

Note 17.3 Property, plant and equipment financing - 2018/19

	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 2019									
Owned - purchased	9,841	138,022	-	6,583	18,195	133	7,127	78	**179,979**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	27,654	-	-	-	-	-	**27,654**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	58	-	-	-	-	-	-	**58**
Owned - donated	-	332	-	-	680	25	12	9	**1,058**
NBV total at 31 March 2019	**9,841**	**138,412**	**27,654**	**6,583**	**18,875**	**158**	**7,139**	**87**	**208,749**

Note 17.4 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**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
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 18 Donations of property, plant and equipment

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

Donors: United Lincolnshire Hospitals NHS Trust Charitable Fund and United Lincolnshire Hospitals NHS Trust Charitable Funds.

	Plant & machinery	Total Property, Plant and Equipment	Software licences	Total Intangibles	Fair value of asset
Asset Description - Donation of physical asset	**£000**	**£000**	**£000**	**£000**	**£000**
BK3000 Ultrasound Scanner	55	**55**			**55**
Solar GI Manometry System	23	**23**			**23**
Motomed LETT02 LEG Model	7	**7**			**7**
TE7 Colour Doppler Ultrasound	13	**13**			**13**
Digital Reminiscence Therapy Software		**0**	52	**52**	**52**
Motomed Lett02 Leg Model	7	**7**			**7**
Total value of physical assets donated	105	**105**	52	**52**	**157**

Note 19 Revaluations of property, plant and equipment

The Trust commissioned a desktop revaluation of land, buildings and dwellings in March 2019. This revaluation was conducted by Mr D.M. Wilson MRICS of Cushman & Wakefield formerly (DTZ Debenham Tie Leung Ltd (DTZ)) and was based upon depreciated replacement cost using the modern equivalent basis of valuation.

This desktop revaluation 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.

The alternative site basis takes into account that the modern equivalent replacement with the same service potential as the existing hospitals would be on smaller sites than the existing and whilst in appropriate locations within the existing towns/cities not necessarily in the same locations as the existing. The sites are Lincoln, Pilgrim and Grantham Hospitals.

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 2019.

	2018/19	2017/18
	£000s	£000s
Land	700	700
Dwellings	27,654	22,844
Buildings	0	0
	28,354	23,544

Accounting policies Note 1.7 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.

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

Details of the method the Trust uses to recognise the lives of its assets is disclosed in Note 1.7.1

The gross value of fully depreciated assets still in use is £6.22m (2018 £7.37m).

A number of buildings owned by the Trust are leased out under operating leases to other NHS bodies.

	2018/19	2017/18
	£000s	£000s
Net book value 1 April 2018	4,549	3405
New leases	466	96
Additions	295	88
Depreciation	(86)	(59)
Increase in valuation 31 March 2019	2	1,447
Impairments	(441)	(158)
Terminated Leases	0	(270)
Net book value 31 March 2019	**4,785**	**4,549**

Notes 20 - 22: Not used

Note 23 Disclosure of interests in other entities

The holds no interests in other entities.

Note 24 Inventories

	31 March 2019		31 March 2018
	£000		£000
Drugs	2,754		2,551
Work In progress	-		-
Consumables	4,684		4,246
Energy	2		2
Other	-		-
Total inventories	**7,440**		**6,799**
of which:			
Held at fair value less costs to sell	-		-

Inventories recognised in expenses for the year were £53,847k (2017/18: £54,054k). Write-down of inventories recognised as expenses for the year were £98k (2017/18: £190k).

Note 25.1 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	18,308	
Contract assets*	-	
Trade receivables*		7,667
Accrued income*		13,469
Allowance for impaired contract receivables / assets*	(773)	
Allowance for other impaired receivables	-	(1,882)
Deposits and advances	-	5
Prepayments (non-PFI)	3,465	4,066
PDC dividend receivable	-	677
VAT receivable	470	414
Corporation and other taxes receivable	-	-
Other receivables	566	977
Total current trade and other receivables	**22,036**	**25,393**
Non-current		
Contract receivables*	1,997	
Allowance for impaired contract receivables / assets*	(437)	
Allowance for other impaired receivables	-	(665)
Other receivables	-	2,493
Total non-current trade and other receivables	**1,560**	**1,828**
Of which receivables from NHS and DHSC group bodies:		
Current	15,203	20,413
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables

and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 25.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**2,547**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018*	1,022	(2,547)
New allowances arising	508	-
Reversals of allowances	(247)	-
Utilisation of allowances (write offs)	(73)	-
Allowances as at 31 Mar 2019	**1,210**	**-**

