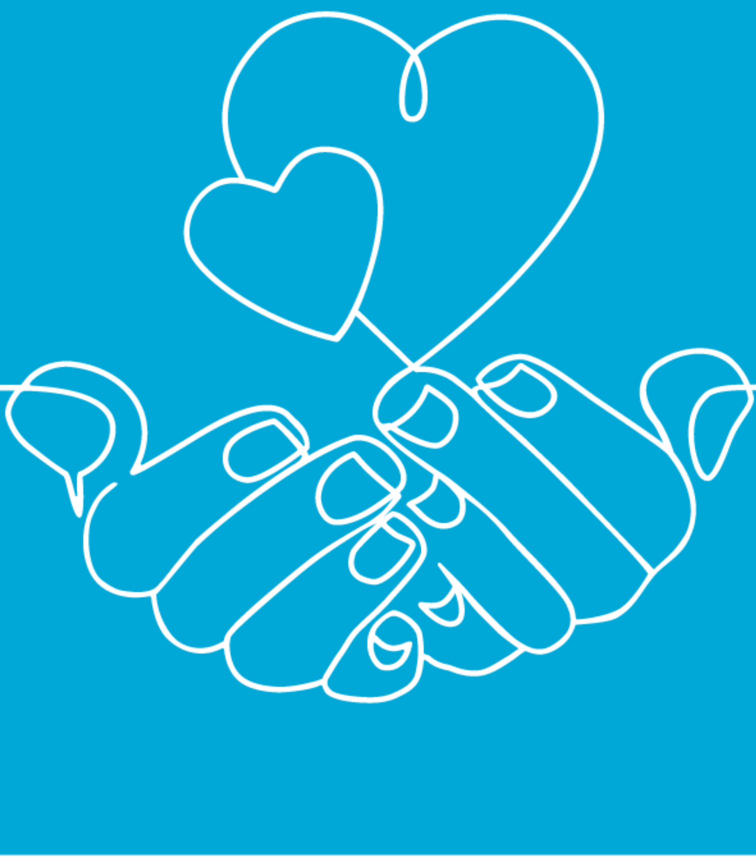
NHS
United Lincolnshire Hospitals
NHS Trust

Annual Report and Accounts for the year ended 31 March 2022



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

Chief Executive and Chair's Foreword

We are pleased to be able to share with you our Annual Report for the year 2021/22. This report covers another challenging year for the NHS both nationally and locally. It reflects the very difficult circumstances that our patients, the public, their loved ones and our own staff have faced over a sustained period of time.

Working together as a team the Trust have made huge improvements to the quality of care provided to our patients and also to our financial management arrangements. During 2021/22 the Care Quality Commission (CQC) visited and recognised the progress that we had made. Following this visit we were delighted to be able to announce that we were no longer in "special measures".

We do however recognise that there is still more we need to do to ensure we continue to provide the best care possible to all of our patients and as such we will continue our improvement journey.

As we work to continue the restoration of services impacted by the pandemic and to addressing the legacy for our patients and those waiting for treatment we know our staff will continue to go above and beyond to support our patients and keep our services running safely.

We are also looking forward to working with our partners across Lincolnshire and beyond as part of the new Lincolnshire Integrated Care System. Under these new arrangements we will be working more collaboratively with health and social care providers across the county in a new way that will help us to integrate and further improve the experience of the thousands of people who rely on the services every day.

During 2021/22 the Trust achieved the largest capital funding programme in its history, seeing significant spending on estates schemes, medical devices and digital schemes. We continue to seek ways to review and improve. We will continue to build on our achievements in 2021/22 and look positively to the future.

Elaine Baylis, Chair

Andrew Morgan, Chief Executive

Performance Report

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 the areas in which we need to continue to improve.

Whilst we are required by law to include technical and financial detail, we have tried to make this overview as easy as possible to read and understand, whilst sharing with you information about our Trust and the services we provide for the residents of Lincolnshire and beyond. The Performance Report is a summary of what we provide, how we have performed against the national mandated standards for clinical care, what we achieved in 2021/22, and how your money was invested to improve services for patients.

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 England and NHS Improvement (NHSE/I).

About Us

United Lincolnshire Hospitals Trust (ULHT) serves one of the largest geographical areas in England with a population of around 761,224 (Office of National Statistics 2019).

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

We have an annual income for 2021/22 of £680m. Our main contract is with NHS Lincolnshire Clinical Commissioning Group (CCG).

We provide services from three acute hospitals in Lincolnshire with a bed stock, excluding obstetrics, of 974 beds.

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by NHS property Services. These include:

- County Hospital Louth
- 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 140,000 inpatients, and deliver around 4,000 babies. Services during 2021/22 continued to be significantly affected by the pandemic.

For 2021/22 vs 2020/21 our attendances were as follows:

	2020/21	**2021/22**
Outpatient	558,546	657,465
A&E Attendances	100,992	129,893
Inpatients	106,567	128,510

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

Whilst the Trust is the largest provider of elective care for NHS Lincolnshire CCG, Northern Lincolnshire and Goole NHS Foundation Trust and North West Anglia NHS Foundation Trust provide a significant share of elective care in East and South Lincolnshire respectively.

Trust Organisational Structure

The table below shows the services provided by the Trust and how they are managed through each of the four Trust divisions:

Division	Clinical Business Unit	Clinical Service
Family Health	Women's Health	Breast Obstetrics Gynaecology
	Children and Young People	Paediatrics Neonatology
Clinical Support Services	Diagnostics	Radiology Radiotherapy Medical Physics Pathology Audiology
	Therapies and Rehabilitation	Rehabilitation medicine Occupational Therapy Speech and Language Therapy Dietetics Physiotherapy
	Pharmacy	
	Outpatients	
	Cancer Services	
Surgery	Surgery	General Surgery Vascular Urology Head and Neck
	Orthopaedics and Opthalmology	Orthopaedics Opthalmology Orthoptics
	Theatres, Anaesthetics, Critical Care and Pain	Theatres Critical Care
Medicine	Urgent and Emergency Care	A&E Acute Medicine Cardiology (including cardiac physiology)
	Cardio Vascular	Diabetes Renal Stroke Endocrinology

	Specialist Medicine	Dermatology Rheumatology Neurology Gastroenterology Respiratory Health care of the older person

The four Divisions reduce the variation of care across the sites through the implementation of consistent structures with strengthened roles, clearer decision making closer to the front line of service delivery.

Vision, ambitions and strategies for 2020-2025

As a Trust Board in February 2020 we committed to delivering our 5 year Integrated Improvement Plan (IIP) reaching year two of delivery in 2021/22. At this time little did we know that we would be experiencing, a few weeks later, a global pandemic that disrupted healthcare delivery as we knew it. As a result the first two years of our plans were severely affected. Of the 71 original projects, 50 remain live but with either altered scopes, timelines or expected benefits. As would be expected focus has remained on those areas deemed by the project teams to have most impact on patient safety.

The following strategic framework was agreed to shape our plans for 2020-2025:

	Patients	People	Services	Partners
Strategic objectives	To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities.	To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT.	To ensure that **services** are sustainable, supported by technology and delivered from an improved estate.	To implement new integrated models of care with our **partners** to improve Lincolnshire's health and wellbeing.
Our five year priorities	• Deliver harm free care • Improve patient experience • Improve clinical outcomes	• A modern and progressive workforce • Making ULHT the best place to work • Well led services	• A modern, clean and fit for purpose environment • Efficient use of our resources • Enhanced data and digital capability	• Establish new evidence based models of care • Advancing professional practice with partners • Becoming a University Hospitals Teaching Trust
Our outcomes	• HSMR and SHMI are within the top quartile nationally • Patient surveys in top quartile • Top quartile for national clinical audits and benchmarking • Meeting all of our regulatory requirements	• Top quartile for vacancy and turnover rates • Staff survey results in top quartile • Rated outstanding for well led	• Capital funding secured to deliver Trust strategies • Financial plan delivered • Staff will have access to real-time data via electronic systems	• All nationally required access standards delivered • A full partner in a functioning Integrated Care System (ICS) • Reduced activity delivered in acute setting • Acute Service Review delivered in partnership • Becoming a University Hospitals Teaching Trust

The last 12 months has been a challenging time for the Trust dealing with continued increase in demand in terms of operational pressures, waves of COVID-19, redeployment, internal critical incidents and a major incident in January 2022.

This has impacted on the delivery of year-2 IIP as projects have not been fully scoped up and only delivered what they can, in addition projects have been in a cycle of stopping and starting to support our operation staff in 'reducing the burden' which has hindered the delivery of our IIP.

From the 12 priorities within the IIP, there has been some achievement but insufficient for any of these priorities to achieve full delivery. Aligned to these 12 priorities are 10 strategic metrics which show where progress has been achieved with the Trust's ambition for 2021/22. However, these metrics need to progress in setting the new ambitions for 2022/23 through to 2024/25.

Of the 41 projects to help achieve the Trust's 12 priorities, the following is a breakdown summary of deliverables:

- 16 projects achieved full delivery of their 2021/22 deliverables
- 9 projects achieved part delivery of their 2021/22 deliverables
- 13 projects achieved no delivery of their 2021/22 deliverables
- 2 projects did not commence
- 1 project (Recovery Planning) was reverted to Operations Team.

Project	Deliverables	Deliverables Outcome	Status/Mitigation
PMO_2020_002 Ensuring early detection and treatment of deteriorating patients	• Implementation of Acute Illness Management (AIM) course • Increased BLS training provision to support all staff involved with paediatric care (part of the hidden child) • e-learning elements of sepsis screening training completed • Introduce Deteriorating patients training into Trust induction and clinical staff mandatory training	✓ ✓ ✓ X	Awaiting impact assessment following postponement of training due to COVID and redeployment.
PMO_2020_003 Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff	• Resource funding approved and recruited into posts • Implementation of Safeguarding Group Supervision and monitored through ESR • Development and implementation of a training schedule and pathway to support staff required to attend family court • Safeguarding training at a level of 90% to be achieved across Trust • Launch Liberty Protection Safeguards (LPS)	✓ ✓ ✓ X X	• Currently slightly below target, but robust reporting mechanisms in place • LPS rollout delayed by Department of Health. Will now be rolled out as 'business as usual' in 2022
PMO_2020_004 Maintaining HSMR and improving our SHMI	• Maintain Trust's HSMR performance • Top 25% for SHMI	X X	The Trust has moved to a 'Higher than expected SHMI' despite all 3 sites being within expected level. The Trust are currently in the process with their system partners in rolling out the Medical Examiner (ME) service for community deaths. This will enable greater learning on deaths in 30 days post discharge.
PMO_2020_005 Delivering on all CQC must do actions and regulatory notices	• The Trust is no longer in special measures	✓	
PMO_2020_006 Ensure continued delivery of The Health and Social Care Act (2008): code of Practice on the prevention and control of infections and related guidance 'Hygiene Code'	• Estates Refurbishment Project is in place and now being implemented to ensure compliance • Robust governance process implemented and embedded	✓ ✓	

Project	Deliverables	Deliverables Outcome	Status/Mitigation
PMO_2020_010 Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers	• Patient Panel • Expert Reference Groups • Experts by Experience • Reaching out to Community Groups	✓ ✓ X X	Patient panel continues to develop and mature with regular review. Expert Reference Group developing with an aim towards Experts by Experience. Delay in reaching out to Community Groups
PMO_2020_014 Review of Pharmacy model and service	• Aseptic Joint Venture with the University and Co-op Phase One • Review of Pharmacy Staff Structure, gap analysis and workforce review	X X	Aseptic new build project is progressing with an end date expected 31/07/2022. Business cases being written/reviewed/ identifying funding; these factors are dependent on the skill mix review/ structure.
PMO_2020_063 Development and implementation of new pathways for Paediatric Services		X	Project continually re-scoped throughout year-2. Charity bid successful and agreement reached for this project. Work being undertaken to understand future requirements and focus.
PMO_2021_002 Ensuring safe surgical procedures	• Achieved 100% compliance with the Five Steps to Safer Surgery • Embedded monthly Quality Observational Audits • Shared learning from incidents now embedded through monthly team meetings • Achieved and sustained 15% reduction medication incidents	✓ ✓ ✓ ✓	All year-2 deliverables achieved.
PMO_2021_003 Improving the safety of Medicines management		X	Highlighted in CQC report. Poor Divisional attendance at Action Group Meetings and Medicines Quality Group is hindering delivery of progress. Awaiting report from Grant Thornton.
PMO_2021_005 Trust wide Children's standards		X	Project being re-scoped as to what a paediatric setting entails.
PMO_2021_006 Maternity Transformation	• Achieved a 20% reduction in the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries • Reduction in term admissions	✓ ✓	This is an agile project and the team are working through the national guidance as and when this is received to ensure compliance with all relevant standards. There is no project end date as this work will be ongoing. Work is monitored through the Maternity Improvement Plan which is managed as a live document, updated with any new standards received, which is reported into the Maternity and Neonatal Oversight Group.
PMO_2021_007 Fractured neck of femur rehab	• Delivering the national target of #NOF 36 hours • Delivering the Trust's ambition of #NOF 48 hours	X ✓	This performance metric continues to be monitored through the Surgery's Division Scorecard.

Project	Deliverables	Deliverables Outcome	Status/Mitigation
PMO_2020_015 Embed robust workforce planning and development of new roles		X	In December 2021 this project was paused on the instruction from the interim Director of People & OD as further defining is required. A follow up meeting with PMO on 22 February 2022, this work is still in progress and will be completed early 2022/23.
PMO_2020_017 Delivery of annual appraisals and individual performance management system that ensures quality discussions and alignments of objectives to improve performance (organisational and individual)	• Implemented WorkPal an online management system • Achieved 20% target of appraisals now completed within WorkPal	✓ ✓	Project is completed around the rollout of WorkPal. This is 'business as usual' and will be monitored through the Division's scorecards.
PMO_2020_018 Talent Management: Creating a framework for people to achieve their full potential	This project did not commence as still awaiting for the national framework to be launched.	X	In December 2021 this project was paused on the instruction from the interim Director of People & OD as further defining is required. A follow up meeting with PMO on 22 February 2022, this work is still in progress and will be completed early 2022/23.
PMO_2020_021 Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	• Implementation of revised TNA system	X	In December 2021 this project was paused on the instruction from the interim Director of People & OD as further defining is required. A follow up meeting with PMO on 22 February 2022, this work is still in progress and will be completed early 2022/23.
PMO_2020_024 Improving the consistency and quality of leadership and line management across ULHT	• Launch of leaders toolkit V2.0 • Implemented preceptorship (RTS) Programme	✓ ✓	Two deliverables were achieved, however, in December 2021 this project was paused on the instruction from the interim Director of People & OD as further defining is required. A follow up meeting with PMO on 22 February 2022, this work is still in progress and will be completed early 2022/23.
PMO_2020_025 Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation	• Creation of Patient Equality, Diversity & Inclusion dashboard • Implementation of Council of Staff Networks • Commencement of Cultural Intelligence Awareness Sessions	✓ ✓ ✓	The three deliverables set for 2021/22 have been achieved, however, further deliverables are required to address the concerns around equity of treatment and opportunity within ULHT for 2022/23.
PMO_2020_037 Implementing a robust policy management system	Project was removed from IIP as 'business as usual'.	N/A	Project is closed and handed over as 'business as usual'. Monitoring is through the Executive Leadership Team.

Project	Deliverables	Deliverables Outcome	Status/Mitigation
PMO_2020_058 Support the consultation for Acute Service Review (first phase)	• Public consultation ended 31/12/2021 • Trust responding to public comments and suggestions by 28/04/2022	✓ X	Trust currently responding to public consultation comments and suggestions and will achieve the 28/04/2022 deadline.
PMO_2020_059 Improvement programmes for cancer	This project did not achieve the deliverable of the strategic metric **Deliver 62 Day Combined Standard Trust ambition of 77%.**	X	Due to key areas of services within a cancer pathway being paused, ie, diagnostics, surgery, the Trust's ambition of achieving 77% has not been achieved. The reasons for these pauses are due continued operational pressures, waves of COVID, internal critical incidents and a major incidents. The impact of this has led to an increase in the waiting list backlog for patients awaiting their treatment.
PMO_2020_060 Improvement programmes for outpatients	Achieved and sustained the strategic metric **deliver outpatient activity on non face-to-face >25% since April 2021.**	✓	
PMO_2021_013 University Hospital Teaching Trust status	• A draft Joint Strategy between ULHT and University of Lincoln • Road map developed to engage Divisional teams to work towards the increased number of Clinical Academics • Relationships developed between the project team and Research & Innovation, Medical Education and wider stakeholders such as nursing colleagues and AHP leads	X X ✓	The reason for the two deliverables that have not achieved are due to awaiting for finances to be agreed and for a formal discussion through TLT. Original ambition set for 2021/22 was to achieve, but as project progressed it became clear that post the changes to UHA Guidance in the Summer 2021, this was going to be unrealistic. Board and People & OD updated to that effect and an acceptance the original aim to have achieved by 2025 as per IIP was more deliverable.

