



United Lincolnshire
Teaching Hospitals
NHS Trust

Annual report and accounts 2024/25



Caring and building a
healthier future for all

Contents

Accessibility	9
Group Chair and Chief Executive's perspective on the performance of the organisation during 2024/25.....	10
Performance report	13
Performance overview	14
About us	14
Purpose and activities of the organisation.....	15
Performance appraisal.....	18
Vision, ambitions and strategies for 2020-2025	18
Achievements during 2024/2025.....	19
Our key risks and issues	52
Performance challenges	54
Development of the Lincolnshire Community and Hospitals NHS Group.....	54
The future: looking ahead to our vision, ambitions and strategies for 2024/25 .	56
Going Concern.....	56
Performance analysis	57
Purpose of the performance analysis.....	57
Key performance measures and how they are measured.....	57
Performance against national targets.....	61
Sustainability report.....	66
Emergency Preparedness, Resilience and Response (EPRR).....	69
Overseas visitors.....	71
Accountability report.....	74
Corporate governance report.....	75
Directors report	75
Board Changes	76
Audit and Risk Committee.....	77
Code of Governance for NHS provider trusts.....	77
Declaration: Audit of the Trust Annual Report and Accounts 2023/24	82

Statement of accounting/accountable officer's responsibilities.....	84
Annual Governance Statement.....	85
Scope of Responsibility	85
The Purpose of the system of internal control	85
Capacity to handle risk.....	85
The risk and control framework.....	86
Review of economy, efficiency and effectiveness of the use of resources	91
Developing workforce safeguards	92
Stakeholder engagement	93
Information Governance.....	93
Data quality and governance	93
Review of effectiveness	93
The Audit and Risk Committee	94
Clinical Audit	94
Internal Audit.....	95
Conclusion	95
Remuneration and staff report.....	97
Remuneration policy	98
Terms and Conditions	98
Single total figure remuneration table (the figures incorporated within the note below are subject to audit)	100
Remuneration Split.....	102
Definitions:	103
Pensions entitlement table	105
Compensation on early retirement or for loss of office	107
Payments to past directors.....	107
Fair pay disclosure	107
Percentage change in remuneration of highest paid director	108
Staff report	110
Staff numbers and costs	111

Staff composition.....	111
Sickness absence	112
Fairness and equity.....	113
Staff policies applied during the financial year	115
Trade union facility time reporting requirements	115
Other employee matters.....	117
National Staff Survey	117
Review of economy, efficiency and effectiveness of the use of resources.....	118
Freedom to speak up	119
Consultancy expenditure.....	120
Off-payroll engagements.....	120
Exit packages.....	122
Parliamentary accountability and audit report	124
Financial statements	126
Statement of Comprehensive Income	127
Statement of Financial Position.....	128
Statement of Cash Flows	129
Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025	130
Statement of Changes in Taxpayers' Equity for the year ended 31 March 2024	130
Information on reserves	131
Notes to the Accounts.....	132
Note 1.1 Basis of preparation.....	132
Note 1.2 Going concern	132
Note 1.3 Consolidation.....	132
Note 1.4 Revenue from contracts with customers.....	133
Note 1.5 Other forms of income	135
Note 1.6 Expenditure on employee benefits	136
Note 1.7 Expenditure on other goods and services.....	136

Note 1.8 Discontinued operations	137
Note 1.9 Property, plant and equipment.....	137
Note 1.10 Intangible assets.....	143
Note 1.11 Inventories	145
Note 1.12 Cash and cash equivalents.....	145
Note 1.13 Financial assets and financial liabilities	145
Note 1.14 Leases	148
Note 1.15 Provisions	150
Note 1.16 Contingencies	151
Note 1.17 Public dividend capital (PDC)	152
Note 1.18 Value added tax.....	153
Note 1.19 Corporation tax	153
Note 1.20 Climate change levy	153
Note 1.21 Foreign exchange	153
Note 1.22 Third party assets	153
Note 1.23 Losses and special payments.....	154
Note 1.24 Gifts	154
Note 1.25 Early adoption of standards, amendments and interpretations.....	154
Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted.....	154
Note 1.27 Critical judgements in applying accounting policies.....	156
Note 1.28 Sources of estimation uncertainty.....	157
Note 1.29 Adjusted performance results	158
Note 2 Operating Segments.....	158
Note 3 Operating income from patient care activities.....	160
Note 3.1 Income from patient care activities (by nature)	160
Note 3.2 Income from patient care activities (by source)	161
Note 3.3 Overseas visitors (relating to patients charged directly by the provider)	161
Note 4 Other operating income	162