*An amount of £1,525k was reclassified to debtors income accruals in 2018/19 and the change is not as a result of a change in calculation

Note 25.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

		All receivables
		£000
Allowances as at 1 Apr 2017 - as previously stated		**867**
Prior period adjustments		
Allowances as at 1 Apr 2017 - restated		**867**
Transfers by absorption		
Increase in provision		1,810
Amounts utilised		(59)
Unused amounts reversed		(71)
Allowances as at 31 Mar 2018		**2,547**

Note 25.4 Exposure to credit risk

Ageing of impaired financial assets		
	31 March 2019	31 March 2018
	£000	£000
0 - 30 days	18	0
30-60 Days	0	0
60-90 days	36	0
90- 180 days	86	18
Over 180 days	1,070	2,529
Total	1,210	**2,547**

Note 25.4 Exposure to credit risk

Ageing of non-impaired financial assets past their due date		
	31 March 2019	31 March 2018
	£000	£000
0 - 30 days	1,753	1,171
30-60 Days	833	(1,229)
60-90 days	545	424
90- 180 days	462	1,211
Over 180 days	874	2,218
Total	4,467	**3,795**

NHS receivables past their due date account for £3.9m of the total financial assets at 31 March 2019. As CCGs are funded by Government the credit quality of these receivables is considered to be good."

Note 26 Other assets

	31 March 2019	31 March 2018
Current	**£000**	**£000**
EU emissions trading scheme allowance	-	-
Other assets	-	-
Total other current assets	**-**	**-**
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	-	-
Total other non-current assets	**-**	**-**

Note 27 Non-current assets held for sale and assets in disposal groups

	2018/19	2017/18
	£000	**£000**
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,225**	**1,251**
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**1,225**	**1,251**
Assets classified as available for sale in the year	2	156
Assets sold in year	(567)	(182)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**660**	**1,225**

The Trust is holding two properties for sale at 31 March 2019:

(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 one part of the sale for £0.5m was completed within the 2018/19 reporting year. It is anticipated that the the remainder of the site will be sold in 2019/20

(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 2019/20.

Note 27.1 Liabilities in disposal groups

	31 March 2019	31 March 2018
	£000	£000
Categorised as:		
Provisions	-	-
Trade and other payables	-	-
Other	-	-
Total	**-**	**-**

Note 28.1 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.

	2018/19	2017/18
	£000	£000
At 1 April	**10,533**	**1,675**
Prior period adjustments	-	-
At 1 April (restated)	**10,533**	**1,675**
Net change in year	(3,147)	8,858
At 31 March	**7,386**	**10,533**
Broken down into:		
Cash at commercial banks and in hand	10	10
Cash with the Government Banking Service	7,376	10,523
Total cash and cash equivalents as in SoFP	**7,386**	**10,533**
Total cash and cash equivalents as in SoCF	**7,386**	**10,533**

Note 28.2 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 2019	31 March 2018
	£000	£000
Bank balances	-	-
Monies on deposit	1	1
Total third party assets	**1**	**1**

Note 29.1 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	15,350	19,516
Capital payables	10,791	11,727
Accruals	13,469	10,221
Social security costs	4,065	3,732
Other taxes payable	3,491	3,052
PDC dividend payable	-	-
Accrued interest on loans*		1,127
Other payables	4,246	4,106
Total current trade and other payables	**51,412**	**53,481**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	4,419	6,038
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 41.3. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 29.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2019	31 March 2019	31 March 2018	31 March 2018
	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 30 Other financial liabilities

	31 March 2019	31 March 2018
	£000	£000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**

Note 31 Other liabilities

	31 March 2019	31 March 2018
	£000	£000
Current		
Deferred income: contract liabilities	2,869	2,707
PFI deferred income / credits	479	479
Lease incentives	24	24
Total other current liabilities	**3,372**	**3,210**
Non-current		
PFI deferred income / credits	12,451	12,929
Lease incentives	630	655
Total other non-current liabilities	**13,081**	**13,584**