Project	Deliverables	Deliverables Outcome	Status/Mitigation
PMO_2020_011 Improving Respiratory services programme	• Develop a Trust wide model for non-invasive ventilation (NIV) • Executive agreement to ring fence NIV beds on both Pilgrim and Lincoln Hospital sites • Treatment Rooms for Pleural Procedures in line with NCEPOD compliance • Complete a review of the COPD pathway and implementation of best practice	✓ ✓ ✓ X	The COPD pathway will now be addressed in line Integrated Care System plans.
PMO_2020_042 Continual improvement towards meeting PLACE assessment outcomes	• Catering leads attending wards to complete food service survey • Handy Persons appointed • PLACE Lite Audits implemented on a monthly basis • Develop a cleaning equipment management process to include asset records, maintenance and repair schedules and life-cycling • PLACE communication document to outline protocols and impacts on scoring plus training sessions for PLACE team leaders	✓ ✓ ✓ ✓ X	PLACE communications and training will be addressed as 'business as usual' in the months leading up to the next official PLACE assessment due in September 2022.
PMO_2020_044 Continued progress on improving infrastructure to meet statutory Health and Safety compliance		X	
PMO_2020_046 Delivering Financial Plan	For the deliverables around this project, please refer to the Finance Assurance Report submitted to FPEC as a separate report.	✓	
PMO_2020_048 Implementing the CQC Use of Resources Report recommendations	This project is one of the elements within the PMO_2020_045 Delivering Financial Plan.	✓	
PMO_2020_050 Commence implementation of the electronic health record		X	This project is still being worked up into a business case hence why no deliverables achieved during 2021/22.
PMO_2020_051 Implement a single new business intelligence platform that supports decision making and drives improvement	• Implementation of a business intelligence platform (Microsoft Power BI)	✓	

Project	Deliverables	Deliverables Outcome	Status/Mitigation
PMO_2021_004 Improving Gastroenterology Services Programme		X	Project did not start during 2021/22.
PMO_2021_008 Recovery Planning	This project was handed over to the interim Deputy Director of Operations as agreed by Executive Leadership Team in August 2021. The Recovery Plan had its own reporting, governance and assurance process which fell outside of IIP and PMO.		
PMO_2021_011 Urgent Care improvement programme	Project did not start during 2021/22.	N/A	Carried forward into year-3 of the IIP as a programme.
PMO_2021_012 Community Hospital review	• Re-scope of project completed with new objectives in place.	✓	Focus for year-3 is working up a project initiation document into implementation.

Our key risks and issues

Workforce

During 2021/22, we maintained our efforts to recruiting to vacant medical posts. However recruitment and retention of medical and nursing staff remains one of our key risks. The Trust continues to focus on staff and engagement and the restructuring of development pathways and alternative workforce models to mitigate the risk to service provision and poor patient experience.

The most recent staff survey highlighted that the Trust has a long journey ahead to improve the experience of staff within the Trust with the Trust ranking among the bottom of acute trusts in terms of average ranking. The Trust has taken this opportunity to focus on a number of areas for action. The Trust has joined the NHS Culture and Leadership programme with seven key actions:

- Prioritise investment in our leaders and their development;
- Engage staff in resetting our organisational values and better using them as part of our recruitment and appraisal processes to hold people to account;
- An overhaul of the appraisal process;
- Ensuring our organisational priorities resonate with staff;
- Further development of work already underway to improve our organisational culture;
- Look at more opportunities to engage and involve staff directly in improving patient care and services;
- Introduce an employee assistance programme.

Removal of Special Measures

In March 2022 the Trust was delighted to be able to announce that it was no longer considered to be in quality and financial special measures, following a re-inspection by the Care Quality Commission (CQC) during October, November and December 2021.

The outcome from the most recent inspection in 2021 was ‘requires improvement’ however the widespread improvements made in quality and safety of services was reported by the CQC across a number of domains. The Trust ratings for being effective and well led went from requires improvement to good. The safe and responsive domains remain requires improvement and caring remains good.

While widespread improvements had been made, there were still concerns regarding access and flow in the urgent and emergency department at Lincoln County Hospital. People continued to experience delays in accessing the service and receiving care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were still below national standards.

The Trust is still the subject of two section 31 notices under the Health and Social Care Act 2008, which impose conditions on the registration of the Trust as a provider in respect of regulated activities. The CQC took this urgent action in 2019 as they believed a person would or may be exposed to the risk of harm if they had not done so. Imposing conditions means that the Trust must manage regulated activity in a way which complies with the conditions set by the CQC. The conditions related to the emergency department at Pilgrim Hospital, Boston and the emergency department at Lincoln County Hospital.

On 6 July 2021 and 7 July 2021, a virtual visit took place to Radiotherapy and Interventional Radiology with regards to ‘Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)’. This identified that a number of improvements were required and the CQC issued an Improvement Notice to the Trust with actions to be completed by 31 August 2021. On 24 August 2021 the Trust received an interim visit from the CQC to review progress on actions taken to date. Following this visit, communication was received from the CQC on 31 August 2021 advising that the Improvement Notice had been removed due to the progress noted at the visit on 24 August 2021.

On 1 September 2021 the Trust received confirmation that the CQC intended to pursue a prosecution of the Trust for offences under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for breaches of Regs 12 and 22 in respect of failures in the care of service users including a patient. The Trust appeared at Boston Magistrates Court on 25th March 2022. The Trust pleaded guilty to the charge and were awarded a fine of £100,000 in addition to payment of the CQC costs relating to the prosecution. The Board continues to receive updates on the closure of actions relating to this case with assurances provided on residual actions by both the Audit and Risk Committee, Quality Governance Committee and Finance, Performance and Estates Committee.

Within the 2022 CQC report there are 5 “Must Do” areas for improvement identified and 38 “Should Do” areas for improvement. These improvement initiatives have been been built into improvement plans for 2021/22.

In summary, the CQC report showed the ratings following the 2021 inspections as follows:

Title	**Rating**
Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well Led	Good
Overall	Requires Improvement

It is our ambition to continue to improve the CQC rating to ‘good’ at our next inspection.

Ockenden Response

On 10 December 2020, the Ockenden report was published outlining the ‘Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust’.

The Ockenden reports make recommendations regarding information Boards should receive to ensure that they have sufficient oversight and assurance regarding maternity services. In addition to this, there are criteria within the CNST safety standards that require oversight by the Board. To ensure that the Board receives the appropriate level of data and information to discharge its responsibilities, whilst also ensuring that the correct level of challenge takes place at the Quality Governance Committee, a review was undertaken and recommendations made regarding the information to be received by both parties. This has taken the form of a Maternity Dashboard and supplementary Maternity Assurance Report outlining those aspects not able to be included in a dashboard and other issues for escalation and by exception.

To ensure that the Trust had sufficient support to and assurance of Midwifery Services, it was agreed to set up a Maternity and Neo-natal Oversight Group chaired by the Director of Nursing and a sub-group of the Quality Governance Committee.

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 but unfortunately these have not been able to meet the underlying demand and additional growth.

Work continues with the Lincolnshire health and social care system to reduce delays in handovers when ambulance convey patients to the Trust.

The Future: Looking ahead to our vision, ambitions and strategies for 2022/23

Our Integrated Improvement Plan (IIP) describes our ambition for “outstanding care personally delivered”. We will deliver our vision through four strategic objectives that form the basis of our 5 year plan, which covers our patients, services, people and partners.

In setting our IIP, we specified a series of outcomes that we aim to achieve by 2025. This paper provides an overview of the process undertaken to refresh year 3 of our IIP.

We have adopted a top down and bottom up approach to help co-create our 2022/23 priorities and associated outcomes. We have achieved this through several workshops and strategic thinking sessions held with our Trust Board, Executive Team, Divisional Leadership Teams and our senior teams.

In April 2022, we refreshed our priorities, metrics and outcomes – aligning these with the ambitions of the Trust and the new operating environment post COVID.

The Trust is working with the whole Lincolnshire health and care system – engaging with the whole community on proposals for improvements to services, where patients can be seen and treated rapidly in the right care setting, first time. 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.

The system has just concluded its consultation with the public on some of these changes, changes that will address the fragility issues of some services.

Going Concern

In preparing these Financial Statements, all organisations are required to consider whether it is appropriate to prepare financial statements on a ‘going concern basis’.

HM Treasury's Financial Reporting Manual provides the following interpretations of going concern in the public sector context:

- For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.
- DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

On-going service provision by the United Lincolnshire Hospitals NHS Trust is confirmed. It is therefore appropriate to prepare the Annual Financial Statements on a Going Concern basis.

There is an expectation the Trust will continue in operation for the foreseeable future and will be able to realise assets and discharge liabilities in the normal course of operations.

Performance Analysis

Overview

Performance has remained below our expectations during 2021/22. 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 (IPR) 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. This has been reviewed this year, incorporating Statistical Process Control (SPC) charts, and changes well received by both the Board and also regional and national colleagues, including NHSE/I and the Making Data Count team.

We have kept our focus on infection control and constitutional standards throughout another year impacted by the Covid-19 pandemic. 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.

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 number of factors including: the impact of the Covid-19 pandemic on our ability to see and treat patients within acceptable timescales; and a growth in demand for services that has increased at a greater rate than we have been able to increase capacity for, 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 Apr to Jun	Quarter 2 Jul to Sep	Quarter 3 Oct to Dec	Quarter 4 Jan to Mar	Total 2021/22
A&E: Proportion of patients spending less than 4 hours in A&E	83%	72.51%	64.67%	64.16%	62.12%	65.87%
A&E: 12 hour trolley waits	0	4	92	757	1,936	2,789
Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	>99%	70.05%	66.38%	64.12%	62.09%	65.65%
Referral To Treatment (RTT) waiting times incomplete pathways (18 weeks)	84%	59.64%	57.12%	55.27%	52.33%	56.09%
RTT over 52 weeks	0	1,056	1,114	1,989	3,418	22,729

Performance Indicator	Target	Quarter 1 Apr to Jun	Quarter 2 Jul to Sep	Quarter 3 Oct to Dec	Quarter 4 Jan to Mar	Total 2021/22 up to Mar
Cancer: % of 2 week GP referral to 1st outpatient appointment	93%	79.32%	77.39%	65.45%	60.14%	70.58%
Cancer: % of 2 week GP referral to 1st outpatient- breast symptoms	93%	7.78%	16.19%	5.24%	6.73%	8.99%
Cancer: % of patients treated within 62 days of referral from screening	90%	72.87%	71.72%	68.17%	39.83%	63.15%
Cancer: % of patients treated within 62 days of referral from hospital specialist	85%	80.11%	73.77%	71.62%	66.83%	73.08%
Cancer: % of patients treated within 62 days of referral to treatment of all cancers	85%	62.90%	62.92%	48.37%	50.51%	56.18%
Cancer: % of patients treated within 31 days	96%	92.83%	90.09%	91.46%	87.59%	90.49%
Cancer: % of patients for second or subsequent treatment treated within 31 days – surgery	94%	81.83%	70.65%	65.61%	67.35%	71.36%
Cancer: % of patients for second or subsequent treatment treated within 31 days – drug	98%	99.43%	99.76%	99.27%	97.55%	99.00%
Cancer: % of patients for second or subsequent treatment treated within 31 days – radiotherapy	94%	97.80%	94.58%	97.66%	97.39%	96.86%

Challenges do remain as we move into 2022/23, with a strong recovery focus on elective waiting lists and reducing waiting times; and an improvement focus on A&E and cancer standards. These areas are underpinned by system-wide action plans in collaboration with our health and social care partners. With activity levels increasing, improved efficiency and increased productivity are key. However, targeted investment and successful recruitment will also be required in order to meet the demand upon our services.

Delivery of financial plan

The Trust plan for the year 2021/22 was a surplus of £1.8m, and the Trust delivered an adjusted financial performance surplus of £1.982m or £182k favourable to plan. For the purpose of measuring system financial performance, gains of £142k from disposal of assets are removed, such that the Trust delivered a surplus of £1.84m or £40k favourable to the Trust's plan to deliver of surplus of £1.8m. Within the financial envelope, the Trust managed the operational pressures in respect of COVID whilst trying to restore services to pre-pandemic levels. The financial performance of the Trust is scrutinised on a monthly basis by the Finance, Performance and Estates Committee to gain assurance in respect of financial delivery.

The Trust fully maximised the capital resources of £48.6m available to it in 2021/22 through investment in its Estate infrastructure and improving and modernising its Digital and Equipment assets.

Performance against national targets

A&E performance

The Trust's performance for urgent care remained below the improvement trajectory of 83.12%, set in 2019/20. Based on the onset of Covid-19, and in the absence of a further request to set a new trajectory, performance was mapped, during 2021/22 against the 83.12%. Whilst this was not a nationally challenged trajectory the 82.12% remained as an internal ambition during 2021/22.

In May 2021 the format of reporting Urgent and Emergency Care (UEC) to both the Finance, Performance and Estates Committee and Trust Board changed in line with the organisations desire to retain historic performance targets, such as the 4 hour transition at 83.12%, and in order to prepare for the revised constitutional standards. The new reporting format would allow once the constitutional standards, based on clinical review, had been accepted, the Trust to declare performance against these standards at the appropriate time.

During 2021/22 the Trust made significant reporting changes based on one of the field sites for the constitutional standards review, adopting the Integrated Performance Report (IPR) format and worked, in shadow form, against the UEC standards.

Following suspension of the emergency department at Grantham Hospital to create a “Green” site from June 2020 this was returned to the original model in June 2021 and reporting of ED type activity returned.

The key drivers for this under performance include:

- Increased attendances in our Emergency Departments
- Increased number of ambulance conveyances across the 3 acute sites
- Ongoing workforce issues with both Medical and Nursing, particularly at Pilgrim and Lincoln
- High acuity, increased admission demand and sub-optimal discharges resulted in higher bed occupancy (consistently over 90%) which impacted on an 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%
- Segregation of departments between high risk and low risk patients from a Covid-19 perspective, had an unintended consequence of affecting 4 hour performance
- Impact of critical incidents and unprecedented levels of staff sickness due to the impact of the Covid-19 Omicron variant
- Multiple exit blocks were seen during 2021/22 resulting in delayed discharges and flow issues through the hospitals

Because 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 that have been taken during 2021/22 included:

- Since October 2019, the Midlands Region agreed the 'rapid handover process' in an attempt to eradicate >4 hours handover delays and an improvement trajectory was agreed to significantly reduce >60minutes ambulance handover delays. A formal process is now in place to enact "immediate" handover where a lack of confidence by site in collective Acute and East Midlands Ambulance Services NHS Trust (EMAS) conversation will not result in release of crews

- The completion of plans to increase both the Pilgrim and Lincoln Emergency Department footprint including a complete 'rebuild' of the Emergency Department at Pilgrim continues. Agreed work completed at Lincoln with the UTC and internal redesign and continued construction is underway at Lincoln for the Emergency Department

- 2021/22, the Trust continued to lobby and achieve agreement on the use of the £21.2m to rebuild the Pilgrim Emergency Department

- 2021/22 has continued to demonstrate in excess of 35% primary care streaming

- Investment in the nursing and medical rotas to right size the staffing to meet demand (recruitment continues)

- In June 2021, 6 week intensive support intervention from Emergency Care Intensive Support Team (ECIST), to review discharge and flow for pathway 0 proved successful during the intervention period. Traction decreased once ECIST moved away however subsequently, as of beginning of May 2022, the Trust has enlisted and agreed medium to long term support form ECIST and flow key leaders now in place to realise sustained improvement

- Clinically led Multi Provider Discharge Events (MADE) take place every 8 weeks across all sites

- System wide MADE programme now in place, under direction of System Flow Director

- Work now completed with East Midlands Ambulance Service to redesign the Computer Aided Dispatch. Non ED conveyance to alternative pathway is now in place

Ongoing plans are in place for improvement in 2022/23. These include:

- Improved ambulance handovers and conveyance
- Streaming services co-located where possible, with the introduction of a “Health Assessment Village” which serves as one front door for UEC activity. This starts with nurse triage to direct patients as appropriate, flowing through GP Streaming, UTC, Pharmacy or ED
- Workforce issues are being addressed including sickness levels and calibre of locums or trained nursing staff
- Continued advancement of the Care Closer to Home project
- Joint offer from Health and Social Care in terms of discharge to asses, part of Home First Partnership
- Urgent assessment centre for mental health to support direct pathways and more timely response to ED
- Extended use of LIVES and Clinical Emergency Medicines Support (CEMS) team through EMAS

Diagnostic performance

Ultrasound is gaining a backlog and is around 1400 and growing, due to the AQP provider being closed down by the CQC. We are seeing around 2000 additional requests a month for ultrasound which we do not have funded capacity for - business cases are being worked up.