Note 5 Fees and charges	163
Note 5.1 Other Schemes.....	163
Note 6 Operating leases - United Lincolnshire Teaching Hospitals NHS Trust as lessor	164
Note 6.1 Operating lease income.....	164
Note 6.2 Future lease receipts	164
Note 7 Operating expenses	165
Note 7.1 Limitation on auditor's liability	166
Note 8 Impairment of assets	166
Note 8.1 Material Impairment losses / (reversals)	166
Note 8.2 Property, Plant and Equipment impairments and reversals charged to the revaluation reserve.....	167
Note 9 Employee benefits	168
Note 9.1 Retirements due to ill-health	168
Note 10 Pension Costs	168
Note 11 Finance income	170
Note 12 Finance expenditure	170
Note 12.1 The late payment of commercial debts (interest) Act 1998.....	170
Note 13 Other gains / (losses)	171
Note 14 Intangible assets - 2024/25.....	172
Note 14.1 Intangible assets - 2023/24.....	173
Note 15 Property, plant and equipment - 2024/25	174
Note 15.1 Property, plant and equipment - 2023/24.....	175
Note 15.2 Property, plant and equipment financing - 31 March 2025	176
Note 15.3 Property, plant and equipment financing - 31 March 2024	176
Note 16 Donations of property, plant and equipment.....	177
Note 17 Revaluations of property, plant and equipment	177
Note 18 Leases - United Lincolnshire Teaching Hospitals NHS Trust as a lessee	179
Note 18.1 Right of use assets - 2024/25	181

Note 18.2 Right of use assets - 2023/24	182
Note 18.3 Reconciliation of the carrying value of lease liabilities	183
Note 18.4 Maturity analysis of future lease payments.....	184
Note 19 Inventories	184
Note 20 Receivables	185
Note 20.1 Allowances for credit losses	186
Note 20.2 Exposure to credit risk	186
Note 21 Finance leases (United Lincolnshire Teaching Hospitals NHS Trust as a lessor)	187
Note 22 Cash and cash equivalents movements	188
Note 22.1 Third party assets held by the trust.....	188
Note 23 Trade and other payables.....	189
Note 24 Other liabilities	189
Note 25 Borrowings.....	190
Note 26 Reconciliation of liabilities arising from financing activities	190
Note 27 Provisions for liabilities and charges analysis.....	192
Note 27.1 Clinical negligence liabilities	193
Note 28 Contingent assets and liabilities	194
Note 29 Contractual capital commitments.....	194
Note 30 On-SoFP PFI, LIFT or other service concession arrangements	194
Note 30.1 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities	195
Note 31 Financial instruments.....	195
Note 31.1 Financial risk management.....	195
Note 31.2 Carrying values of financial assets	196
Note 31.3 Carrying values of financial liabilities	197
Note 31.4 Maturity of financial liabilities	197
Note 31.5 Fair values of financial assets and liabilities	198
Note 32 Losses and special payments.....	198
Note 33 Gifts	198

Note 34 Related parties	198
Note 35 Better Payment Practice code	201
Note 36 Capital Resource Limit.....	201
Note 37 Breakeven duty financial performance	201
Note 38 Breakeven duty rolling assessment	202

Accessibility

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

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

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

Jei Jums reikia šio dokumento lietuviu kalba, skambinkite telefonu (01522) 573986. Jesli chciał(a)by Pan(i) uzyskac ten dokument w jezyku polskim, prosimy zadzwonic na numer (01522) 573986.

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

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

Group Chair and Chief Executive's perspective on the performance of the organisation during 2024/25



Welcome to the Annual Report for United Lincolnshire Teaching Hospitals NHS Trust (ULTH) for 2024/25. This document provides an overview of the activity that has been taking place within our hospitals over the past year.

This year has seen the organisation come together as a Group with Lincolnshire Community Health Services NHS Trust (LCHS), which has enabled us to focus more than ever before on improving our services together for the benefit of the residents of Lincolnshire.

We are already seeing benefits in terms of more streamlined, effective and efficient services that are easier for patients to understand and access. There are examples of fantastic Group working across our services which have reduced bureaucracy and put the patient at the heart of the design of our services.

During the year, we also received the fantastic news that we were successful in our application for teaching hospital status. This is awarded by the Secretary of State for Health and Social Care, and will not only benefit our patients, but will further enhance our ability to attract top-tier talent to our hospitals, the Group and the wider NHS in Lincolnshire.

However, this past year has not been without its challenges. We have continued to experience increased pressure on our Emergency Departments and continued challenges around cutting our waiting lists, as well as the impact of a spike in respiratory viruses and norovirus during the winter season which affected both our staff and our services. We have also faced a number of estates issues such as water and power outages.