*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 32 Borrowings

	31 March 2019	31 March 2018	
	£000	£000	
Current			
Loans from the Department of Health and Social Care	114,340	35,946	
Other loans	-	59	
Obligations under finance leases	-	152	
Total current borrowings	**114,340**	**36,157**	
Non-current			
Loans from the Department of Health and Social Care	188,196	165,075	
Total non-current borrowings	**188,196**	**165,075**	
Borrowings / Loans - repayment of principal falling due in:	**31 March 2019**		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 Years	114,340		**114,340**
1 - 2 Years	83,422		**83,422**
2 - 5 Years	92,675		**92,675**
Over 5 Years	12,099		**12,099**
TOTAL	**302,536**	**0**	**302,536**

Note 32.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**201,021**	**59**	**152**	**-**	**201,232**
Cash movements:					
Financing cash flows - payments and receipts of principal	99,551	(59)	(152)	-	**99,340**
Financing cash flows - payments of interest	(5,476)	-	(5)	-	**(5,481)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	1,127	-	5	-	**1,132**
Application of effective interest rate	6,312	-	-	-	**6,312**
Other changes	1	-	-	-	**1**
Carrying value at 31 March 2019	**302,536**	**-**	**-**	**-**	**302,536**

Note 33 Finance leases

Note 33.1 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 three properties where it has granted long leases to other NHS bodies; each has an annual peppercorn rent of £1.

	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 2019	31 March 2018
	£000	£000
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	156	158

Note 33.2 United Lincolnshire Hospitals NHS Trust as a lessee

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

	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**-**	**158**
of which liabilities are due:		
- not later than one year;	-	158
Finance charges allocated to future periods	-	(6)
Net lease liabilities	**-**	**152**
of which payable:		
- not later than one year;	-	152
- later than one year and not later than five years;	-	-
- 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 34.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**1,031**	**2,158**	**468**	**72**	**3,729**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	(12)	(51)	-	-	**(63)**
Arising during the year	57	83	207	-	**347**
Utilised during the year	(98)	(99)	(129)	-	**(326)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	(12)	-	(207)	-	**(219)**
Unwinding of discount	1	2	-	-	**3**
At 31 March 2019	**967**	**2,093**	**339**	**72**	**3,471**
Expected timing of cash flows:					
- not later than one year;	98	99	339	72	**608**
- later than one year and not later than five years;	393	394	-	-	**787**
- later than five years.	476	1,600	-	-	**2,076**
Total	**967**	**2,093**	**339**	**72**	**3,471**

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 34.
Other provisions relate to costs associated with relocation expenses.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

Note 34.2 Clinical negligence liabilities

At 31 March 2019, £270,917k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of United Lincolnshire Hospitals NHS Trust (31 March 2018: £220,518k).

Note 35 Contingent assets and liabilities		
	31 March 2019	**31 March 2018**
	£000	**£000**
Value of contingent liabilities		
NHS Resolution legal claims	(80)	(40)
Employment tribunal and other employee related litigation	(181)	(431)
Redundancy	-	-
Other	(42)	-
Gross value of contingent liabilities	**(303)**	**(471)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(303)**	**(471)**
Net value of contingent assets	**-**	**-**

A provision for legal claims brought against the Trust in relation to Employment issues has been disclosed at Note 34. 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 36 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	10,285	15,789
Intangible assets	29	14
Total	**10,314**	**15,803**

Note 37 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 2019	31 March 2018
	£000	£000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 38 Defined benefit pension schemes

The Trust has no Defined benefit Pension schemes.

Note 38.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2018/19	2017/18
	£000	£000
Present value of the defined benefit obligation at 1 April	**-**	**-**
Prior period adjustment		-
Present value of the defined benefit obligation at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Current service cost	-	-
Interest cost	-	-
Contribution by plan participants	-	-
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	-	-
Benefits paid	-	-
Past service costs	-	-
Business combinations	-	-
Curtailments and settlements	-	-
Present value of the defined benefit obligation at 31 March	**-**	**-**
Plan assets at fair value at 1 April	**-**	**-**
Prior period adjustment		-
Plan assets at fair value at 1 April -restated	**-**	**-**
Transfers by normal absorption	-	-
Interest income	-	-
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets	-	-
- Actuarial gain / (losses)	-	-
ceiling	-	-
Contributions by the employer	-	-
Contributions by the plan participants	-	-
Benefits paid	-	-
Business combinations	-	-
Settlements	-	-
Plan assets at fair value at 31 March	**-**	**-**
Plan surplus/(deficit) at 31 March	**-**	**-**