MRI, CT and Dexa have been affected by the fire in Lincoln at the end of March 2022. Although inpatient capacity has been managed, this is at the cost of OP and GP requests, we are seeing a steady growth in breaches in these areas. We are looking at mutual support and additional capacity via mobile solutions.

Endoscopy is in general achieving the target but when additional clinics are undertaken within the Trust this causes temporary changes in performance.

Overall demand is increasing post Covid and is putting pressure on capacity.

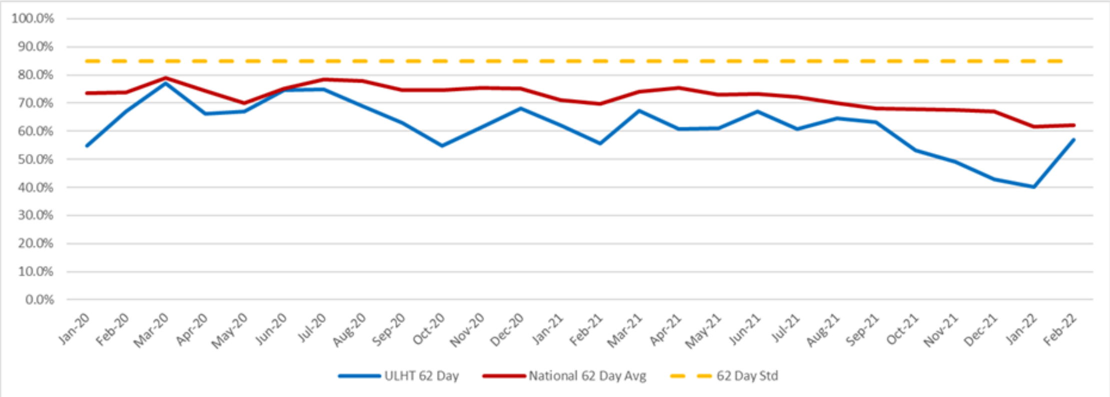
The backlog for echocardiograms is currently 6101 over 6 weeks, increasing at a rate of circa 200 per month. We are working through options to increase activity with locum agencies and by using new reporting software due to go live at end of July which should increase our activity in the Community Diagnostic Hub and on the acute sites. An external consultancy is supporting us by working through efficiency options with the Clinical Business Unit (CBU) as well as assisting in moving the admin function back to the Medicine CBU.

Cancer

Cancer performance within the Trust was below the national standard for 14-day and 62-day during 2021/22. 31 day first treatments also remained below the national standard for the same period. 31-day subsequent chemotherapy and radiotherapy were achieved during 11 of the 12 months. However, 31-day subsequent surgery performance has been less successful, not achieving the standard at all during this period.

During 2021/22 there was a 25% increase in referrals on the suspected cancer pathway compared with 2020/21 and an increase of 17% compared to 2019/20.

For the first two quarters we saw relatively stable performance against the 62 day standard, averaging at 60-67%. The winter months saw a deterioration of performance nationally though our performance reduced more rapidly to as low as 40.2% in Jan '22. This was partly due to the challenges with recruiting to Consultant posts across a number of specialties, the impact of critical incidents and unprecedented levels of staff sickness, and continuing capacity challenges spanning from 2week wait and Follow up outpatient capacity to Theatre capacity.



The over 62 day backlog has reached unprecedented levels of as high as 556 in January 2022 and remains elevated in May 2022 at 496. The Trust is managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and Upper GI. Treating the diagnosed element of the backlog will continue to impact performance against the 62 Day Standard until the backlog, particularly in Colorectal, is recovered.

Performance against the 62 standard is forecast to recover to 54% in March 2022.

The Trust has focused on reducing the backlog of patients over 62-days, maintaining a level within trajectory until Easter '22 where the impact of multiple Bank Holidays with associated annual leave has shown a significant deterioration, together with the ongoing pathway, staffing and capacity challenges.

Actions undertaken to improve performance

During the course of 2021/22 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 Divisional Managing Director for Clinical Support Services.

18 weeks referral to treatment (RTT)

The Trust's performance in March 2022 was 52.9%, in March 2019 it was 84.6%, a decrease of 30.7%.

The number of incomplete pathways waiting for treatment has jumped from 49,793 to 75,472, rising by 51.57% (25,679) in 3 years.

35,541 patients are waiting over 18 weeks. Of these 4,776 are over 52 weeks and 44 are over 104 weeks. Compared to 2019 when there were 8,175 over 18 weeks, 10 over 52 weeks and 0 over 104 weeks.

The decrease in performance from March 2019 to March 2022, shows the detrimental effect the Covid 19 pandemic has had, particularly the ongoing issues with workforce. The Trust has, at times during this period; had to cease elective activity. The delivery of planned, routine elective work, has been challenging. Non admitted activity services continued; implementing new ways of working to use all available media. This included changing face to face consultations to telephone, and introducing advice and guidance and results clinics to consult with patients.

Admitted patients are now individually graded and allocated a priority code. It is anticipated that the introduction of the artificial intelligence systems will positively affect the efficiency and effectiveness of this process. Available capacity remains focussed on cancer, paediatrics, daycases and patients classified as being Priority 2.

Recovery of routine elective work for both admitted and non- admitted activity, has also been hampered due to the Trust experiencing extreme pressure in its emergency service provision necessitating in declaring several Critical Incidents.

To aid recovery, patients are being assessed for their suitability to be transferred to Independent Sector Providers and offered this choice for treatment. This piece of work is being undertaken jointly, through collaboration with health and social care colleagues. A review of the Trust's Infection Prevention and Control measures are currently taking place, together with assessment of high volume low complexity cases; which could also have a positive impact on utilisation of elective capacity.

The figures below show the specialities with the biggest change between 2019 and 2022, with regard to open/incomplete pathways.

- ENT had the highest increase in incomplete pathways at 3,859 (70.6%), rising from 5,464 to 9,323
- Gastroenterology increases by 3,163 (120.5%), rising from 2,625 to 5,788
- Dermatology increases by 3,151 (111.6%), rising from 2,823 to 5,974.

These three specialties also account for 58% of open pathways waiting over 52 weeks

Sustainability

The Trust's newly drafted Green Plan seeks to embed sustainability and low carbon practice in the way vital healthcare services are offered and help the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions.

The climate crisis is also a health crisis. Rising temperatures and extreme weather will disrupt care and impact the health of patients and the public, especially the most vulnerable in society.

People with mental health issues may experience a higher degree of 'climate anxiety', and there may be co-morbidities associated with the physical impacts of climate change and a deterioration in mental health.

Then Trust has a central role to play in reducing health inequalities and helping the NHS to reach net zero.

The Trust's Green Plan serves as the central document for ULHT's sustainability agenda and provides the rationale for sustainability at the Trust. Through this Green Plan, ULHT will work with staff, patients and partners to take powerful sustainable development and climate action as part of the Trust's commitment to offer the highest quality care to the Lincolnshire community.

The Trust will establish a Sustainability Committee that will project manage the delivery of Green Plan activities by multiple teams. The Green Plan will be incorporated as a part of the Sustainability Committee agenda, reviewed annually, and updated where necessary to ensure continual improvement.

Emergency Preparedness

In 2021/22 the Trust self assessed as fully compliant with 39 of the 46 Emergency Preparedness Resilience and Response (EPRR) core standards. The standards which were partially compliant related to review of business continuity planning and decontamination training.

During 2021/22 the self assessment submission was completed at a system level. The Lincolnshire system received an overall assessment of compliance as substantial.

A living framework travel plan is being developed, together with site-specific plans on an online platform, where initiatives and actions are updated to meet the targets and objectives that the Trust has set. The objectives include working with partners, including local authorities and service providers, to support the local transport strategies and local transport plans. As one of the largest employers in the county, the Trust is committed to reducing CO2 emissions, improving the local environment and improving air quality. The travel plan will be utilised when progressing with the emerging estates strategy and development control plan.

Overseas Visitors

The National Health Service provides NHS funded healthcare to people who are ordinarily resident in the United Kingdom. When a person who is not ordinarily resident in the UK (an "overseas visitor") needs NHS treatment they will be subject to the National Health Service (Charges to Overseas Visitors) Regulations 2017 (the "Charging Regulations") and may incur a charge for treatment.

In accordance with the Charging Regulations the Trust has a legal obligation to make and recover charges for NHS treatment in relation to any person who is not ordinarily resident in the United Kingdom.

Operational requirements

In order to enforce our legal responsibilities the Trust is required to have systems and staff in place who possess the appropriate skills to:

I. Identify, without discrimination, and at the earliest possible opportunity, all patients who may be liable to charges;
II. Interview patients to establish if they are ordinarily resident or not, and if not, whether they are exempt from or liable for charges;
III. Make and recover charges from individuals who are not covered by an exemption category, providing them with a written statement of why charges apply, the level of charge/s and how they can pay.

The Trust must ensure that it's human rights obligations are not compromised by the application of the patient eligibility assessment, failure to provide immediately necessary treatment may be unlawful under the Human Rights Act 1998. In situations where the patient is not eligible for NHS funded care, but where treatment is immediately necessary, the Trust will seek to begin the recovery of treatment fees as soon as the patient is well enough.

Similarly, treatment which is not immediately necessary, but is classed as urgent by clinicians (in that it cannot wait until the patient can be reasonably expected to return home), should also be provided, although in these instances payment would be sought ahead of treatment.

The Overseas Visitors Team are responsible for delivering training to all relevant front line staff in order to ensure they have an awareness of the requirements for assessment of overseas patient eligibility. This training includes examples of baseline questions that are used in the assessment process and examples of documentation that can be used to assess patient eligibility.

The Overseas Visitors team have access to a national support network ensuring that legislative changes and ways of working are continuously refreshed where appropriate.

Signed……………………..

Chief Executive   Date: 17 June 2022

Accountability report

The purpose of the accountability section of the annual report is to meet key accountability requirements to Parliament. The requirements are based upon those dealt with in a Directors' Report, under the Companies Act 2006 and adapted for the public sector context.

The Trust external auditors have reviewed the accountability report for consistency with other information in the financial statements. Specific items which have been audited are marked as such.

The accountability report contains two sections:

- The corporate governance report.
- The remuneration and staff report.

Corporate Governance Report

Directors' report

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 2021/22, this committee consisted of the chair and the non-executive directors.

Board Changes

During the year there were the following changes to the Trust Board membership and the status of director secondments as described below :

Andrew Morgan was substantively appointed following a long term secondment to the organisation as Chief Executive.

Dr Colin Farquharson joined the Trust as Medical Director in August 2021 replacing Dr Neill Hepburn.

Mr Martin Rayson left the post of Director of People and Organisational Development on the 31st July 2021. On an interim basis Mr Paul Matthew took on the role of Director of People and OD alongside his existing role of Director of Finance & Digital.

Mr Mark Brassington was seconded to NHS England and his role of Director of Improvement and Integration was covered through the secondment of Mrs Sameedha Rich-Mahadker to the Trust in November 2021.

Dr Karen Dunderdale took on the role of Deputy Chief Executive in addition to her role as Director of Nursing

Non Executive Directors Mrs Elizabeth Libiszewski, Mrs Gill Ponder and Mr Geoff Hayward left the Trust. Professor Philip Baker, and Mrs Daniela Cecchini joined the Trust as Non Executive Directors with Ms Gail Shadlock joining the Trust as an Interim Non Executive Director.

A full list of directors who have served during the year is shown within the remuneration report on page 59.

Audit and Risk Committee

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

For 2021/22, Audit and Risk Committee membership was as follows:

Sarah Dunnett, Chair (October 2017 – ongoing)

Geoffrey Hayward (July 2013 – July 2021)

Gill Ponder (April 2017 – July 2021)

Elizabeth Libiszewski (March 2018 – December 2021)

Chris Gibson (January 2022 – ongoing)

Philip Baker (July 2021 – ongoing)

David Woodward (July 2021 – December 2021)

Daniela Ceccini (January 2022 – ongoing)

Declarations of interest for each member of the Trust Board can be found on the Trust website

https://www.ulh.nhs.uk/about/trust/declarations-of-interest/

Data-related incidents

The Trust had 14 information governance data breaches which were reportable in line with the Information Commissioners Office guidance in 2021/22. In all cases the ICO were satisfied with action taken by the Trust and have closed the incident. No financial penalties were issued.

Declaration: Audit of the Trust Annual Report and Accounts 2021/22

The Trust Board collectively and Directors individually confirm that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; have taken “all the steps that ought to have taken” to make themselves aware of any such information and to establish that the auditors are aware of it.

Statement of accounting officer’s responsibilities

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them

- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

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

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

Signed...Chief Executive

Date 17 June 2022

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 2022 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 Director of Nursing, 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:

- Identification and as far as possible the management of risks that they identify in the course of their duties
- Maintaining an awareness of the primary risks within their service or department
- Bringing to the attention of their line manager any risks that are beyond their ability or authority to manage
- 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 has been reviewed in year and 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.

As the Trust entered 2021/22 it continued to follow all national guidance and the Trust Board continued to where necessary apply streamlined governance arrangements which allowed rapid response to the changing situation whilst maintaining appropriate controls. The Board, Audit and Risk Committee and Assurance Committees continued to meet and received reports on how the pandemic was impacting on the operation of Trust services.

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 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 2021/22 adjustments were made to the board assurance framework to reflect the impact of the pandemic in relation to the progress with and assurances on the Trust strategic objectives. The Trust Board continued to consider the board assurance framework at each of its meetings

During 2021/22 the Board saw the following changes. Andrew Morgan was substantively appointed following a long term secondment to the organisation as Chief Executive.

Dr Colin Farquharson joined the Trust as Medical Director in August 2021 replacing Dr Neill Hepburn.

Mr Martin Rayson left the post of Director of People and Organisational Development on the 31st July 2021. On an interim basis Mr Paul Matthew took on the role of Director of People and OD alongside his existing role of Director of Finance & Digital.

Mr Mark Brassington was seconded to NHS England and his role of Director of Improvement and Integration was covered through the secondment of Mrs Sameedha Rich-Mahadker to the Trust in January 2022.

Dr Karen Dunderdale took on the role of Deputy Chief Executive in addition to her role as Director of Nursing.

Non Executive Directors Mrs Elizabeth Libiszewski, Mrs Gill Ponder and Mr Geoff Hayward left the Trust. Professor Philip Baker, and Mrs Daniela Cecchini joined the Trust as Non Executive Directors with Ms Gail Shadlock joining the Trust as an Interim Non Executive Director. Mrs Alison Dickinson joined the Trust in August 2021 as Non Executive Director before leaving in January 2022.

The role of each Board committee is to consider evidence provided by members of the Executive Team and the reporting assurance groups 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 Trust-wide in scope and extreme in terms of its potential severity. These are the risks that would fundamentally destabilise the organisation if they were to materialise.

During their well led review in November 2021 the Care Quality Commission (CQC) recognised the effectiveness of the BAF. The Head of Internal Audit (HOIA) Opinion found that the Assurance Framework in place is founded on a systematic risk management process and does provide assurance to the Board. The Assurance Framework does reflect the Trust's key objectives and risks and has continued to be reviewed at least quarterly by the Board.

There are 4 key strategic objectives defined within the 2021/22 BAF underpinned by more detailed underlying objectives with metrics and 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 metrics were identified in relation to each strategic risk in the BAF. Reporting against these metrics was included in regular management reports that provide the lead committees with evidence that associated corporate risks are being managed effectively. Lead assurance committees reviewed and challenged each corporate risk that is included in the BAF, to provide guidance and set expectations to support Trust management teams in developing and delivering their risk treatment strategies.

The Trust Board agreed a risk appetite statement in March 2019 during a facilitated Board Development session which was held to develop this. The risk appetite statement as part of the Risk Strategy was considered and agreed at the Trust Board in May 2019 and can be found on the Trust website. The risk appetite statement is currently under review.

In year significant work has been completed to strengthen the clinical governance function to support risk management. The Quality Governance Committee has given oversight to these actions.

The Integrated Performance Report continues to be reviewed in response to challenge from the Board about its ability to meet the Board's needs and has been aligned to the IIP. This improvement work continues.

Compliance with the CQC registration requirements are considered both by the Trust Board and Quality Governance Committee and the Audit and Risk Committee.

Risks to data security are specifically highlighted within the 2021/22 BAF. The treatment of these risks is through a cyber security plan and digital strategy which are reviewed at the Finance Performance and Estates Committee.

The key strategic risks to the organisation during 2021/22 that were the focus of consideration by the Trust Board and Executive were:

- The local impact of the global coronavirus (covid 19) pandemic
- The Trust financial position and financial controls during the pandemic;

- The ability of the Trust to attract and retain staff;
- Workload Management and staff morale
- Management of emergency demand
- Delays to planned care as a result of service changes during the pandemic

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

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

Managed and mitigated through:

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

And outcomes assessed through:

- Number & severity of patient safety incidents;
- Number of Serious Incidents / Never Events;

- Number & severity of Healthcare Acquired Infections (HCAIs);
- Number & severity of safeguarding incidents;
- Number & severity of medication safety incidents;
- Harm free care rate;
- Hospital Standardised Mortality Ratio (HSMR);
- Number & type of complaints;
- Number & severity of health & safety incidents;
- Delivery of constitutional standards.