In spite of these, there is much to be proud of and celebrate. This includes examples of improved performance in a number of national standards, notably including huge progress made in improved performance on the four-hour A&E standard and significantly reducing ambulance handover times in our Emergency Departments which has freed up ambulance service colleagues to serve our communities. We were also proud to have been moved out of the 'tiering' programme for elective and diagnostics by the NHS National Elective Recovery and Diagnostics Programme.

Other achievements over the past year have included:

- Construction of the first phase of the multi-million pound Emergency Department at Pilgrim Hospital, Boston is almost complete.
- Opening of two new Community Diagnostic Centres in Skegness and Lincoln, at a cost of £38 million.
- Recruiting hundreds of patients to a wide range of clinical trials and studies.
- Starting work on the build of a £19 million new Endoscopy Unit at Lincoln County Hospital.
- Numerous national award wins for individuals and teams across the Trust.
- Continued to assess and recognise clinical areas as part of our ambitious Diamond Award in Quality Accreditation programme.
- Rollout of 'Martha's Rule' Call For Concern service at both Lincoln and Boston hospitals, offering patients, their families and carers 24-hour access to a rapid review if they have concerns about a person's deteriorating condition.
- Opening of a new hub to support the wellbeing of care partners and provide practical advice and guidance at Pilgrim Hospital, Boston.
- Approval to procure an electronic patient record (EPR) which will transform how we manage patient records.
- Finished the implementation of a digital solution for Electronic Prescribing and Medicines Administration (ePMA).
- The expansion of the United Lincolnshire Hospitals Charity, which supports our staff and patients.

Over the next year we will continue with our focus on moving more of our services closer to the people that need them, improving quality of care for our patients and making sure that people are seen and treated in the right place, at the right time, by the most appropriate healthcare professional as part of Lincolnshire Community and Hospitals NHS Group.

Elaine Baylis, Chair

Professor Karen Dunderdale, Chief Executive

Performance report



Performance 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 the Trust is 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 2024/25, 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 (NHSE).

About us

United Lincolnshire Teaching Hospitals NHS Trust (ULTH) serves one of the largest geographical areas in England with a population of around 782,808 (Office of National Statistics, Mid 2003 Population Estimate).

Services are provided by four core clinical divisions: Medicine, Surgery, Family Health and Clinical Support Services with support from corporate divisions.

The Trust provides a comprehensive range of hospital based medical, surgical, paediatric, obstetric and gynaecological services and primarily operate from four hospital sites in Lincoln, Boston, Grantham and Louth.

Services are also delivered from a number of community hospitals providing additional capacity closer to patients' homes; John Coupland Hospital in Gainsborough, Johnson Community Hospital in Spalding, Skegness and District Hospital and Community Diagnostic Centres in Grantham, Lincoln and Skegness.

The Trust has an annual income for 2024/25 of £899.5m and the main contract is with NHS Lincolnshire Integrated Care Board (ICB)

In an average year, ULTH treats more than 150,000 accident and emergency patients, over 700,000 outpatients and over 130,000 inpatients, and deliver around 4,000 babies.

2023/24 vs 2024/25 activity was as follows:

	2023/24	2024/25
Outpatient	679,357	730,699
A&E Attendances*	154,418	166,430
Inpatients	131,213	139,837

*Grantham A&E changed to an urgent treatment centre (UTC) on 31 October 2023, this is Lincoln A&E, Boston A&E and Grantham UTC

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

Purpose and activities of the organisation

ULTH delivers acute hospital services for the people of Lincolnshire. These services are delivered via four clinical divisions and 14 clinical business units, as detailed below.

Clinical Support Services Division

Clinical Business Units	Services
Cancer	Haematology
	Oncology
	Radiotherapy/Radiotherapy Physics
	Cancer centre
Palliative and End of Life Care	
Diagnostics	Endoscopy
	Respiratory Physiology
	Neurophysiology
	Audiology
	Radiology
	Nuclear Medicine
	Clinical Engineering
	Radiation Protection and Radiation Physics
	Screening Services
Outpatients	Outpatient Appointments Services
	Health Records
	Outpatient Nursing
Therapies and Rehabilitation	Rehabilitation Medicine
	Occupational Therapy
	Orthotics
	Dietetics
	Physiotherapy
Pharmacy	In-patient pharmacy
	Aseptic services

Family Health Division

Clinical Business Units	Services
Women's Health and Breast Services	Breast
	Maternity
	Gynaecology
Children and Young Person's	Paediatrics
	Community Paediatrics