Note 38.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2019	31 March 2018
	£000	£000
Present value of the defined benefit obligation	-	-
Plan assets at fair value	-	-
Net defined benefit (obligation) / asset recognised in the SoFP	**-**	**-**
Fair value of any reimbursement right	-	-
Net (liability) / asset recognised in the SoFP	**-**	**-**

Note 38.3 Amounts recognised in the SoCI

	2018/19	2017/18
	£000	£000
Current service cost	-	-
Interest expense / income	-	-
Past service cost	-	-
Losses on curtailment and settlement	-	-
Total net (charge) / gain recognised in SOCI	**-**	**-**

Note 39 On-SoFP PFI, LIFT or other service concession arrangements

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 41 Financial instruments

Note 41.1 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%. Subsequently the interest rate reduced to 3.5% for new borrowings in 2018/19. 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 2019 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 41.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

		Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9		**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets		19,661	-	-	**19,661**
Cash and cash equivalents at bank and in hand		7,386	-	-	**7,386**
Total at 31 March 2019		**27,047**	**-**	**-**	**27,047**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
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**

Note 41.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	302,536	-	**302,536**
Trade and other payables excluding non-financial liabilities	43,856	-	**43,856**
Provisions under contract	1,595	-	**1,595**
Total at 31 March 2019	**347,987**	**-**	**347,987**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	201,021	-	**201,021**
Obligations under finance leases	152	-	**152**
Other borrowings	59	-	**59**
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**

Note 41.4 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 41.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	158,268	81,727
In more than one year but not more than two years	83,422	75,586
In more than two years but not more than five years	92,675	82,285
In more than five years	13,622	12,377
Total	**347,987**	**251,975**

Note 42 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	19	7	7	20
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	58	68	90	69
Stores losses and damage to property	7	98	5	190
Total losses	**84**	**173**	**102**	**279**
Special payments				
Compensation under court order or legally binding arbitration award	40	170	25	1,292
Extra-contractual payments	1	384	1	185
Ex-gratia payments	161	18	70	10
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**202**	**572**	**96**	**1,487**
Total losses and special payments	**286**	**745**	**198**	**1,766**
Compensation payments received		-		-

Special payments include payments made to Progress Housing under an occupancy guarantee £0.38m (2017/18 £0.18m)

Note 43 Gifts

	2018/19			2017/18	
	Total number of cases	Total value of cases		Total number of cases	Total value of cases
	Number	£000		Number	£000
Gifts made	-	-		-	-

Note 44.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £1,127k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a -£1,525k increase in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,232k.

The application of this standard has had no material impact on the Trust in the reporting year.

Note 44.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The application of this standard has had no material impact on the Trust in the reporting year.

Note 45 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 2018/19 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
	£000	**£000**	**£000**	**£000**
Mrs E Baylis - Chairman ULHT / Chair - Lincolnshire Community Health Services NHS Trust	2336	1933	245	528
Mr J Sobieraj - Chief Executive Office ULHT Vice Chair - National Centre for Rural Health and Care	94			
Mrs E Libiszewski - Non Executive Director ULHT / Non-Executive - Lincolnshire Community Health Services NHS Trust	2336	1933	245	528
Mrs S Dunnett - Non Executive Director ULHT / Trustee / Hon Treasurer - Health Quality Improvement Partnership	25			
Mrs S Dunnett - Non Executive Director ULHT / Non-Executive Director - North West Anglia NHS Foundation Trust	212	67	120	68
Mr Alan Lockwood - Interim Non Executive Director ULHT / Non Executive Director - Lincolnshire Partnership NHS Foundation Trust	657	1,679	64	378