It is noted that these areas will have seen the continued impact of the pandemic during 2021/22

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

Reporting to the Audit and Risk Committee has been maintained throughout the pandemic with regular assurance given in the form of reports on governance compliance, internal control weaknesses, the Board Assurance Framework and Risk Management.

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 encourages 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 Board Assurance Framework (BAF) and routinely monitored through the assurance committees of the Trust Board. Lead management groups (such as the Patient Safety Group; Information Governance Group; Health & Safety Committee) are responsible for reviewing and updating corporate risks within their areas of responsibility. With this framework the Trust utilises data from reported incidents to better understand areas of significant risk, so that mitigating action can be taken and reporting to both the Board and its Committees has been developed in year. Divisional

Triumverates are responsible for maintaining oversight of the management of operational risks by their Clinical Business Units (CBUs), 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 division within the Trust is expected to make active use of the risk register to support their management of risks. In addition, divisions provide a regular report on the content of their risk registers as part of the Trust's risk confirm and challenge process.

Following a review commissioned by the Director of Nursing a new Risk Register Confirm and Challenge Group was established and a revised risk register structure developed. The Risk Management Report presented to Board and Committees has also been strengthened. These developments have been reviewed and considered for effectiveness by the Audit and Risk Committee.

The Trust is not fully compliant with the registration requirements of the Care Quality Commission.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) 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 plans in place which takes account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with through this plan.

The Trust's approach in meeting the requirements of the above Modern Slavery and Human Trafficking Act 2015 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. The Trust also achieves this through ensuring that services are procured through approved suppliers or tendered through robust processes.

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 receives assurance reports from the Finance, Performance and Estates Committee following its monthly review of Trust financial and operational performance. In 2019 the CQC completed a Use of Resources review for the Trust which resulted in the Trust being rated inadequate. In 2022 following a CQC inspection in 2021 the Trust was able to announce that it was no longer in financial special measures.

The Trust did not set an operational plan for 2021/22 as a result of the pandemic.

The National Health Service Act 2006 requires that ‘in auditing the accounts of any NHS trust an auditor must by examination of the accounts and otherwise satisfy himself that... (d) the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources’. External audit planning work involved an assessment against a number of criteria, including those issued by the National Audit Office, to identify any significant risks to the above conclusion. External Audit present to the Audit Committee any significant risks identified and the planned audit response for consideration by the Committee. In April 2022 the Trust’s External Audit provider highlighted the following significant risks to the financial statements

- Management override of controls
- Risk of fraud in expenditure recognition
- Valuation of property plant and equipment
- Capital expenditure

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 and Registered Nurses is challenging, as is recognised in the 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 accordance with the published requirements and given day-to-day operational challenges, the Trust has business-as usual dynamic staffing risk assessments 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.

In accordance with CQC's well-led framework guidance (2018) and National Quality Board'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 to nursing associates and advanced clinical practitioners) would be considered a service change and must have a full QIA.

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 remains at an emerging level.

Stakeholder engagement

The Trust has continued a programme of engagement events with patients, members of the public, staff and other key stakeholders where possible particularly to help inform and develop the clinical and financial strategies, to support arrangements for service change. In 2020 the Trust was subject to a judicial review in relation to the public involvement ahead of the decision to create the Grantham green site and in April 2021 the Trust was found to have acted unlawfully. The Trust accepted the decision and agreed to review the machinery it had in place to engage and involve patients in it's decision making whilst reiterating that the actual decision taken had been found to have been made in good faith in responding to the unprecedented situation.

The Trust continues to work with the whole Lincolnshire health and care system – engaging with the whole community on proposals for improvements to services. This includes the centralisation of some services to provide centres of excellence. During 2021, the system have consulted with the public on these changes to address the fragility issues of some services. The output from this work is being collated to share in 2022.

Information Governance

The Trust had 14 information governance data breaches which were reportable in line with the Information Commissioners Office guidance in 2021/22. The incidents involved sharing personal information without consent with relatives, patient identifiable data in paper records misplaced, inappropriate access to Trust systems . In all cases the ICO were satisfied with action taken by the Trust and have closed the incident.

Data quality and governance

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, resource for refresher training and the inconsistent application of RTT codes to pathways despite training, as potential areas of risk to the data. The training programme developed and delivered by the 18 week team has slowed due to the pandemic. The team have ensure monthly returns have been validated were possible to ensure that figures were accurate.

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.

The roll out of a Data Quality Kite Mark continues. This is being applied to all metrics that are in the Trust Board Integrated Performance Report (IPR).

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.

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 Committee, Finance, Performance and Estates Committee and People and OD Committee as well as considering the Trust Integrated Performance Report and Board Assurance Framework. The

Board have continued to direct their work to improve the identified weaknesses in the control framework and governance arrangements throughout the pandemic whilst recognising the need to take action to reduce the burden where possible.

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 Board Assurance Framework and the risk improvement plans and have monitored the delivery of internal and external audit plans. Internal Audit plans were adjusted in year to reflect the demands of the pandemic, with some reviews being carried forward to 2022/23. The key reviews which would allow the Head of Internal Audit Opinion to be given were prioritised.

Clinical Audit

During 2021/22 the Trust participated in 100% 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 2021/22 of partial assurance with improvement required. The Opinion was based on:

- an assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- an assessment of the range of individual assurances arising from core and risk based internal audit assignments that have been reported

throughout the year. This assessment has taken account of the relative materiality of these areas;

- the extent to which the Trust responded to audit recommendations.

Partial Assurance with Improvement required has been given based on the scope of reviews undertaken and the sample tests completed during the period. Partial assurance with improvement required was given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control.

Internal Audit reported the following high risk areas and reported that the level of non-compliance in a number of areas puts some system objectives at risk.

Weaknesses were identified in relation to 13 out of the 16 areas reviewed.

- The most significant weaknesses were identified in the Recruitment review. The review identified a number of themes and weaknesses in controls which leaves the Trust vulnerable to fraud and/or unsafe recruitment through misrepresentations.
- The Data Quality – 12 hour waits review highlighted issues with discharge times and the accuracy of the audit trail to aid reporting.
- 16 high risk recommendations remained outstanding at the end of 2021/22 (9 overdue and 7 not yet due) it was noted that insufficient progress has been made in implementing the recommended actions from the Estates and Medicines Management reviews.

As such, the recommendations in these areas were rated high risk and until embedded, could impact on the ability of the Trust to achieve its strategic objectives.

Internal Audit recommendations should continue to be implemented in full to address the gaps identified in either design and / or operation of internal controls. In particular, recommendations from all reports receiving partial assurance with improvement required remain a key focus for attention.

Conclusion

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

- The Trust exited Quality special measures following the CQC inspection in February 2022, the Trust was assessed overall as

Requires Improvement. The Trust is not fully compliant with all registration requirements of the CQC.

- The Trust exited Financial Special Measures in February 2022. The Trust has continued to face significant financial challenges. A system led financial plan is in place for 2022/23 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 Trust has been placed in the NHS System Oversight Framework support segment 3, described as significant support needs against one or more of the five national themes and in actual or suspected breach of the licence (or equivalent for NHS trusts).
- The Trust also faces operational pressures with increasing demand as it restores services heavily affected by the pandemic. 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 county. The organisation relies heavily on agency staff to maintain services, this in turn increasing the challenge to further improve quality.

Overall, the Trust is clear on the issues and progress continues to be made in developing and implementing improvement plans, as well as the ongoing impact of the pandemic on the Trust plans, the Trust recognises that there remain some further improvements which it can make to its governance arrangements. The Board Assurance Framework remains under regular review 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: 17 June 2022

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 very 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.

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.

The Chief Executive has confirmed that the key decision makers within the Trust for the purposes of the Remuneration and Staff Report are Board Executive and Non-Executive Members.

The tables below detail the Salaries and Allowances paid during the year to each Senior Executive along with a table showing Pension Benefits at 31 March 2022.

There were no payments made to former Directors in 2021/22.

Single total figures remuneration table (the figures incorporated within the note below are subject to audit)

Name	Position	Notes	Term in post: Start	Term in post: Finish	2021/22 Salary (bands of £5,000) £000's	2021/22 Expense payments - taxable (total to nearest £100) £00's	2021/22 All pension-related benefits (bands of £2,500) £000's	2021/22 Benefits in kind total to nearest £100 £00's	2021/22 Total (bands of £5,000) £000's	2020/21 Salary (bands of £5,000) £000's	2020/21 Expense payments - taxable (total to nearest £100) £00's	2020/21 All pension-related benefits (bands of £2,500) £000's	2020/21 Benefits in kind total to nearest £100 £00's	2020/21 Total (bands of £5,000) £000's
Elaine Baylis	Trust Chair		Jan-17	Ongoing	40 - 45	6	-	-	40 - 45	40 - 45	5	-	-	40 - 45
Prof Philip Baker	Non-Executive Director		Aug-21	Ongoing	5 - 10	-	-	-	5 - 10	-	-	-	-	-
Dani Cecchini	Non-Executive Director		Jan-22	Ongoing	0 - 5	-	-	-	0 - 5	-	-	-	-	-
Alison Dickinson	Non-Executive Director		Aug-21	Jan-22	5 - 10	-	-	-	5 - 10	-	-	-	-	-
Sarah Dunnett	Non-Executive Director		Jul-16	Ongoing	10 - 15	-	-	-	10 - 15	10 - 15	-	-		10 - 15
Dr Chris Gibson	Non-Executive Director		Aug-17	Ongoing	10 - 15	-	-	-	10 - 15	10 - 15	-	-	-	10 - 15
Geoff Hayward	Non-Executive Director		Jul-13	Jul-21	0 - 5	-	-		0 - 5	10 - 15	-	-	-	10 - 15
Elizabeth Libiszewski	Non-Executive Director		Mar-18	Dec-22	5 - 10	1	-	-	5 - 10	10 - 15	-	-	-	10 - 15
Gill Ponder	Non-Executive Director		May-15	May-21	0 - 5	1	-	-	0 - 5	10 - 15	1	-	-	10 - 15
Gail Shadlock	Interim Non-Executive Director		Feb-22	Ongoing	0 - 5	-	-	-	0 - 5	-	-	-	-	-
David Woodward	Interim Non-Executive Director		Jul-21	Dec-21	5 - 10	1	-	-	5 - 10	-	-	-	-	-
Andrew Morgan	Chief Executive	1, 5	Jul-19	Ongoing	225 - 230	1	-	-	225 - 230	215 - 220	7	-	-	220 - 225
Paul Matthew	Director of Finance & Digital / Director of People & Organisational Development		Nov-18	Ongoing	150 - 155	-	40 - 42.5	-	190 - 195	140 - 145	-	155 - 157.5	-	295 - 300
Mark Brassington	Director of Improvement and Integration	2	Mar-16	Sep-21	60 - 65	3	-	-	60 - 65	145 - 150	10	82.5 - 85	-	230 - 235
Dr Karen Dunderdale	Director of Nursing & Deputy Chief Executive	5	Feb-20	Ongoing	160 - 165	3	-	-	160 - 165	160 - 165	-	-		160 - 165
Simon Evans	Chief Operating Officer	5	Jan-20	Ongoing	155 - 160	-	107.5 - 110	-	260 - 265	115 - 120	-	35 - 37.5	-	150 - 155
Dr Colin Farquharson	Medical Director		Aug-21	Ongoing	130 - 135	-	127.5 - 130	-	255 - 260	-	-	-	-	-
Dr Neill Hepburn	Medical Director	3, 5	May-17	Aug-21	70 - 75	4	-	-	70 - 75	-	-	-	-	-
Jacqueline Hunter-Grice	Director of People & Organisational Development	6	Aug-22	Sep-22	25 - 30	-	-	-	25 - 30	-	-	-	-	-
Martin Rayson	Director of People & Organisational Development		Sep-16	Aug-21	40 - 45	1	-	-	40 - 45	110 - 115	1	-	-	110 - 115
Dr Sameedha Rich-Mahadkar	Director of Improvement and Integration	4	Jan-22	Ongoing	20 - 25	-	0 - 2.5	-	20 - 25	-	-	-	-	-

Notes:

1. Andrew Morgan was seconded and costs recharged from Lincolnshire Community Health Services NHS Trust, until joining ULHT on a substantive basis in July 2021

2. Mark Brassington was seconded to NHSEI in September 2021, but remains on the ULHT payroll.

3. The salary for Dr Hepburn incorporates remuneration for his role as Medical Director and also for clinical duties as a Dermatology Consultant. He stepped down as Medical director in August 2021

4. Dr Rich-Mahadkar is seconded from Nottingham University Hospitals NHS Trust

5. Salary payments for Andrew Morgan, Dr Karen Dunderdale, Simon Evans and Neill Hepburn include pension restructuring payments in lieu of employer contributions to the NHS pension scheme

6. The salary for Jacqueline Hunter Grice includes £11,916 payment in lieu of notice. This is included as an 'Other Departure' within the Exit Packages note.

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.

Expense Payments

Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual.
Expense Payments relate to reimbursement for travel, subsistence and where appropriate re-location expenses. Figures presented are shown gross, before tax.

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 benefits in kind, performance related pay or bonus payments have been made in 2020/21 or 2021/22.

Pensions entitlement table (the figures incorporated within the note below are subject to audit)

The Trust operates the standard NHS Pension Scheme. The benefits and related CETVs disclosed in the table below do not allow for a potential future adjustment for some eligible employees arising from the McCloud judgement.

Name	Position	Notes	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Andrew Morgan	Chief Executive	1	-	-	-	-	-	-	-	
Paul Matthew	Director of Finance & Digital / Director of People & Organisational Development		2.5 - 5	0 - 2.5	35 - 40	20 - 25	398	40	439	
Mark Brassington	Director of Improvement and Integration		0 - 2.5	-	45 - 50	90 - 95	719	10	745	
Dr Karen Dunderdale	Director of Nursing & Deputy Chief Executive	1	-	-	-	-	-	-	-	
Simon Evans	Chief Operating Officer		5 - 7.5	5 - 7.5	25 - 30	50 - 55	292	77	371	
Dr Colin Farquharson	Medical Director		7.5 - 10	22.5 - 25	45 - 50	100 - 105	549	195	846	
Dr Neill Hepburn	Medical Director	1	-	-	-	-	-	-	-	
Jacqueline Hunter-Grice	Director of People & Organisational Development		0 - 2.5	-	25 - 30	65 - 70	549	2	579	
Martin Rayson	Director of People & Organisational Development	1	-	-	-	-	-	-	-	
Dr Sameedha Rich-Mahadkar	Director of Improvement and Integration		0 - 2.5	-	15 - 20	-	126	8	163	

Notes:

1. Andrew Morgan, Dr Karen Dunderdale, Dr Neil Hepburn and Martin Rayson are not current members of the NHS the pension scheme and have made no contributions during 2020/21.

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 and senior managers over Normal Pension Age (NPA).
NPA is age 60 in the 1995 Section, age 65 in the 2008 Section or State Pension Age (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).

Inflation

The inflation applied to the accrued pension, lump sum (where applicable) 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.
The Consumer Prices Index up to September 2020 was 0.5%, therefore, an increase of 0.5% has been applied to pensions and CETV at April 2021.

Fair pay disclosure (the figures incorporated within the note below are subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director / member in the United Lincolnshire Hospitals NHS Trust in the financial year 2021-22 was £227,500 (2020/21 £232,500). This represents a -2.2% decrease on the previous year.

The relationship between the remuneration of the highest paid director to organisation's workforce is disclosed in the following tables.

The first table sets out the remuneration and salary of the 25th, median and 75th percentiles within the workforce; while the second shows these as a ratio to the salary of the highest paid director.

To illustrate, the remuneration of the highest paid director in 2021/22 was £227,500, this being 5.28 times that of the 25th percentile worker who received £43,115 remuneration over the same period.

Year	25th percentile total remuneration £	25th percentile Salary £	Median total remuneration £	Median salary £	75th percentile total remuneration £	75th percentile salary £
2021/22	43,115	39,027	31,194	25,655	22,708	19,918
2020/21	41,939	37,890	30,090	24,907	21,955	19,337

Year	25th percentile total remuneration ratio	25th percentile Salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2021/22	5.28	5.19	7.29	7.89	10.02	10.17
2020/21	5.42	5.34	7.56	8.13	10.36	10.47

In 2021/22, 25 (2020/21,15) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £428,850 to £8,092 (2020/21 £385,056 to £8,897)

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

The movement in the pay ratios is attributable to there being a change in the highest paid Director between 2020/21 and 2021/22. In 2021/22 the Chief Executive was the highest paid Director. In 2020/21 this had been the Medical Director; remuneration for the post-holder at this time also included payment for clinical duties.