	Neonatology
--	-------------

Medicine Division

Clinical Business Units	Services
Urgent and Emergency Care	A&E
	Acute Medicine
	Urgent Treatment Centre (Grantham only)
Cardiovascular	Cardiology (including Cardiac Physiology)
	Stroke
	Endocrinology
	Diabetes
	Renal
Specialty Medicine	Dermatology
	Rheumatology
	Neurology
	Gastroenterology
	Respiratory

Surgical Division

Clinical Business Units	Services
General Surgery, Vascular, Head and Neck	General Surgery
	Vascular
	Head and Neck
Urology, Trauma and Orthopaedics and Ophthalmology	Trauma and Orthopaedics
	Ophthalmology
	Orthoptics
	Urology
Theatres Anaesthesia and Critical Care	Theatres
	Critical Care
	Anaesthesia

The four divisions were introduced to provide consistent structures with strengthened roles, clearer decision making closer to the front line of service delivery.

Performance appraisal

Vision, ambitions and strategies for 2020-2025

In February 2020, the Trust Board committed to delivering ULTH's five-year integrated improvement plan (IIP). At this time little did we know that we would be experiencing a global pandemic that disrupted healthcare delivery as we knew it. As a result the first two years of the plans were severely affected. In 24/25 we established a Group between ULTH and LCHS. As we moved into the transitional year of working as Group, our strategic plan proposed alignment to key benefits and deliverables. Our strategic aims (common across LCHS and ULTH) are detailed below.

For consistency of language and common understanding, strategic aims and objectives are defined as below:

- **Strategic aims** capture the five things we must do to deliver our vision. They are an organisation's long-term goals and create the bridge between our vision and the annual goals needed to achieve it.
- **Strategic objectives** are the things we must do to deliver each of the strategic aims. They act as a roadmap, aligning efforts across teams to ensure that every action contributes to overarching aims. Assurance ratings are assigned to each strategic objective in the Board Assurance Framework.
- We have also added an additional strategic aim on 'populations' to capture the key deliverables across the group where we can demonstrate impact and improvement in patient care, clinical pathways, our people and wider health of the populations we serve.

Strategic aim 1: Patients

To deliver high quality, safe and responsive patient services

Strategic aim 2: People

To enable our people to lead, work differently, be inclusive, motivated and proud to work within the Group

Strategic aim 3: Services

To ensure services are sustainable, supported by technology and delivered from an improved estate

Strategic Aim 4: Communities

To implement new models of care with our ICS/partners to improve Lincolnshire's health and wellbeing

Strategic Aim 5: Populations

To deliver personalised health services for our population that are accessible and responsive

The integrated improvement plan sets out the Trust's commitment to continual improvement and a map for the next stages of the improvement journey. The annual integrated improvement plan detailed the work to progress and the actions to be taken during the year under the key objectives. The Trust pledged to put quality improvement, productivity and efficiency at the heart of what it does to support delivery of better patient outcomes, improve operational and financial sustainability.

Achievements during 2024/2025

To monitor progress during 2024/25, the Trust identified key performance indicators. These are displayed in the following tables.

For our patients:

- Falls incidents resulting in harm: The total number of fall incidents reported as causing harm (moderate, severe or death) per 1,000 OBD
- Percentage of medication incidents reported as causing harm (low, moderate, severe or death) per 1,000 OBD
- DKA incidents resulting in harm: The total number of DKA incidents reported as causing harm (moderate, severe or death) per 1,000 OBD

Patient objective 1a: Deliver high quality care which is safe, responsive and able to meet the needs of the population

What we will achieve in 2024/25

Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm and reviewing external reports and assessments of our services.

Falls incidents resulting in harm: The total number of fall incidents reported as causing harm (moderate, severe or death) per 1,000 OBD

Target: <0.19

2024/25 Q1 target:			2024/25 Q2 target:			2024/25 Q3 target:			2024/25 Q4 target:		
<0.19			<0.19			<0.19			<0.19		
M 01	M 02	M 03	M 04	M 05	M 06	M 07	M 08	M09	M10	M11	M12
0.09	0.17	0.12	0.08	0.20	0.12	0.22	0.09	0.08	0.11	0.12	0.05

Incidents occurring in ED resulting in harm: Total number of incidents in ED reported as causing harm (moderate, severe or death)

Target: 0

2024/25 Q1 target:			2024/25 Q2 target:			2024/25 Q3 target:			2024/25 Q4 target:		
0			0			0			0		
M 01	M 02	M 03	M 04	M 05	M 06	M 07	M 08	M09	M10	M11	M12
6	1	3	1	0	2	2	0	1	2	2	0

Improve our medication management safety and reduce medication-related incidents resulting in harm, supported by implementation of an e-Prescribing system.