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		68,579	302	1,693
NHS Lincolnshire East CCG		121,241	972	3,223
NHS Lincolnshire West CCG		114,143	803	3,643
NHS South West Lincolnshire CCG		64,793	372	2,153
NHS South Lincolnshire CCG	480	23,406	497	103
NHS Newark and Sherwood CCG		4,236	2	123
NHS North Lincolnshire CCG		1,269	4	30
NHS East Leicestershire and Rutland CCG		666	19	
NHS Cambridgeshire and Peterborough CCG		369		83
NHS Bassetlaw CCG		491		12
NHS North East Lincolnshire CCG		412		
NHS Sheffield CCG		297	11	
NHS Rushcliffe CCG		242		5
NHS Nottingham City CCG		218	11	
NHS Mansfield and Ashfield CCG		194	3	
NHS Doncaster CCG		177	2	31
NHS Nene CCG		166		6
NHS Resolution (formerly NHS Litigation Authority)	21,290			
NHS Improvement (TDA legal entity)		522		
Department of Health and Social Care		5,100		
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	10,792	1,018	17	125
Lincolnshire Partnership NHS Foundation Trust	661	1,679	64	378
North West Anglia NHS Foundation Trust	212	67	120	68
Sheffield Teaching Hospitals NHS Foundation Trust	160		33	
Sherwood Forest Hospitals NHS Foundation Trust	127		14	
Bradford Teaching Hospitals NHS Foundation Trust	81		16	
Leeds Teaching Hospitals NHS Trust	288		46	1
St Helens and Knowsley Hospital Services NHS Trust	1,723		134	130
Lincolnshire Community Health Services NHS Trust	2,336	1,933	245	528
University Hospitals of Leicester NHS Trust	294	1,625	185	347
Nottingham University Hospitals NHS Trust	789	1,245	269	1,144
Northumbria Healthcare NHS Foundation Trust			51	
St Helens and Knowsley Hospital Services NHS Trust			134	130
Leicestershire Partnership NHS Trust	136		50	
East Midlands Ambulance Service NHS Trust		72		4
Torbay and South Devon NHS Foundation Trust	74		18	
Oxford Health NHS Foundation Trust	78		10	
NHS Property Services	2,439	246	2,107	269
Public Health Endland		204		
Care Quality Commission	307			
Health Education England		16,345		1,518

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	28,425		7,556	
HM Revenue & Customs	24,438		3,936	470

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 2018/19including the purchase / donation of various capital assets to the Trust.

The value of these in 2018/19 was £0.157m (2017/18: £0.46m).

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
United Lincolnshire Hospitals Charity		296	9	10

Note 46 Transfers by absorption

The Trust has had not transfers by absorption in 2018/19

Note 47 Prior period adjustments

The Trust has no Prior period adjustments

Note 48 Events after the reporting date

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

Note 49 Final period of operation as a trust providing NHS healthcare

The Trust is not in its Final period of operation as a Trust providing NHS Healthcare

Note 50 Better Payment Practice code

	2018/19	2018/19	2017/18	2017/18
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	131,088	207,633	125,963	166,841
Total non-NHS trade invoices paid within target	108,382	160,962	93,945	114,611
Percentage of non-NHS trade invoices paid within target	82.7%	77.5%	74.6%	68.7%
NHS Payables				
Total NHS trade invoices paid in the year	2,387	43,521	2,092	44,444
Total NHS trade invoices paid within target	1,508	35,340	1,336	33,943
Percentage of NHS trade invoices paid within targe	63.2%	81.2%	63.9%	76.4%

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 51 External financing

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

	2018/19	2017/18
	£000	£000
Cash flow financing	104,966	83,229
External financing requirement	104,966	83,229
External financing limit (EFL)	106,199	92,416
Under spend against EFL	1,233	9,187

Note 52 Capital Resource Limit

	2018/19	2017/18
	£000	£000
Gross capital expenditure	31,114	23,483
Less: Disposals	(681)	(213)
Less: Donated and granted capital additions	(157)	(464)
Charge against Capital Resource Limit	**30,276**	**22,806**
Capital Resource Limit	31,038	23,886
Under spend against CRL	**762**	**1,080**

Note 53 Breakeven duty financial performance

	2018/19
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(88,178)
IFRIC 12 breakeven adjustment	233
Breakeven duty financial performance deficit	**(87,945)**

Note 54 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£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)	(87,945)
position	4,071	5,353	(8,527)	(8,207)	(8,083)	(33,896)	(49,057)	(105,974)	(162,865)	(242,529)	(330,474)
Operating income		391,141	392,202	407,975	422,802	425,524	433,250	423,428	437,324	433,161	447,492
Cumulative breakeven position as a percentage of operating income		1.4%	(2.2%)	(2.0%)	(1.9%)	(8.0%)	(11.3%)	(25.0%)	(37.2%)	(56.0%)	(73.9%)

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.