Staff report (the figures incorporated within the note below are subject to audit)

The following tables contain details of staff costs and numbers employed in 2021/22 alongside comparators for 2020/21.

Permanently employed staff are defined as: members of staff with a permanent (UK) employment contract directly with the Trust.

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

The tables exclude non-executive directors but include executive board members and staff recharged by other DHSC group bodies.

Staff Costs

Staff costs

	Permanent	Other	2021/22 Total	2020/21 Total
	£000	£000	£000	£000
Salaries and wages	323,895	2,187	**326,082**	307,805
Social security costs	30,953	-	**30,953**	27,861
Apprenticeship levy	1,613	-	**1,613**	1,483
Employer's contributions to NHS pension scheme	50,694	-	**50,694**	47,141
Pension cost - other	143	-	**143**	139
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	46,385	**46,385**	42,254
Total gross staff costs	**407,298**	**48,572**	**455,870**	**426,683**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**407,298**	**48,572**	**455,870**	**426,683**
Of which				
Costs capitalised as part of assets	1,278	321	**1,599**	559

Average number of employees (WTE basis)

	Permanent	Other	2021/22 Total	2020/21 Total
	Number	Number	Number	Number
Medical and dental	922	231	**1,153**	1,137
Ambulance staff	11	-	**11**	6
Administration and estates	1,486	102	**1,588**	1,122
Healthcare assistants and other support staff	1,479	84	**1,563**	2,532
Nursing, midwifery and health visiting staff	2,419	594	**3,013**	2,236
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	849	35	**884**	814
Healthcare science staff	150	2	**152**	132
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**7,316**	**1,048**	**8,364**	**7,979**
Of which:				
Number of employees (WTE) engaged on capital projects	35	2	**37**	16

A breakdown of staff by gender (as at 31/3/21)

	Gender (Fte)	
Pay Band/Grade	**Female**	**Male**
Band 1	94.14	19.40
Band 2	1622.28	345.45
Band 3	538.29	121.46
Band 4	358.15	97.60
Band 5	1135.62	189.88
Band 6	775.02	153.69
Band 7	421.09	97.32
Band 8A	160.52	49.95
Band 8B	47.48	19.07
	21.60	10.00
Band 8D	7.00	7.85
Band 9	7.00	6.00
Director	1.00	5.00
Consultant	89.36	242.29
Associate Specialist	3.28	20.34
Staff Grade		0.73
Specialty Doctor	45.77	114.90
GPCA/Hospital Practitioner	1.18	0.73
Specialty Registrar	83.34	66.74
Foundation Year 2	46.19	48.56
Foundation Year 1	27.00	51.00

Females make up 78.71% and males make up 21.29% of the workforce.

The Trust reports annually on its gender pay gap. The deadline for the publication of the data for the last financial year was extended to October 2021 owing to COVID. The latest report will be found here. https://www.ulh.nhs.uk/about/equality-diversity/gender-pay-gap-reporting/

Staff Turnover

Staff turnover rates are published by NHS organisation on a rolling basis each month and are available on the NHS Digital website.

NHS workforce statistics - NHS Digital

Sickness Absence

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

The following table shows the average number of days lost to sickness absence in 2021/22

Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

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

	2021/22 **No.**
Total days lost	82,898
Total staff years	7,069
Average working days lost (per WTE)	**12**

Fairness and equity

As a large, public sector employer, the Trust is committed to promoting equality, diversity and inclusion and to tackling any inequalities that are identified in the workforce.

We have an agreed set of people policies, which provide a framework for the management and development of our staff. 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 an equality and diversity perspective to ensure there can be no detriment to any group of staff through their application.

The Trust is committed to ensuring that all current and potential staff are able to achieve what they want. The Trust has an 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.

Our staff networks continue to grow in strength and we have networks for our BAME and LGBT staff, MAPLE, which is for staff with disabilities, and an Armed Forces Network.

A women's network has also been established and each of our staff networks have been given the active support of an executive/senior leadership sponsor.

The Trust holds Disability Confident Employer status.

We recognise from our staff survey data that staff from protected groups believe we could do more to ensure there is fairness in all aspects of the recruitment and management of staff. We need to do more to ensure that all staff groups are properly represented at all level within the organisation. We know that staff with protected characteristics are underrepresented at more senior levels in the Trust (BME staff and female staff for example). Equality and Diversity is at the heart of our Integrated Improvement Plan. We have a particular focus around talent management and enabling all people with talent in ULHT to progress and we will identify and address the barriers preventing them from doing so.

Working in Partnership

The Trust is committed to building strong partnerships with all stakeholders. One key partner is our Trade Union staff representatives. The Trust has a Change Management Policy that states that:

“The Trust will enter into consultation with recognised staff professional organisations and trade unions before decisions are taken with a view, wherever practicable, to taking account of the views expressed.

The Trust will seek to introduce and effect change by agreement, but also to establish a climate within the organisation which actively encourages staff at all levels themselves to participate in and to support changes which affect them. “

The policy sets out a process a process and structure for consultation that ensures that there is consistency and that adequate time is set aside for the process.

The Trust meets with its staff representatives on at least a monthly basis, in two forums. The Executive Partnership Forum is an opportunity for staffside and Executives to meet to discuss strategic issues which will impact on our employees and provides an opportunity for staff representatives to help shape Trust strategy. The Joint Negotiating Forum (and its equivalent for Medical Staff) is the forum at which changes to terms and conditions are negotiated and consultation takes place on significant changes to policy (outside of terms and conditions) and working arrangements.

We provide facility time for Trade Union representatives to participate as staffside and to represent their members.

The Trade Union (Facility Time Publication Requirement) Regulations 2017 requires NHS employers 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 2020/21 financial year):

TMA

	24 (14 zero time and 10 paid time)
	6373.04
	£112,366
Total pay bill	£29,859 million
Percentage of the total pay bill spent on facility time, calculated as:	0.04%

Throughout the pandemic we built on that spirit of working in partnership and involved staffside colleagues in the decision making processes around COVID. We held weekly partnership meetings between the Executive Leadership Team and staffside and members of staffside were part of the Gold Command structure. We want to build on that strengthened partnership as we review the formal agreements that we have in place that underpin that relationship.

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 2021/22:

	Total Cases	**Cases received**	**Cases with element of**	**Cases with element of**	**Cases where**

		anonymously	patient safety	bullying/ harassment	detriment reported
Q1	5	0	1	0	0
Q2	7	0	1	2	0
Q3	62	0	13	18	4
Q4	36	1	1	10	1

The Trust has a freedom to speak up policy in place and appointed a full time freedom to speak up guardian, who has completed the national training programme.

The NHS staff survey for 2021 showed that our staff feeling safe to raise concerns and being confident the organisation would address these concerns showed some of the lowest scores in the country a deterioration from 2020

The 2022 CQC well led report highlighted the progress that had been made with speaking up arrangements and the actions that were being taken to address the areas where there were still weaknesses. In 2019 the Trust created a network of staff FTSU champions to promote and increase awareness of speaking up. These champions all completed the nationally recognised training.

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 2021/22 was £80,000 (2020/21: £15,000).

Off-payroll engagements

The Review of the tax arrangements of public sector appointees published by the Chief Secretary to the Treasury in 2012 set out the requirement for Government departments and their arm's length bodies to publish information on their highly paid and/or senior off-payroll engagements.

Subsequent changes to tax legislation, applicable to public sector bodies from April 2017, further reformed the 'off-payroll' tax rules. Under the reformed off-payroll working rules (commonly known as IR35), Departments must determine whether the rules apply when engaging a worker.

A worker (or contractor) in this context is defined as:

"someone who is not employed by the client department, the supplier or any other organisation within the supply chain, that instead provides their services through their own limited company or another type of intermediary to the client. An intermediary will usually be the worker's own personal service company but could also be a partnership or an individual."

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, not being classed as employees) using the format set out in the tables below.

Off-payroll engagements

For all off payroll engagements as of 31 March 2022 for more than £245 per day or greater

No of existing engagements as of 31 March 2022 *	**468**
Of which	
No that have existed for less than one year at time of reporting	**457**
No that have existed for between one and two years at time of reporting	**8**
No that have existed for between two and three years at time of reporting	**0**
No that have existed for between three and four years at time of reporting	**1**
No that have existed fo four years or more at time of reporting	**2**
*** This number includes 413 agency nurses who were employed on an adhoc basis at the period end 31st March 2022**	

Off-payroll engagements

For all new off payroll engagements, or those that reached six months duration between 1 April 2021 and 31 March 2022 for more than £245 per day

No of off-payroll workers engaged during the year ended 31st March 2022 *	1,130
Of Which	
Not Subject to off-payroll legislation	1,119
Subject to off payroll legislation and determined as in scope of IR35	9
Subject to off payroll legislation and determined as out of scope of IR35	2
No of engagements reassessed for compliance or assurance purposes during the year	0
Of which: Number of engagements that saw a change to IR35 status following review	0
*** This number includes 1,075 agency nurses who were employed on an ad-hoc basis during the year ended 31st March 2022**	

Off-payroll board members/senior official engagements

For all off payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022

No of off-payroll enagements of board members and/or senior officials with significant financial responsibility during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off payroll and on payroll engagements.	21

Exit packages (the figures incorporated within the note below are subject to audit)

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 2021/22.

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.

Reporting of compensation schemes - exit packages 2021/22

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	1	-	**1**
£10,000 - £25,000	-	1	**1**
Total number of exit packages by type	**1**	**1**	**2**
Total cost (£)	£3,000	£12,000	**£15,000**

Reporting of compensation schemes - exit packages 2020/21

	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	-	5	**5**
Total number of exit packages by type	**-**	**5**	**5**
Total resource cost (£)	£0	£13,000	**£13,000**

Any reported redundancy and other departure costs are paid in accordance with the provisions of the NHS Agenda for Change and Medical and Dental Terms and Conditions.

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 United Lincolnshire Hospitals NHS Trust and not by the NHS Pensions Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year.

Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Exit packages: other (non-compulsory) departure payments

	2021/22		2020/21	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	1	12	5	13
Total	**1**	**12**	**5**	**13**
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 *the Exit Package table (above)* which will be the number of individuals.

In 2021/22 the Trust made zero non-contractual payments in lieu of notice.

Parliamentary accountability and audit report

The Parliamentary accountability and audit report is required by those entities that report directly to Parliament. It is also required in the consolidated Department of Health and Social Care annual report.

Whilst individual DHSC bodies of which the Trust is one, are not required to produce a full Parliamentary accountability report, they must include where applicable, disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges within its financial statements.

These can be within the Final Accounts Section of this Annual Report at notes 27, 31 and 5.3.

Audit Completion Certificate issued to the Directors of United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2022

United Lincolnshire Hospitals NHS Trust

Annual accounts for the year ended 31 March 2022

CONTENTS

FOREWORD TO THE ACCOUNTS

Financial Review - year ended 31 March 2022

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		
	2021-22 £000		2020-2021 £000
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)	**(7,221)**	**(Deficit)**	**3,597**
	8,259	**Impairments**	2,753
	944	**Impact of Grants & Donations**	(3,976)
	1,982	**Reported Performance**	**2,374**
	130	**Exclude DEL impairments**	368
	553	**IFRIC 12 adjustments**	407
	2,665	**Performance against breakeven duty**	**3,149**
	(366,536)	**Cumulative position against breakeven duty (deficit)**	**(369,201)**
To achieve a capital cost absorption rate of 3.5%	**3.5%**	**Achieved**	**3.5%**
To operate within an External Financing Limit set by the Department of Health and Social Care	**£0m**	**Underspent**	**£19.98m**
To operate within a Capital Resource Limit set by the Department of Health and Social Care	**£3.27m**	**Underspent**	**£2.28m**
To pay 95% of creditor invoices within 30 days (by number of invoices)	83%	**Trade (Non-NHS)**	87%
	82%	**NHS**	76%

External Factors

The Trust has no direct exposure to any implications arising from the conflict in Ukraine. It is however affected by any impact on Global prices resulting from the situation.

Paul Matthew
Director of Finance and Digital
17 June 2022

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

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

• value for money is achieved from the resources available to the Trust;

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

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

• annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

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

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

Name	Andrew Morgan
Position	Chief Executive Officer
Date	17 June 2022

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, other items of comprehensive income 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 and

• prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

Signed

Name	Andrew Morgan
Position	Chief Executive Officer

Signed

Name	Paul Matthew
Position	Director of Finance and Digital
Date	17 June 2022

Independent auditor's report to the Directors of United Lincolnshire Hospitals NHS Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of United Lincolnshire Hospitals NHS Trust ('the Trust') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report and Accounts, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion 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 such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in 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 in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2021/22 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit and Risk Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit and Risk Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit and Risk Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

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

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have identified the following significant weaknesses in the Trust's arrangements for the year ended 31 March 2022.

In September 2021 we identified significant weaknesses in relation to Financial Sustainability, and Improving Economy, Efficiency and Effectiveness. In our view these significant weaknesses remain for the year ended 31 March 2022:

Significant weakness in arrangements – issued in a previous year	Recommendation(s)
Capital Backlog and Fire Safety Notices	
NHS trusts are given a "Capital Resource Limit" (CRL), which means NHS trusts cannot incur capital expenditure above that limit and it is managed, in part, through the external finance limit of the Department of Health and Social Care. Within the confines of the CRL, the Trust continues to make progress with capital spending and backlog maintenance, which eventually saw the lifting of Fire Enforcement Notices in 2021/22. The capital backlog at the end of 2020/21 was £230m, down from £236m in the previous year, but remains clearly significant.	1) The Audit and Risk Committee should seek regular assurance regarding the progress on the Estates Management action plan and the extent of capital backlog maintenance.
Overall, the long-standing and ongoing issues regarding the scale of the Trust's capital backlog indicates that there is a significant weakness in the Trust's arrangements that can be reasonably expected to lead to a significant impact on the quality or effectiveness of service and the Trust's reputation.	2) The Trust should engage with the ICS to ensure its capital plan is consistent with system-wide discussions on prioritisation and deliver its capital programme.
Workforce: agency spend & staffing indicators	
Covid-19 has disrupted organisational development and staff engagement plans across the country. The Trust has already begun to initiate a Culture and Leadership Programme and is undertaking regular pulse surveys to monitor improvements in staff engagement, however actions taken by the Trust to improve workforce arrangements have not yet demonstrated sufficient traction to deliver sustained levels of improvement, including:	1) The Trust's People and Organisation Development Committee should provide oversight and challenge on the implementation and progress of the Culture and Leadership Programme to monitor staff engagement and morale.
· NHS Staff Survey results show the Trust is performing poorly across a range of areas, including morale and staff engagement; and · the Trust remains heavily reliant on agency and bank staff, although data on staff turnover indicates there is an underling workforce shortage that is contributing to the current position.	2) The Trust should work with system partners to tackle the recruitment deficit and manage agency costs.
Cumulatively, this exposes the Trust to a significant risk to the quality and effectiveness of service as well as a risk of increased expenditure on agency costs.	
The Trust's financial sustainability	
The audited 2020/21 financial statements showed an Operating Surplus of £9m, compared to a £34m deficit in 2019/20. The Trust's Annual Report, explains the Trust's surplus, delivered in-line with the system envelope, was inclusive of £72m of planned system support. The Trust's cumulative break-even position, for 2020/21 was a £369m deficit.	1) The Trust must agree a Financial Recovery Plan with NHSI, and monitor its progress in achieving that plan, including addressing the underlying issues the Trust faces in relation to workforce and site configuration planning.
The Trust's financial sustainability is dependent on the resolution of long-standing issues in workforce planning and in implementing the outcomes of the public consultation on the future configuration of Lincolnshire health services initiated in March 2019. It is also dependent on the national funding structures yet to be determined. These unresolved and ongoing issues have not been addressed by the Trust and this continues to prevent it from improving arrangements to secure financial sustainability during 2020/21. Overall, therefore, we have concluded that there is an ongoing significant weakness in arrangements to secure financial sustainability.	

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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 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 guidance issued by the Comptroller and Auditor General in December 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 7 June 2022, we made a referral to the Secretary of State for Health under Section 30 of the Act because we had reason to believe the Trust breached its statutory 'breakeven duty' as set out in paragraph 2 (1) of Schedule 5 to the National Health Service Act 2006, taking into account the guidance issued by NHS Improvement in April 2018 entitled 'Statutory breakeven duty: a guide for NHS trusts'.