Percentage of medication incidents reported as causing harm (low, moderate, severe or death) per 1,000 OBD

Target: 10.70%

2024/25 Q1 target:			2024/25 Q2 target:			2024/25 Q3 target:			2024/25 Q4 target:		
15.00%			13.00%			11.50%			10.70%		
M 01	M 02	M 03	M 04	M 05	M 06	M 07	M 08	M09	M10	M11	M12
20.40%	7.40%	12.30%	9.50%	8.50%	13.50%	17.60%	17.60%	10.90%	19.60%	8.30%	10.50%

We will embed the Patient Safety Incident Response Framework (PSIRF): There will be a corporate focus on the five areas identified through PSIRF: Inpatient falls, delayed review or missed review of diagnostic tests, end of life and ReSPECT, medication errors and DKA.

DKA incidents resulting in harm: The total number of DKA incidents reported as causing harm (moderate, severe or death) per 1,000 OBD

Target: 0

2024/25 Q1 target:			2024/25 Q2 target:			2024/25 Q3 target:			2024/25 Q4 target:		
0			0			0			0		
M 01	M 02	M 03	M 04	M 05	M 06	M 07	M 08	M09	M10	M11	M12
1	0	0	0	0	0	0	1	0	2	0	0

Patient objective 1b: Improve patient experience

What we will achieve in 2024/25

Focus on improving the top three patient complaint themes: Communication, appointments and clinical practice.

Number of avoidable complaints where a complaint or PALS enquiry states that there was difficulty in getting through to the ward, phone not being answered or relative being informed (participating wards).

Target: 0

2024/25 Q1 target:			2024/25 Q2 target:			2024/25 Q3 target:			2024/25 Q4 target:		
0			0			0			0		
M 01	M 02	M 03	M 04	M 05	M 06	M 07	M 08	M09	M10	M11	M12
6	2	3	3	6	2	4	1	3	2	4	3

Patient objective 1c: Improve clinical outcomes

What we will achieve in 2024/25

Ensure we provide clinically safe services, through an increased volume of Diamond Accredited Wards.

DKA incidents resulting in harm: The total number of DKA incidents reported as causing harm (moderate, severe or death) per 1,000 OBD.

This qualitative measurement will be reported every quarter starting from January 2025 and the next report will be due in April 2025. The reason for shifting from monthly to quarterly is to allow clinical areas the time to progress through the Diamond Award criteria.

M 01	M 02	M 03	M 04	M 05	M 06	M 07	M 08	M09	M10	M11	M12
1	0	0	0	0	0	0	1	0	2	0	0

Patient objective 1d: Deliver clinically led integrated services

What we will achieve in 2024/25

Develop a regional model for Oncology, Haematology and Stroke that reduces fragility and improves outcomes/resilience.

Improved delivery of equitable specialised care to our population supported through the delivery of the EMAP work programme

This qualitative measurement will be reported every quarter (October/January/April)

Quarter 1:

Reporting started in October 2024.

Quarter 2:

Quarterly update submitted to QCC in October 2024.

Quarter 3:

Submitted to Finance Committee in January 2025 under the Partners (4a) progress update report.

Quarter 4:

Submitted to Finance Committee in April 2025 under the Partners (4a) progress update report.

Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme.

Total number of frail/elderly patients managed as a day case through the Frailty Assessment Unit
This qualitative measurement will be reported every quarter (October/January/April)
Quarter 1: Reporting started in October 2024.
Quarter 2: Quarterly update submitted to QCC in October 2024.
Quarter 3: Submitted to Finance Committee in January 2025 under the Partners (4a) progress update report.
Quarter 4: Submitted to Finance Committee in April 2025 under the Partners (4a) progress update report.

Total number of non-elective admissions for frail elderly and reduction in unplanned admissions for moderate to severe frail elderly
This qualitative measurement will be reported every quarter (October/January/April)
Quarter 1: Reporting started in October 2024.
Quarter 2: Quarterly update submitted to QCC in October 2024.
Quarter 3: Submitted to Finance Committee in January 2025 under the Partners (4a) progress update report.
Quarter 4: Submitted to Finance Committee in April 2025 under the Partners (4a) progress update report.

Working with partners to utilise alternative pathways to ED through increasing the use of UTCs, UCRs and ARIs

This qualitative measurement will be reported every quarter (October/January/April)

Quarter 1:

Reporting started in October 2024.

Quarter 2:

Quarterly update submitted to Quality Committee in October 2024.

Quarter 3:

Submitted to Finance Committee in January 2025 under the Partners (4a) progress update report.

Quarter 4:

Submitted to Finance Committee in April 2025 under the Partners (4a) progress update report.

Implement ASR – establish an successful integrated stroke service across the group alongside UTC and frailty service at Grantham and District Hospital

Improvement in Stroke Integrated Care and SNAPP performance

This qualitative measurement will be reported every quarter (October/January/April)

Quarter 1:

Reporting started in October 2024.

Quarter 2:

Quarterly update submitted to Quality Committee in October 2024.

Quarter 3:

Submitted to Finance Committee in January 2025 under the Partners (4b) progress update report.

Quarter 4:

Submitted to Finance Committee in April 2025 under the Partners (4b) progress update report.

Fully maximising Grantham UTC – activity trajectory

This qualitative measurement will be reported every quarter (October/January/April)

Quarter 1:

Reporting started in October 2024.

Quarter 2:

Quarterly update submitted to Quality Committee in October 2024.

Quarter 3:

Submitted to Finance Committee in January 2025 under the Partners (4b) progress update report.

Quarter 4:

Submitted to Finance Committee in April 2025 under the Partners (4b) progress update report.

Deliver transformational change in key pathways across the group such as OPAT

Development of key prioritised transformation pathways with associated KPIs

This qualitative measurement will be reported every quarter (October/January/April)

Quarter 1:

Reporting started in October 2024.

Quarter 2:

Quarterly update submitted to Quality Committee in October 2024.

Quarter 3:

Submitted to Finance Committee in January 2025 under the Partners (5c) progress update report.

Quarter 4:

Submitted to Finance Committee in April 2025 under the Partners (5c) progress update report.

For our people:

- Mandatory training compliance has exceeded the 2024/25 target position of 90%, as the M12 position is 92.95%
- Sickness absence rate has exceeded the Q4 target of being at a rolling 12-month average of 5.50%, as the M12 position is 5.31%

People objective 2a: Making Lincolnshire Community and Hospitals NHS Group (LCHG) the best place to work through delivery of the People Promise

What we will achieve in 2024/25

Work to increase substantive recruitment into all our roles, deliver a plan for every vacant post where this is possible and change our workforce skill-mix where recruitment to posts are not possible, redesigning work and roles to deliver the best possible care.

Total vacancy rate at 4.50% or less by March 2025

Target: 4.50%

2024/25 Q1 target: 9.31%			2024/25 Q2 target: 7.71%			2024/25 Q3 target: 6.11%			2024/25 Q4 target: 4.50%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
6.18%	5.70%	5.33%	8.51%	8.51%	7.89%	7.09%	6.23%	6.67%	6.10%	5.97%	6.21%

Turnover Rate at 9.00% by 31 March 2025

Target: 9.90%

2024/25 Q1 target: 12.72%			2024/25 Q2 target: 11.48%			2024/25 Q3 target: 10.24%			2024/25 Q4 target: 9.00%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
10.30%	10.09%	9.98%	10.00%	10.15%	10.22%	10.04%	9.65%	9.54%	9.34%	9.47%	9.40%

Support divisions to achieve 90% of our people having completed all relevant statutory and mandatory training by March 2025.

Minimum of 90.00% of our people have completed their mandatory training by 31 March 2025											
Target: 90%											
2024/25 Q1 target: 90%			2024/25 Q2 target: 90%			2024/25 Q3 target: 90%			2024/25 Q4 target: 90%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
93.71%	93.67%	93.42%	93.71%	93.99%	93.81%	93.75%	93.55%	93.69%	93.53%	93.26%	92.95%

Support our divisions to provide all staff with an appraisal and clear objectives.

Improved combined appraisal rate, achieving a minimum of 90.00% by 31 March 2025											
Target: 90%											
2024/25 Q1 target: 76.78%			2024/25 Q2 target: 81.18%			2024/25 Q3 target: 85.58%			2024/25 Q4 target: 90%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
77.59%	77.97%	77.84%	79.31%	81.94%	81.75%	81.15%	81.34%	81.68%	78.31%	77.25%	78.79%

Proactively support staff to remain well and at work, however should the need arise, supporting them through illness and their return to work.

Sickness Absence Rate at a rolling 12 month average of 5.50% by 31 March 2025											
Target: 5.50%											
2024/25 Q1 target: 5.51%			2024/25 Q2 target: 5.47%			2024/25 Q3 target: 5.54%			2024/25 Q4 target: 5.50%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
5.40%	5.39%	5.41%	5.42%	5.36%	5.28%	5.23%	5.23%	5.24%	5.26%	5.28%	5.31%

People objective 2b: To be the employer of choice

What we will achieve in 2024/25

Improve Acute Trust consultant and middle tier stabilisation and succession planning (ULHT)