Use of the audit report

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

Certificate

We certify that we have completed the audit of United Lincolnshire hospitals NHS Trust in accordance with with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Mark Surridge, *Key Audit Partner*
For and on behalf of Mazars LLP

2 Chamberlain Square, Birmingham, B3 3AX

17 June 2022

Statement of Comprehensive Income

	Note	2021/22	2020/21
		£000	**£000**
Operating income from patient care activities	3	638,695	531,696
Other operating income	4	41,499	112,182
Operating expenses	6	(680,694)	(635,100)
Operating surplus from continuing operations		**(500)**	**8,778**
Finance income	11	54	-
Finance expenses	12	18	9
PDC dividends payable		(6,561)	(4,943)
Net finance costs		**(6,489)**	**(4,934)**
Other losses	13	(232)	(247)
Surplus / (deficit) for the year		**(7,221)**	**3,597**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,458)	(191)
Revaluations		3,928	2,966
Other reserve movements		(1)	1
Total comprehensive income / (expense) for the period		**(4,752)**	**6,373**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	14	7,675	4,600
Property, plant and equipment	15	267,753	247,119
Receivables	19	1,848	2,790
Total non-current assets		**277,276**	**254,509**
Current assets			
Inventories	18	6,006	6,510
Receivables	19	15,520	25,935
Cash and cash equivalents	21	88,297	54,042
Total current assets		**109,823**	**86,487**
Current liabilities			
Trade and other payables	22	(89,018)	(69,644)
Borrowings	24	(402)	-
Provisions	26	(8,773)	(2,056)
Other liabilities	23	(1,130)	(1,587)
Total current liabilities		**(99,323)**	**(73,287)**
Total assets less current liabilities		**287,776**	**267,709**
Non-current liabilities			
Borrowings	24	(3,623)	(4,025)
Provisions	26	(3,183)	(4,069)
Other liabilities	23	(11,572)	(12,075)
Total non-current liabilities		**(18,378)**	**(20,169)**
Total assets employed		**269,398**	**247,540**
Financed by			
Public dividend capital		704,180	677,570
Revaluation reserve		29,294	27,522
Other reserves		190	190
Income and expenditure reserve		(464,266)	(457,742)
Total taxpayers' equity		**269,398**	**247,540**

The notes on pages 19 to 73 form part of these accounts.

The financial statements on pages 14 to 73 were approved by the Board on 17 June 2022 and signed on its behalf by;

Signed

Name	Andrew Morgan
Position	Chief Executive Officer
Date	17 June 2022

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2021 - brought forward	**677,570**	**27,522**	**190**	**(457,742)**	**247,540**
Deficit for the year	-	-	-	(7,221)	**(7,221)**
Other transfers between reserves	-	(698)	-	698	**-**
Impairments	-	(1,458)	-	-	**(1,458)**
Revaluations	-	3,928	-	-	**3,928**
Public dividend capital received	26,610	-	-	-	**26,610**
Other reserve movements	-	-	-	(1)	**(1)**
Taxpayers' equity at 31 March 2022	**704,180**	**29,294**	**190**	**(464,266)**	**269,398**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2020 - brought forward	**267,906**	**26,049**	**190**	**(462,642)**	**(168,497)**
Surplus for the year	-	-	-	3,597	**3,597**
Other transfers between reserves	-	(960)	-	960	**-**
Impairments	-	(191)	-	-	**(191)**
Revaluations	-	2,966	-	-	**2,966**
Transfer to retained earnings on disposal of assets	-	(342)	-	342	**-**
Public dividend capital received	409,664	-	-	-	**409,664**
Other reserve movements	-	-	-	1	**1**
Taxpayers' equity at 31 March 2021	**677,570**	**27,522**	**190**	**(457,742)**	**247,540**

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.

Other reserves
Liabilities transferred to NHS Resolution on 1st April 2000 have been recorded as 'other reserves'.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus		(500)	8,778
Non-cash income and expense:			
Depreciation and amortisation	6.1	15,736	13,674
Net impairments	7	8,389	3,121
Income recognised in respect of capital donations	4	(27)	(3,923)
Amortisation of PFI deferred credit		(503)	(503)
Decrease in receivables and other assets		11,261	16,119
Decrease in inventories		504	527
Increase in payables and other liabilities		9,288	14,903
Increase in provisions		5,860	1,556
Net cash flows from operating activities		**50,008**	**54,252**
Cash flows from investing activities			
Interest received		34	12
Purchase of intangible assets		(994)	(1,245)
Purchase of PPE and investment property		(35,132)	(39,483)
Sales of PPE and investment property		148	625
Net cash flows used in investing activities		**(35,944)**	**(40,091)**
Cash flows from financing activities			
Public dividend capital received		26,610	409,664
Movement on loans from DHSC		-	(377,859)
Movement on other loans		-	2,543
Interest on loans		-	(2,517)
Other interest		(1)	(5)
PDC dividend paid		(6,418)	(5,662)
Net cash flows from financing activities		**20,191**	**26,164**
Increase in cash and cash equivalents		**34,255**	**40,325**
Cash and cash equivalents at 1 April - brought forward		**54,042**	**13,717**
Cash and cash equivalents at 31 March	21.1	**88,297**	**54,042**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Secretary of State for 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 2021/22 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.

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

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

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.

The Trust does not hold further interests in other entities.

Note 1.4 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).

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. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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 1.5 Other forms of income

Grants and donations

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. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 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 Schemes

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.7 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 the consideration payable. 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 1.8 Property, plant and equipment

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 and either
    • 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, then these components are treated as separate assets and depreciated over their own useful economic lives.

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.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. 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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

The valuation using the alternative site basis takes into account that the modern equivalent replacement offering the same service potential as the existing hospitals:
- may only require a smaller site footprint
- whilst in appropriate locations to deliver the service within the existing towns (Lincoln, Boston and Grantham) may not be sited in the same location as the current hospitals.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

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 (< 10 years) or low values (<£1m) or both, as this is not considered to be materially different from current value in existing use.

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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 expenditure.

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.

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 i.e.:

- 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.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at current value in existing use if they will be held for their service potential, or otherwise 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.

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and measured at current value in existing use.

The nature of the PFI held by United Lincolnshire Hospitals NHS Trust means that no unitary payment is included within operating expenses. Instead the operator derives income from charges made to users rather than from payments by the Trust.
Further description of the scheme is set out in note 29

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 Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	53
Dwellings	60	77
Plant & machinery	3	15
Transport equipment	5	11
Information technology	2	10
Furniture & fittings	6	11

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

Note 1.9 Intangible assets

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; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets, being recognised as an operating expense in which the expenditure is incurred.

Expenditure on research is not capitalised, being recognised as an operating expense in which the expenditure is incurred. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

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, by reference to an active market. Where no active market exists, at the lower of amortised 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 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.

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.

Useful lives 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**
Information technology	5	5
Websites	6	6
Software licences	1	15

Note 1.10 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.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

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 Financial assets and financial liabilities

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, i.e., when receipt or delivery of the goods or services is made.

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 due to their nature.

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.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, 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, in accordance with IFRS9, 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).

Expected credit losses are made up of three constituent elements:
- Compensation Recovery Unit, where a provision of 23.76% is made based upon historic recovery rates as set out within the DHSC GAM.
- Full 100% provision for those debts referred to the Trust's appointed debt collection agent.
- All other non-NHS sales invoices based upon expected recovery rates for each category and ageing of debt, except for other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds' assets where repayment is ensured by primary legislation.

For financial assets that have become credit impaired 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.

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.

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, or has not retained control of the asset.

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

Note 1.13 Leases

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

The Trust as a 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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

The annual rental 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 in other liabilities on the Statement of Financial Position 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.

The Trust as a 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 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount as a result of a past event; 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 HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

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. The contribution is charged to operating expenses. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.15 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 Trust's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust'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 1.16 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.

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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at .

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

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 calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.17 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

The Trust has no Corporation tax liability.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption. In the cllimate change levy documentation:

https://www.gov.uk/guidance/pay-climate-change-levy

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise.

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.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. 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.

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 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	12,961
Additional lease obligations recognised for existing operating leases	(12,829)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**132**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(2,490)
Additional finance costs on lease liabilities	(119)
Lease rentals no longer charged to operating expenditure	2,531
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(78)**
Estimated increase in capital additions for new leases commencing in 2022/23	**1,113**

The impact of IFRS 16 upon the Trust's existing PFI arrangement with Progress Housing (note 29), has yet to be confirmed. This remains uncertain pending the publication of updated PFI guidance.

Other standards, amendments and interpretations

Subject to UKEB and HM Treasury endorsement, IFRS 17 Insurance Contracts will become effective for DHSC bodies from financial year 2023/24.
The scope of the standard is not different to IFRS 4, but it is expected that the implementation of the new standard will require a review of existing arrangements which may result in reclassification of contracts as insurance contracts.
HM Treasury has put together a working group to assess the impact of IFRS 17 and as such the impact can not yet be assessed.

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:

Valuation of Buildings
The Department of Health and Social Care (DHSC) guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as 'the cost of a modern replacement asset that has the same productive capacity as the property being valued'. Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds but a theoretical calculation for accounting purposes of what the Trust could need to spend in order to replace the current assets.
In determining the MEA the Trust supported by its appointed valuer (Cushman and Wakefield) has made judgements around alternative sites and required footprint for an MEA build. In determining the MEA, the Trust has to make assumptions that are practically achievable and would meet the service needs of users, but the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust and would not impact on service delivery or the level and volume of service provided. The Trust has no plans to implement any of the theoretical assumptions that underpin the MEA valuation.

For the purposes of the MEA valuation, the Trust has defined that the services provided at the:
• Lincoln County Hospital site could theoretically be provided from a location on the outskirts of Lincoln with easy access to the A46 ring road.
• Grantham District General Hospital site could theoretically be provided from a location on the outskirts of Grantham with access to the A1 / A52.
• Boston Pilgrim Hospital would not be re-sited.
Further details concerning the valuation of Property, Plant and Equipment are provided in note 1.8 and note 15.

Note 1.26 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property Plant and Equipment Valuations (carrying value 31 March 2022: £197.1m):

An annual revaluation of Trust Property is conducted by Cushman & Wakefield. The value of land, buildings and dwellings post revaluation was £197.1m and is detailed at Note 15.

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 1.8.

Depreciation and asset lives:

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion), internal review and profession assessment (equipment and IT assets predominantly) and physical asset verification exercises.

Progress Housing (carrying value 31 March 2022: £29.6m):

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 occupancy levels have been estimated for the relevant properties based upon average occupancy levels over the preceding 24 months ending February 2022.

The valuation of Progress Housing Dwellings recognised as a PFI asset on the Trust Statement of Financial Position is based upon it being a non-specialised asset in existing use. The valuation undertaken by Cushman and Wakefield takes into account factors including annual rental charges for each unit, management charges and assessment of future occupancy levels. The selection of average occupancy levels over the preceding 24 months as a basis for future occupancy is therefore a key source of estimation uncertainty.

Note 2 Operating Segments

The Trust 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.

	2021/22		2020/21	
	£000s	**%**	£000s	%
Revenue from HM Government sources	**652,316**	**95.9**	**604,984**	94.0
Revenue from non HM Government sources	**27,878**	**4.1**	**38,894**	6.0
Total	**680,194**	**100.0**	643,878	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

Note 3.1 Income from patient care activities (by nature)	2021/22	2020/21
	£000	£000
Acute services		
Block contract / system envelope income*	611,102	500,773
High cost drugs income from commissioners (excluding pass-through costs)**	4,087	3,088
Other NHS clinical income***	2,382	3,395
All services		
Private patient income	192	232
Elective recovery fund****	3,377	-
Additional pension contribution central funding*****	15,395	14,310
Other clinical income******	2,160	9,898
Total income from activities	**638,695**	**531,696**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of 2020/21, a revised financial framework built on these arrangements but with a greater focus on system partnership was introduced and providers derived most of their income from these system envelopes. These arrangements continued for the 2021/22 financial year.

** The value reported as high cost drugs expenditure is limited to funding over and above that included within the block contact.

*** Other NHS Clinical income is primarily made up of income from provider to provider block contracts £2.1m (2020/21 - £2.9m).

**** The Elective Recovery Fund was introduced in 21/22 as part of the financial arrangements to aid recovery from the pandemic.

*****The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

****** Other Clinical Income includes: income earned through the Injury Cost Recovery Scheme £1.0m (2020/21: £0.9m), treatment of Overseas Patients £0.4m (2020/21: £0.4m) and central funding to support additional pay / annual leave costs £nil (2020/21: £8.3m).

Note 3.2 Income from patient care activities (by source)

	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England	98,059	95,387
Clinical commissioning groups*	536,041	431,165
Department of Health and Social Care	288	108
Other NHS providers	2,217	2,941
NHS other	-	329
Local authorities	116	115
Non-NHS: private patients	192	232
Non-NHS: overseas patients (chargeable to patient)	439	292
Injury cost recovery scheme	995	916
Non NHS: other	348	211
Total income from activities	**638,695**	**531,696**
Of which:		
Related to continuing operations	638,695	531,696
Related to discontinued operations	-	-

* Changes in the financial regime to support NHS providers through the pandemic have resulted in a change to the way that providers are paid. The income is now set on a cost block basis rather than national tariff above normal contract levels.
Through the first half of 2020/21 this 'Top-up' of £57.9m was received via NHS England and was identified separately within other operating income. In the latter six months, 'Top-up' payments of £72.0m were received through Lincolnshire CCG and were classified as Patient related income.
In 2021/22 the equivalent 'top-up' funding was incorporated within the CCG block.

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

	2021/22	2020/21
	£000	£000
Income recognised this year	439	292
Cash payments received in-year	117	69
Amounts added to provision for impairment of receivables	175	221
Amounts written off in-year	138	74

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,513	-	**1,513**	1,390	-	**1,390**
Education and training	19,985	1,257	**21,242**	18,259	851	**19,110**
Non-patient care services to other bodies	6,082		**6,082**	9,434		**9,434**
Reimbursement and top up funding*	1,155		**1,155**	63,038		**63,038**
Income in respect of employee benefits accounted on a gross basis	5,308		**5,308**	2,628		**2,628**
Receipt of capital grants and donations**		27	**27**		3,923	**3,923**
Charitable and other contributions to expenditure***		1,555	**1,555**		7,198	**7,198**
Rental revenue from finance leases		156	**156**		156	**156**
Rental revenue from operating leases		1,200	**1,200**		1,183	**1,183**
Amortisation of PFI deferred income / credits		503	**503**		503	**503**
Other income****	2,758	-	**2,758**	3,619	-	**3,619**
Total other operating income	**36,801**	**4,698**	**41,499**	**98,368**	**13,814**	**112,182**
Of which:						
Related to continuing operations			41,499			112,182
Related to discontinued operations			-			-

* In 2021/22 the Trust received 'top-up' payments of £1.2m (2020/21: £0.7m) specifically for Covid vaccination and testing.
In 2020/21, a further £57.9m 'Provider block top up' was received covering the first six months (note 3.2), along with £4.5m income which was allocated to trusts to compensate for 'other' lost income during the year.

** The 2020/21 figure includes £3.3m of donated equipment from DHSC Group bodies as part of the covid pandemic response.

*** This represents the value of Personal Protective Equipment donated by DHSC to NHS Trusts as part of the pandemic response.

**** Other Income includes: car parking £0.7m (2020/21: £0.2m), catering £0.8m (2020/21: £0.5m), central funding for lost income due to Covid-19 restrictions £Nil (2020/21: £2.0m), Medical Examiner Fees £0.3m (2020/21: £0.1m), staff lease cars £0.1m (2020/21: £0.1m) and miscellaneous other income £0.9m (2020/21: £0.9m)

Note 5 Additional information on contract revenue and performance obligations'

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	436	3,168

Note 5.2 Transaction price allocated to remaining performance obligations

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 5.3 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.

	2021/22	2020/21
	£000	£0
Income	1,460	699
Full cost	(1,405)	(1,756)
Surplus / (deficit)	**55**	**(1,057)**

This note addresses and aggregates schemes that, individually, have a cost exceeding £1m.
This comprises catering and car parking income from the public and staff.

Catering	**2021/22**	**2020/21**
	£000s	£000s
Income	**778**	476
Full cost	**(1,107)**	(918)
Surplus / (deficit)	**(329)**	(442)

Car Parking	**2021/22**	**2020/21**
	£000s	£000s
Income	**682**	223
Full cost	**(298)**	(838)
Surplus / (deficit)	**384**	(615)

The impact of the pandemic has meant that fewer patients and visitors have been on site utilising services through 2020/21.
As a consequence income and costs for car parking and catering have reduced and are below the limit required for disclosure. However to ensure continuity and consistency in reporting this note has been retained.
Car Parking costs for 2020/21 were reported inclusive of the Trust's Security contract. In 2021/22 this has been excluded. Car parking costs for 20/21 on a comparable basis were £198k.