Total reduction in staff vacancy rate %

Target: 4.50%

2024/25 Q1 target: 9.31%			2024/25 Q2 target: 7.71%			2024/25 Q3 target: 6.11%			2024/25 Q4 target: 4.50%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
5.84%	5.36%	4.99%	7.25%	4.50%	7.23%	13.09%	11.37%	10.30%	8.43%	7.93%	7.73%

Increased compliance (monthly improvement when compared to previous month) seen in 2024/25

Job plan completion for 2024/25

Target: 100%

2024/25 Q1 target: 10%			2024/25 Q2 target: 60%			2024/25 Q3 target: 90%			2024/25 Q4 target: 100%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
60%	71%	78%	82%	88%	89.0%	90.31%	90.31%	90.00%	91.33%	92.03%	92.50%

ED recruitment for PHB (WTE)

Target: 38

2024/25 Q1 target: 27			2024/25 Q2 target: 30			2024/25 Q3 target: 33			2024/25 Q4 target: 38		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
22	25	26	30	31	33	34	34	34	34	33	33

ED recruitment for LCH (WTE)

Target: 38

2024/25 Q1 target: 28			2024/25 Q2 target: 33			2024/25 Q3 target: 36			2024/25 Q4 target: 38		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
25	28	29	29	30	31	31	31	33	33	31	31

For our services:

- At M12, ULTH has deliver £40.5m against a cost improvement plan of £40.1m, which is £0.4m surplus
- Explore innovative technology solutions: Catering offers across key areas, such as outpatients, to extend their opening times
- Deployment of a seven-day working model across urgent care services
- Number of patients on a cancer pathway diagnosed within 28 days or less of referral
- Number of patient ED attendances transferred, admitted or discharged within 4 hours of arrival
- Percentage of adult general and acute bed occupancy. National asks 92% or below
- Through the Impact Charity Garden Project, the gardens at Grantham District Hospital, Lincoln County Hospital and Pilgrim Hospital are officially open

Services objective 3a: Deliver financially sustainable healthcare, making best use of resources

What we will achieve in 2024/25

Operate within our financial envelope, supported through our cost improvement programmes and capital investments.

Financial Plan: Variance against the Trust Financial Plan

Target: £6.9m deficit

2024/25 Q1 target: £(9,815)k			2024/25 Q2 target: £(748)k			2024/25 Q3 target: £2,052k			2024/25 Q4 target: £38k		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
£1k	£55k	£(1,895)k	£(2,521)k	£(707)k	£(2,497)k	£(4,831)k	£(2,805)k	£(5,647)k	£(4,052)k	£16,070k	£(2,547)k

Cost Improvement Plan: Variance against Year To Date Plan

Target: £40.1m

2024/25 Q1 target: £3,832k			2024/25 Q2 target: £9,914k			2024/25 Q3 target: £12,296k			2024/25 Q4 target: £14,058		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
£(243)k	£1	£538k	£2,232k	£2,385k	£2,187k	£2,338k	£(377)k	£(1,722)k	£(1,863)k	£(1,558)k	£371k

Deliver the Capital Programme

Target: £88.1m

2024/25 Q1 target: £10,140k			2024/25 Q2 target: £20,315k			2024/25 Q3 target: £22,942k			2024/25 Q4 target: £34,733k		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
£2,183k	£2,773k	£2,956k	£5,634k	£6,838k	£7,822k	£7,513k	£6,901k	£8,000k	£3,483k	£8,973k	£25,052k

Address capacity across Fragile Services and ensure there is a clear governance framework that drives the local, system and regional improvements in Fragile Services.

Reduction in the number of Fragile Services and/or the risk scores in our Fragile Services

This qualitative measurement will be reported every quarter (July/October/January/April)

Target: N/A

Quarter 1:

Please refer to the standalone Fragile Services Report submitted to June's FPEC.

Quarter 2:

Please refer to the standalone Fragile Services Report submitted to October's FPEC.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Maximise our opportunities for driving productivity.

Increased theatre utilisation (planned)

Target: 95%

2024/25 Q1 target: 91.30%			2024/25 Q2 target: 95%			2024/25 Q3 target: 95%			2024/25 Q4 target: 95%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
90.81%	89.65%	88.67%	89.13%	88.08%	90.67%	87.81%	88.89%	88.29%	85.14%	89.87%	91.32%

Services objective 3b Drive better decisions and impactful action through insight

What we will achieve in 2024/25

Develop a common Integrated Performance Report across the group ensuring utilisation of the population health data metrics is being used to offer insights.

Alignment of the Performance Review Meetings across the Group

This qualitative measurement will be reported every quarter
(July/October/January/April)

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Alignment of the Integrated Performance Reports across the Group

This qualitative measurement will be reported every quarter
(July/October/January/April)

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Services objective 3c A modern, clean and fit for purpose environment across the Group

What we will achieve in 2024/25

Reduce our backlog maintenance liability.