Note 6 Operating expenses

Note 6.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	619	-
Purchase of healthcare from non-NHS and non-DHSC bodies	4,866	-
Staff and executive directors costs	448,364	421,921
Remuneration of non-executive directors	118	104
Supplies and services - clinical (excluding drugs costs)	62,669	66,843
Supplies and services - general	8,735	11,656
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	59,349	51,203
Inventories written down	88	482
Consultancy costs	80	15
Establishment	6,345	5,511
Premises	19,611	21,467
Transport (including patient travel)	1,589	2,087
Depreciation on property, plant and equipment	13,910	11,978
Amortisation on intangible assets	1,826	1,696
Net impairments*	8,389	3,121
Movement in credit loss allowance: contract receivables / contract assets	261	203
Change in provisions discount rate(s)	107	142
Fees payable to the external auditor**		
audit services- statutory audit	138	136
Internal audit costs	212	185
Clinical negligence	22,763	21,058
Legal fees	276	481
Insurance	(18)	80
Research and development***	1,852	1,589
Education and training***	8,254	4,860
Rentals under operating leases	2,905	1,576
Redundancy	3	-
Car parking & security	45	71
Losses, ex gratia & special payments	2,030	217
Other services, e.g. external payroll	2,731	5,474
Other	2,577	944
Total	**680,694**	**635,100**
Of which:		
Related to continuing operations	680,694	635,100

* Note 7 provides further detail relating to the Net Impairments expense

** The External Audit fee is shown net of VAT with non recoverable VAT included within 'other' expenditure.

***The figures presented above for Research and Development along with Education and training include £5.9m pay costs (2020/21: £4.20m) and £2.9m non-pay costs (2020/21: £2.9m).

Note 6.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2021/22 or 2020/21.

Note 7 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
a) Loss or damage from normal operations	152	368
b) Changes in market price	8,279	2,656
c) Other	(42)	97
Total net impairments charged to operating surplus / deficit	**8,389**	**3,121**
d) Impairments charged to the revaluation reserve	1,458	191
Total net impairments	**9,847**	**3,312**

a) Material Impairment losses / (reversals) charged to the SOCI resulting from loss or damage from normal operations are summarised below:

	2021/22	2020/21
	£000	£000
Fluroscopy suite and equipment - water damage	-	368
Radiology equipment damaged in Fire	152	-

The principle asset that was damaged is insured through NHS Resolution. An anticipated insurance receipt has been recognised in the SoCI.
The damaged equipment has been impaired down to market (salvage) value.

b) Material Impairment losses / (reversals) charged to the SOCI in 2021/22 resulting from changes in market price following valuation are summarised below:

	2021/22	2020/21
	£000	£000
Reversals of impairments charged to SOCI in previous years:		
Maternity Unit Lincoln County Hospital	(905)	(1,406)
Phase 2: Lincoln County Hospital	(481)	(590)
Outpatients Pilgrim Hospital		(516)
Other - buildings*	(2,753)	(684)
Impairments charged to SOCI in current year:		
Ward Block 50 Lincoln County Hospital		692
A&E Building Pilgrim Hospital		743
Tower Block Pilgrim Hospital	829	
Generator House Lincoln County Hospital	615	
Endoscopy unit Lincoln County Hospital	1,004	
Out patients Lincoln County Hospital	649	
Urgent Treatment Centre Lincoln County Hospital	1,350	
PARU - Lincoln County Hospital	3,919	
Tower Block Grantham Hospital	705	
Other - buildings*	3,347	4,417
	8,279	**2,656**

* Consists of multiple buildings individually with 'low' value impairment less than £0.5m

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

	2021/22	2020/21
	£000	£000
Reversal of impairments charged to SOCI in previous years		
Progress Care Housing Association **	(166)	97
East Skirbeck House - Boston	94	
Other Medical Equipment	30	
	(42)	**97**

** 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 projected future occupancy levels and therefore projected income streams associated with this contract are reviewed annually. The Annual property valuation takes account of this assessment and may result in an impairment or reversal.

Impairments charged / (reversed) against this contract were:	2021/22	2020/21
	£000	£000
Lincoln	-	-
Boston	-	-
Grantham District Hospital Site	(166)	97
	(166)	97

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

	2021/22	2020/21
	£000	£000
Changes in market price	1,458	191
Total impairments for PPE charged to reserves	**1,458**	**191**

Note 8 Employee benefits

	2021/22	2020/21
	Total	Total
	£000	£000
Salaries and wages	326,082	307,805
Social security costs	30,953	27,861
Apprenticeship levy	1,613	1,483
Employer's contributions to NHS pensions	50,694	47,141
Pension cost - other	143	139
Temporary staff (including agency)	46,385	42,254
Total gross staff costs	**455,870**	**426,683**
Total staff costs	**455,870**	**426,683**
Of which		
Costs capitalised as part of assets	1,599	559

Employer's contributions to NHS pensions
Following consultation and revaluation of public sector pension schemes, the Department of Health and Social Care (DHSC) increased the employer contribution rate from 14.3% to 20.6% (20.68% including the 0.08% administration levy) from 1 April 2019.
During 2020/21 - 2021/22 the scheme administrator, NHS Business Services Authority, has continued to collect an employer contribution of 14.38 per cent from employers. Central payments have been paid to the scheme by NHS England to cover the remaining increase.
NHS trusts are required to account for employer contributions of 20.68% in full and on a gross basis in year end accounts.
The total employer NHS Pension contribution of £50.7m (2020/21: £47.1m) shown in the table above includes £15.4m (2020/21: £14.3m) paid by NHS England on behalf of the Trust.

Pension cost - other relate to payments into the National Employment Savings Trust (NEST) defined contribution scheme.

In line with the HM Treasury requirements a further breakdown of employee benefits across staffing categories is provided within the Annual Report.

Note 8.1 Retirements due to ill-health

During 2021/22 there were 2 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £212k (£208k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care 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 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at:

https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

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.

As at 31 March 2022 there were 9,938 (31 March 2021: 9,947) employees employed by the Trust, of these 8,669 (31 March 2021: 8,436) are members of the NHS Pension Scheme, 373 (31 March 2021: 384) are enrolled within NEST and 896 (31 March 2021:1,127) are not currently contributing through a workplace pension scheme.

Note 10 Operating leases

Note 10.1 United Lincolnshire Hospitals NHS Trust as a lessor

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

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

	2021/22	2020/21
	£000	£000
Operating lease revenue		
Minimum lease receipts	948	1,061
Contingent rent	252	122
Total	**1,200**	**1,183**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	243	275
- later than one year and not later than five years;	871	904
- later than five years.	322	517
Total	**1,436**	**1,696**

Note 10.2 United Lincolnshire Hospitals NHS Trust as a lessee

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

The majority of the 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.

In 2011/12 the Trust entered into a short term operating lease for land on the Lincoln site. This lease expired in March 2016. The two parties then renegotiated an extension to July 2024 though either party can revoke with 6 months notice.

In 2020/21 the Trust entered a six month lease for additional land adjacent to the hospital site, this has subsequently been extended until December 2022, a number of short term agreements were entered to lease additional buildings as a result of COVID 19.

The Trust also leases various items of medical equipment, photocopiers and vehicles. These leases are due to expire in the periods up to September 2027, July 2023 and May 2025 respectively.

Property leases at John Coupland Hospital Gainsborough, Louth County Hospital, Skegness and District Hospital and Johnson Community Hospital Spalding along with Medical Centres at Gainsborough and Mablethorpe leased through NHS Property Services with a collective annual lease cost of £0.7m.

	2021/22	2020/21
	£000	£000
Operating lease expense		
Land	181	77
Buildings	857	975
Other	1,866	524
Total	**2,905**	**1,576**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,656	1,401
- later than one year and not later than five years;	5,949	3,622
- later than five years.	2,123	2,460
Total	**10,728**	**7,483**

Note 11 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	54	-
Total finance income	**54**	**-**

Note 12 Finance Expenses

Note 12.1 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	-	3
Interest on late payment of commercial debt	1	3
Total interest expense	**1**	**6**
Unwinding of discount on provisions	(29)	(15)
Other finance costs	10	-
Total finance costs	**(18)**	**(9)**

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

	2021/22	2020/21
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	821	683
Amounts included within interest payable arising from claims made under this legislation	1	3

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	142	115
Losses on disposal of assets	(374)	(362)
Total gains / (losses) on disposal of assets	**(232)**	**(247)**
Other gains / (losses)	-	-
Total other gains / (losses)	**(232)**	**(247)**

Note 14 Intangible assets

Note 14.1 Intangible assets - 2021/22

	Software licences	Internally generated information technology	Websites	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**14,406**	**20**	**15**	**-**	**14,441**
Additions	1,269	-	-	2,946	**4,215**
Reclassifications	686	-	-	-	**686**
Disposals / derecognition	(98)	-	-	-	**(98)**
Valuation / gross cost at 31 March 2022	**16,263**	**20**	**15**	**2,946**	**19,244**
Amortisation at 1 April 2021 - brought forward	**9,806**	**20**	**15**	**-**	**9,841**
Provided during the year	1,826	-	-	-	**1,826**
Disposals / derecognition	(98)	-	-	-	**(98)**
Amortisation at 31 March 2022	**11,534**	**20**	**15**	**-**	**11,569**
Net book value at 31 March 2022	**4,729**	**-**	**-**	**2,946**	**7,675**
Net book value at 1 April 2021	**4,600**	**-**	**-**	**-**	**4,600**

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 Software Licenses had an original purchase cost of £0.58m.

Note 14.2 Intangible assets - 2020/21

	Software licences	Internally generated information technology	Websites	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**12,898**	**20**	**15**	**-**	**12,933**
Additions	1,458	-	-	-	**1,458**
Reclassifications	90	-	-	-	**90**
Disposals / derecognition	(40)	-	-	-	**(40)**
Valuation / gross cost at 31 March 2021	**14,406**	**20**	**15**	**-**	**14,441**
Amortisation at 1 April 2020 - as previously stated	**8,150**	**20**	**15**	**-**	**8,185**
Provided during the year	1,696	-	-	-	**1,696**
Disposals / derecognition	(40)	-	-	-	**(40)**
Amortisation at 31 March 2021	**9,806**	**20**	**15**	**-**	**9,841**
Net book value at 31 March 2021	**4,600**	**-**	**-**	**-**	**4,600**
Net book value at 1 April 2020	**4,748**	**-**	**-**	**-**	**4,748**

Note 15 Property, plant and equipment

Note 15.1 Property, plant and equipment - 2021/22

	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 2021 - brought forward	**9,991**	**146,346**	**29,640**	**27,419**	**66,531**	**735**	**11,979**	**1,153**	**293,794**
Additions	-	9,998	-	20,963	9,959	31	578	-	**41,529**
Impairments	-	(17,521)	-	-	(1,344)	-	-	-	**(18,865)**
Reversals of impairments	839	2,097	137	-	-	-	-	-	**3,073**
Revaluations	25	1,199	1,570	-	-	-	-	-	**2,794**
Reclassifications	-	13,248	-	(23,238)	4,891	-	4,413	-	**(686)**
Transfers to / from assets held for sale	-	-	-	-	(2,046)	(215)	(63)	-	**(2,324)**
Disposals / derecognition	-	-	-	(374)	(1,766)	-	(1,923)	-	**(4,063)**
Valuation/gross cost at 31 March 2022	**10,855**	**155,367**	**31,347**	**24,770**	**76,225**	**551**	**14,984**	**1,153**	**315,252**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**-**	**-**	**-**	**40,382**	**672**	**5,278**	**343**	**46,675**
Provided during the year	-	5,459	459	-	5,236	41	2,576	139	**13,910**
Impairments	-	(2,312)	-	-	(1,161)	-	-	-	**(3,473)**
Reversals of impairments	-	(2,443)	(29)	-	-	-	-	-	**(2,472)**
Revaluations	-	(704)	(430)	-	-	-	-	-	**(1,134)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	(2,040)	(215)	(63)	-	**(2,318)**
Disposals / derecognition	-	-	-	-	(1,766)	-	(1,923)	-	**(3,689)**
Accumulated depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**40,651**	**498**	**5,868**	**482**	**47,499**
Net book value at 31 March 2022	**10,855**	**155,367**	**31,347**	**24,770**	**35,574**	**53**	**9,116**	**671**	**267,753**
Net book value at 1 April 2021	**9,991**	**146,346**	**29,640**	**27,419**	**26,149**	**63**	**6,701**	**810**	**247,119**

Note 15.2 Property, plant and equipment - 2020/21

	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 2020 - as previously stated	**9,841**	**142,229**	**25,604**	**12,612**	**56,676**	**735**	**9,682**	**302**	**257,681**
Additions	-	4,722	-	29,871	9,066	-	1,348	54	**45,061**
Impairments	-	(12,458)	(128)	-	(406)	-	-	-	**(12,992)**
Reversals of impairments	-	3,210	1,493	-	-	-	-	-	**4,703**
Revaluations	-	(146)	2,671	-	-	-	-	-	**2,525**
Reclassifications	-	8,789	-	(14,702)	2,985	-	2,041	797	**(90)**
Transfers to / from assets held for sale	150	-	-	-	(1,700)	-	-	-	**(1,550)**
Disposals / derecognition	-	-	-	(362)	(90)	-	(1,092)	-	**(1,544)**
Valuation/gross cost at 31 March 2021	**9,991**	**146,346**	**29,640**	**27,419**	**66,531**	**735**	**11,979**	**1,153**	**293,794**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**-**	**-**	**-**	**38,047**	**626**	**4,085**	**239**	**42,997**
Provided during the year	-	4,988	392	-	4,163	46	2,285	104	**11,978**
Impairments	-	(3,723)	(31)	-	(38)	-	-	-	**(3,792)**
Reversals of impairments	-	(1,062)	(123)	-	-	-	-	-	**(1,185)**
Revaluations	-	(203)	(238)	-	-	-	-	-	**(441)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	(1,700)	-	-	-	**(1,700)**
Disposals / derecognition	-	-	-	-	(90)	-	(1,092)	-	**(1,182)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**40,382**	**672**	**5,278**	**343**	**46,675**
Net book value at 31 March 2021	**9,991**	**146,346**	**29,640**	**27,419**	**26,149**	**63**	**6,701**	**810**	**247,119**
Net book value at 1 April 2020	**9,841**	**142,229**	**25,604**	**12,612**	**18,629**	**109**	**5,597**	**63**	**214,684**

Note 15.3 Property, plant and equipment financing - 2021/22

	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 2022									
Owned - purchased	10,855	154,993	-	24,770	32,053	53	9,116	669	**232,509**
On-SoFP PFI contracts and other service concession arrangements	-	-	31,347	-	-	-	-	-	**31,347**
Owned - donated/granted	-	374	-	-	3,521	-	-	2	**3,897**
NBV total at 31 March 2022	**10,855**	**155,367**	**31,347**	**24,770**	**35,574**	**53**	**9,116**	**671**	**267,753**

Note 15.4 Property, plant and equipment financing - 2020/21

	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 2021									
Owned - purchased	9,991	145,985	-	27,419	21,970	57	6,700	806	**212,928**
On-SoFP PFI contracts and other service concession arrangements	-	-	29,640	-	-	-	-	-	**29,640**
Owned - donated/granted	-	361	-	-	4,179	6	1	4	**4,551**
NBV total at 31 March 2021	**9,991**	**146,346**	**29,640**	**27,419**	**26,149**	**63**	**6,701**	**810**	**247,119**

Note 16 Donations of property, plant and equipment

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

Donor: United Lincolnshire Hospitals NHS Trust Charitable Fund

Asset Description - Donation of physical asset	Software licences £000	Fair value of asset £000
Track and Trace system	27	**27**
Total value of physical assets donated	**27**	**27**

Charity, utilising donations provided by the Louth Hospital League of Friends.
The full value of the asset is £72k.

Note 17 Revaluations of property, plant and equipment

The Trust commissioned a desktop revaluation of land, buildings and dwellings in February 2022 with a valuation date of 31 March 2022. This revaluation was conducted by Mr I Hudson MRICS of Cushman & Wakefield Debenham Tie Leung Limited.

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, Boston Pilgrim and Grantham Hospitals.

Land and Buildings which are no longer in operational use and are therefore 'surplus' have been valued at Fair Value.

The following table provides details of property valued on an open market valuation basis at 31 March 2022.

	2021/22 £000s	2020/21 £000s
Land	875	850
Dwellings*	31,347	29,640
Buildings	-	-
	32,222	30,490

* Progress Care Housing Association Ltd accommodation units (non-specialised - dwellings) are valued at open market value based on existing use.

Accounting policies note 1.8 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.

The gross value of fully depreciated assets still in use is £8.0m (31 March 2021: £5.1m).

A number of buildings owned by the Trust are leased out under operating leases.

	2021/22 £000s	2020/21 £000s
Net book value 1 April	4,917	4,904
New leases	17	-
Additions	125	141
Depreciation	(125)	(122)
Increase in valuation 31 March	179	-
Impairments	101	12
Terminated Leases	-	(18)
Net book value 31 March	**5,214**	**4,917**

Note 18 Inventories

	31 March 2022	31 March 2021
	£000	£000
Drugs	2,195	2,073
Consumables	3,811	4,437
Total inventories	**6,006**	**6,510**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £67,765k (2020/21: £63,181k). Write-down of inventories recognised as expenses for the year were £88k (2020/21: £482k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,555k of items purchased by DHSC (2020/21: £7,198k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19 Receivables

Note 19.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	10,677	19,140
Capital receivables	27	-
Allowance for impaired contract receivables / assets	(891)	(786)
Deposits and advances	1	-
Prepayments (non-PFI)	4,173	4,710
Interest receivable	20	-
PDC dividend receivable	576	719
VAT receivable	735	1,157
Other receivables*	202	995
Total current receivables	**15,520**	**25,935**
Non-current		
Contract receivables	1,917	1,978
Allowance for impaired contract receivables / assets	(455)	(444)
Other receivables	386	1,256
Total non-current receivables	**1,848**	**2,790**
Of which receivable from NHS and DHSC group bodies:		
Current	5,881	17,050
Non-current	386	1,256

Other receivables includes:

Clinicians pension tax scheme receivable £0.4m (2020/21:£1.28m)
Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the tax year 2019/20 face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme. Individual trusts have reflected this future liability within the provisions note 26.
NHS England are to meet the cost of this liability, this being reflected within the 2021/22 current (£0.02m) / non current (£0.39m) receivables (2020/21: current £0.03m / non current £1.25m).

* Receivables in relation to Lease Car, Cycle and Home Electronics Salary Sacrifice schemes with Trust employees, totalling £1.2m, has been re-categorised from 'Other' to 'Contract Receivables' in 2021/22. The value included within 'other receivables' at 31 March 2021 was £0.8m.

Note 19.2 Allowances for credit losses

	2021/22	2020/21
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**1,230**	**1,126**
New allowances arising	930	853
Reversals of allowances	(669)	(650)
Utilisation of allowances (write offs)	(145)	(99)
Allowances as at 31 Mar 2022	**1,346**	**1,230**

Note 19.3 Exposure to credit risk

Under IFRS 7 disclosure should be made to demonstrate exposure to credit risk.

The tables below show the level of outstanding invoiced receivables at 31 March split between those which have been impaired / not impaired.

Ageing of impaired financial assets

	31 March 2022	31 March 2021
	£000	£000
0 - 30 days	-	2
30-60 Days	-	2
60-90 days	2	2
90- 120 days	-	2
Over 120 days	622	323
Total	**624**	**331**

Ageing of non-impaired financial assets past their due date

	31 March 2022	31 March 2021
	£000	£000
0 - 30 days	3,358	3,325
30-60 Days	619	517
60-90 days	14	360
90- 120 days	2	82
Over 120 days	320	347
Total	**4,313**	**4,631**

In addition to providing against specific invoiced debt £0.5m (2020/21: £0.3m), the Trust also makes general provision for impairment based upon expected recovery rates.
This covers both invoiced debt ££0.1m (2020/21: £0.2m) and income from the Compensation recovery unit £0.7 (20/21: £0.7m).

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

	2021/22	2020/21
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**660**
Assets classified as available for sale in the year	6	-
Assets sold in year	(6)	(510)
Assets no longer classified as held for sale, for reasons other than sale	-	(150)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 21 Cash and third party assets

Note 21.1 Cash and cash equivalents movements

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

	2021/22	2020/21
	£000	£000
At 1 April	**54,042**	**13,717**
Net change in year	34,255	40,325
At 31 March	**88,297**	**54,042**
Broken down into:		
Cash at commercial banks and in hand	11	12
Cash with the Government Banking Service	88,286	54,030
Total cash and cash equivalents as in SoFP	**88,297**	**54,042**
Total cash and cash equivalents as in SoCF	**88,297**	**54,042**

Note 21.2 Third party assets held by the Trust

United Lincolnshire Hospitals NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2022	31 March 2021
	£000	£000
Monies on deposit	1	1
Total third party assets	**1**	**1**

Note 22 Trade and other payables

	31 March 2022	31 March 2021
	£000	£000
Current		
Trade payables	11,072	18,555
Capital payables	22,643	13,052
Accruals	39,552	25,103
Social security costs	5,398	4,768
Other taxes payable	4,949	3,839
Other payables	5,404	4,327
Total current trade and other payables	**89,018**	**69,644**
Of which payables from NHS and DHSC group bodies:		
Current	9,068	1,816
Other payables includes:		
Outstanding Pension contributions at 31 March	5,038	4,618

Note 23 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	627	1,084
Deferred PFI credits / income	479	479
Lease incentives	24	24
Total other current liabilities	**1,130**	**1,587**
Non-current		
Deferred PFI credits / income	11,014	11,493
Lease incentives	558	582
Total other non-current liabilities	**11,572**	**12,075**

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

Note 24 Borrowings and Financing Activities

Note 24.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Other loans	402	-
Total current borrowings	**402**	**-**
Non-current		
Other loans	3,623	4,025
Total non-current borrowings	**3,623**	**4,025**

Other loans relate to interest free Government loans provided through Salix Finance Ltd to fund initiatives to improve energy efficiency, reduce carbon emissions and lower energy costs.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Total
	£000	£000	£000
Carrying value at 1 April 2021	**-**	**4,025**	**4,025**
Cash movements:			
Financing cash flows - payments and receipts of principal	-	-	**-**
Financing cash flows - payments of interest	-	-	**-**
Carrying value at 31 March 2022	**-**	**4,025**	**4,025**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Total
	£000	£000	£000
Carrying value at 1 April 2020	**380,376**	**1,482**	**381,858**
Cash movements:			
Financing cash flows - payments and receipts of principal	(377,859)	2,543	**(375,316)**
Financing cash flows - payments of interest	(2,517)	-	**(2,517)**
Carrying value at 31 March 2021	**-**	**4,025**	**4,025**

Note 25 Finance leases

Note 25.1 United Lincolnshire Hospitals NHS Trust as a lessor

Future lease receipts due under finance lease agreements where the trust is the lessor:

The Trust owns 3 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 2022	31 March 2021
	£000	£000
Gross lease receivables	-	-
Net lease receivables	-	-
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	156	156

Note 25.2 United Lincolnshire Hospitals NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	-	-
Net lease liabilities	-	-
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as expense in the period	-	-

Note 26 Provisions for liabilities and charges

Note 26.1 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 2021	**933**	**2,070**	**1,838**	**1,284**	**6,125**
Change in the discount rate	12	95	-	-	**107**
Arising during the year	48	57	3,164	4,128	**7,397**
Utilised during the year	(101)	(87)	(106)	-	**(294)**
Reversed unused	(11)	(1)	(463)	(875)	**(1,350)**
Unwinding of discount	(9)	(20)	-	-	**(29)**
At 31 March 2022	**872**	**2,114**	**4,433**	**4,537**	**11,956**
Expected timing of cash flows:					
- not later than one year;	101	88	4,433	4,151	**8,773**
- later than one year and not later than five years;	413	365	-	100	**878**
- later than five years.	358	1,661	-	286	**2,305**
Total	**872**	**2,114**	**4,433**	**4,537**	**11,956**

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) and Pension Injury benefits have 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 £1.6m (2020/21: £4.1m)
(2) Projected liabilities in relation to claims made against the Trust for employment, commercial and other litigation issues £0.3m (2020/21: £0.3m).
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.

***Other provisions comprise:
Costs associated with the Clinicians pension tax scheme - £0.4m (2020/21: £1.3m).
Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the tax year 2019/20 face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme.
Individual trusts have been instructed to reflect this future estimated liability within the provisions note and include a corresponding amount as owing from NHS England within the receivables note.
Estimated costs associated with potential employee pay claims £4.1m (2020/21: £nil).

Note 26.2 Clinical negligence liabilities

At 31 March 2022, £454,749k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of United Lincolnshire Hospitals NHS Trust (31 March 2021: £320,868k).

Note 27 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**-**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**-**
Net value of contingent assets	**-**	**-**

Note 28 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	11,876	9,653
Intangible assets	398	104
Total	**12,274**	**9,757**

Note 29 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 and costs recorded as 'Premises' costs within operating expenses.
An assessment of historic occupancy levels and trends is undertaken annually and is utilised by the Trust Valuer in undertaking the annual property valuation.

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 30 Financial instruments

Note 30.1 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

In April 2020 reforms to the NHS cash regime were announced by the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement.
The effect of these has been that during 2020/21 the Trust has repaid existing revenue and capital loans through the issue of Public Dividend Capital (PDC).
The rate of return on PDC is set at 3.5% of net relevant assets.
The Trust Salix loan carries no interest charge.
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 2022 are in receivables from customers, as disclosed in the trade and other receivables note.

The impact of COVID-19 was initially felt by trusts at the very end of the 2019/20 financial year, with significant impact throughout 2020/21.
DHSC instigated changes to provide stability and support to the wider NHS through additional revenue and capital funding in 2020/21 and 2021/22.
Aligned to this has been the suspension of the Payment by Results mechanism and the introduction of block contract payments from commissioners.
Block payment arrangements remain the predominant contract type in place for 2022/23.
This maintains and further supports the Trust Credit risk as low.

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.

The actions by DHSC in relation to Covid-19 support offers security to NHS bodies, providing and maintaining liquidity and minimising risks in this regard.

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost
	£000
Trade and other receivables excluding non financial assets	11,883
Cash and cash equivalents	88,297
Total at 31 March 2022	**100,180**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost
	£000
Trade and other receivables excluding non financial assets	22,139
Cash and cash equivalents	54,042
Total at 31 March 2021	**76,181**

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost
	£000
Other borrowings	4,025
Trade and other payables excluding non financial liabilities	78,671
Provisions under contract	4,537
Total at 31 March 2022	**87,233**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost
	£000
Other borrowings	4,025
Trade and other payables excluding non financial liabilities	61,036
Provisions under contract	1,284
Total at 31 March 2021	**66,345**

Note 30.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2022	31 March 2021
	£000	£000
In one year or less	83,224	61,466
In more than one year but not more than five years	3,723	3,320
In more than five years	286	1,560
Total	**87,233**	**66,346**

Note 30.5 Fair values of financial assets and liabilities

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

Note 31 Losses and special payments

	2021/22		2020/21	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	2	1	17	7
Fruitless payments and constructive losses*	1	101	1	256
Bad debts and claims abandoned	85	152	51	95
Stores losses and damage to property	5	240	6	334
Total losses	**93**	**494**	**75**	**692**
Special payments				
Compensation under court order or legally binding arbitration award	19	128	27	145
Extra-contractual payments	-	-	-	-
Ex-gratia payments**	37	1,418	184	7
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**56**	**1,546**	**211**	**152**
Total losses and special payments	**149**	**2,040**	**286**	**844**
Compensation payments received		-		-

*Reported losses include payments made to Progress Housing under an occupancy guarantee £0.12m (2020/21: £0.26m)

** In March 2021 the NHS Staff Council agreed a framework to enable NHS employers in England to resolve issues in relation to the correct calculation of pay while on annual leave, in respect of regularly worked overtime and additional standard hours, under the NHS Agenda for Change terms and conditions of service.

It was agreed that corrective payments would (subject to qualifying criteria) be based on overtime earned in the financial years 2019/2020 and 2020/2021.
Costs have been recognised in both 2020/21 and 2021/22 with actual payment of arrears having been made in September 2022.

Note 32 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 2020/21 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 2021/22:	Payments to	Receipts	Amounts	Amounts
	£000	£000	£000	£000
Lincolnshire Community Health Services NHS Trust	1,727	255	909	240
St Barnabas Hospice	150	1,398	17	224
Health Quality Improvement Partnership	-	-	-	-

Details of related party transactions 2020/21:	Payments to	Receipts	Amounts	Amounts
	£000	£000	£000	£000
Lincolnshire Community Health Services NHS Trust	2,799	1,922	365	758
St Barnabas Hospice	109	1,366	2	341
Health Quality Improvement Partnership	37	-	-	-

ULHT Key Management details	Position / related party relationship	Related Party
Mrs Elaine Baylis -Trust Chair	Trust Chair	Lincolnshire Community Health Services NHS Trust
Mr Andrew Morgan - Chief Executive	Employee	
Mrs Gail Shadlock - Non Executive Director	Non Executive Director	
Mrs Elizabeth Libizewski - Non Executive Director	Non Executive Director (part year)	
Mrs Elizabeth Libizewski - Non Executive Director	Spouse is Trustee & Vice Chair	St Barnabas Hospice
Mrs S Dunnett - Non Executive Director	Trustee / Hon Treasurer	Health Quality Improvement Partnership

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.
The main entities with whom the Trust had dealings with during 2021/22 are listed below.

NHS Lincolnshire CCG
Midlands Regional Office
NHS Resolution
Health Education England
NHS England - Central Specialised Commissioning Hub
NHS Nottingham and Nottinghamshire CCG
NHS England
NHS Property Services
NHS Blood and Transplant
NHS North Lincolnshire CCG
South West Regional Office
NHS East Leicestershire and Rutland CCG
NHS Bassetlaw CCG
NHS Improvement
Care Quality Commission
Department of Health and Social Care
Public Health England

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

NHS Pension Scheme
HM Revenue & Customs
South Kesteven District Council
Boston Borough Council
Lincoln City Council

The DHSC Group Accounting Manual identifies DHSC Ministers and senior officials, and entities controlled or influenced by them as being related parties of DHSC group bodies.
The Trust has conducted business in 2021/22 with the following three organisations with whom Ministers or senior officials have declared interests to the Department of Health and Social Care.

Leeds Teaching Hospitals NHS Trust

Lincolnshire Partnership NHS Foundation Trust

Ministry of Defence

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 2021/22 including the purchase / donation of various capital assets to the Trust as detailed at note 16.

Other Direct transactions with the Charity are summarised below:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	**£000**	**£000**	**£000**
United Lincolnshire Hospitals Charity	-	144	-	43

Note 33 Events after the reporting date

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

Note 34 Better Payment Practice code

	2021/22	2021/22	2020/21	2020/21
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	98,812	220,016	93,345	206,228
Total non-NHS trade invoices paid within target	82,405	192,571	81,669	177,707
Percentage of non-NHS trade invoices paid within target	83.4%	87.5%	87.5%	86.2%
NHS Payables				
Total NHS trade invoices paid in the year	2,806	47,339	4,162	46,851
Total NHS trade invoices paid within target	2,310	45,368	3,178	39,368
Percentage of NHS trade invoices paid within target	82.3%	95.8%	76.4%	84.0%
Total Payables				
Total NHS trade invoices paid in the year	101,618	267,355	97,507	253,079
Total NHS trade invoices paid within target	84,715	237,939	84,847	217,075
Percentage of NHS trade invoices paid within target	83.4%	89.0%	87.0%	85.8%

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 35 External financing limit

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

	2021/22	2020/21
	£000	**£000**
Cash flow financing	(7,645)	(5,977)
External financing requirement	**(7,645)**	**(5,977)**
External financing limit (EFL)	(7,645)	13,999
Under / (over) spend against EFL	**-**	**19,976**

Note 36 Capital Resource Limit

	2021/22	2020/21
	£000	£000
Gross capital expenditure	45,744	46,519
Less: Disposals	(380)	(872)
Less: Donated and granted capital additions	(27)	(3,923)
Charge against Capital Resource Limit	**45,337**	**41,724**
Capital Resource Limit	48,606	44,005
Under / (over) spend against CRL	**3,269**	**2,281**

Note 37 Breakeven duty financial performance

	2021/22	2020/21
Adjusted financial performance (control total basis):	£000	£000
Surplus / (deficit) for the period	(7,221)	3,597
Remove net impairments not scoring to the Departmental expenditure limit	8,259	2,753
Remove I&E impact of capital grants and donations	642	(3,541)
Remove net impact of inventories received from DHSC group bodies for COVID response	302	(435)
Adjusted financial performance surplus / (deficit)	**1,982**	**2,374**

	2021/22	2020/21
Adjusted financial performance against breakeven duty:		
Adjusted financial performance (control total basis):	1,982	2,374
Remove impairments scoring to Departmental Expenditure Limit	130	368
IFRIC 12 breakeven adjustment	553	407
Adjusted financial performance against breakeven duty surplus / (deficit)	**2,665**	**3,149**

Note 38 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,282	(13,880)	320	124	(25,813)	(15,161)
Breakeven duty cumulative position	4,071	5,353	(8,527)	(8,207)	(8,083)	(33,896)	(49,057)
Operating income		391,141	392,202	407,975	422,802	425,524	433,250
Cumulative breakeven position as a percentage of operating income		1.4%	(2.2%)	(2.0%)	(1.9%)	(8.0%)	(11.3%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(56,917)	(56,891)	(79,664)	(87,945)	(41,876)	3,149	2,665
Breakeven duty cumulative position	(105,974)	(162,865)	(242,529)	(330,474)	(372,350)	(369,201)	(366,536)
Operating income	423,428	437,324	433,161	447,492	539,248	643,878	680,194
Cumulative breakeven position as a percentage of operating income	(25.0%)	(37.2%)	(56.0%)	(73.9%)	(69.0%)	(57.3%)	(53.9%)

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.