Delivery of the 2024/25 capital programme of the critical estate infrastructure schemes (6 Facet Survey informs the capital prioritisation process).

The first report will be available in August and then will be reported every quarter (October/January/April)

Target: N/A

Quarter 1:

A report will be submitted to the Capital Delivery Group, which is a sub group of the Finance, Performance and Estates Committee. Any escalations will be upwardly reported to FPEC from this group.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Improve the functionality of our space.

Improve the clinical adjacencies of our services

This qualitative measurement will be reported every quarter (October/January/April)

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in August 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Maximise the use of our gardens and outdoor space to offer rehabilitation and wellbeing for patients, staff and visitors.

Quarterly report detailing delivery of charity garden projects
This qualitative measurement will be reported every quarter (July/October/January/April) Target: N/A
Quarter 1: Quarterly update submitted to FPEC in August 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Support capacity maximisation ensuring modernisation and utilisation of space and reduction in backlog maintenance through implementing a long term estates strategy across the Group.

A joint estates strategy that links the clinical vision to the future of our hospital sites
This qualitative measurement will be reported every quarter (October/January/April) Target: N/A
Quarter 1: Quarterly update submitted to FPEC in August 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Improve our catering offer to both patients, staff and visitors across the Group, review centralising processing unit, install new technologies to reduce waste, increase efficiency and choice along with product quality.

The number of retail facilities open to support the catering offer
This qualitative measurement will be reported every quarter (July/October/January/April) Target: N/A
Quarter 1: Quarterly update submitted to FPEC in July 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Develop, install and implement an electronic patient menu by the end of 2024/25
This qualitative measurement will be reported every quarter (July/October/January/April) Target: N/A
Quarter 1: Quarterly update submitted to FPEC in July 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Explore innovative technology solutions: Catering offers across key areas such as outpatients/extended opening hours

This qualitative measurement will be reported every quarter (July/October/January/April)

Target: N/A

Quarter 1:

This achievement has already been delivered.

Quarter 2:

This achievement has already been delivered.

Quarter 3:

This achievement has already been delivered.

Quarter 4:

This achievement has already been delivered.

Services objective 3d: Reduce waits for patients who require urgent emergency care and diagnostics and ensure we meet all constitutional standards

What we will achieve in 2024/25

Develop a plan to ease Emergency Department (ED) flow with a focus on alternative pathways to ED: Ambulance Handovers, 12-hour waits, and appropriate referrals into secondary care. To support 76% of patients transferred, admitted or discharged within 4 hours of arrival.

Number of patient ED attendances transferred, admitted or discharged within 4 hours of arrival

Target: 78%

2024/25 Q1 target: 75.01%			2024/25 Q2 target: 76.01%			2024/25 Q3 target: 77.01			2024/25 Q4 target: 78%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
74.08%	71.72%	72.71%	72.12%	73.67%	74.53%	73.04%	72.87%	71.41%	73.47%	73.72%	78.21%

Percentage of patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendance

Target: 5%

2024/25 Q1 target: 16.19%			2024/25 Q2 target: 13.70%			2024/25 Q3 target: 8.73%			2024/25 Q4 target: 5%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
17.37%	21.71%	22.03%	20.99%	17.67%	20.06%	21.53%	17.87%	18.62%	22.33%	20.47%	11.46%

Percentage of adult general and acute bed occupancy. National asks 92% or below

Target: 92%

2024/25 Q1 target: 92%			2024/25 Q2 target: 92%			2024/25 Q3 target: 92%			2024/25 Q4 target: 92%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
92.29 %	92.88 %	91.65 %	91.20 %	92.04 %	89.66 %	90.89 %	93.85 %	86.98 %	94.75 %	93.46 %	90.51 %

Develop plans for seven days working across all of our services to increase provision and ensure equity across sites linked to delayed discharge priorities.

Deployment of 7 day working model across urgent care services

This qualitative measurement will be reported every quarter
(July/October/January/April)

Target: N/A

Quarter 1:

This achievement has already been delivered.

Quarter 2:

This achievement has already been delivered.

Quarter 3:

This achievement has already been delivered.

Quarter 4:

This achievement has already been delivered.

Services objective 3e: Reducing unwarranted variation in cancer service delivery and ensure we meet all constitutional standards

What we will achieve in 2024/25

Meet all constitutional standards for cancer care including increasing the % of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition for 2028

Number of patients diagnosed within 28 days or less, of referral as a percentage of total cancer pathways

Target: 75%

2024/25 Q1 target: 75%			2024/25 Q2 target: 75%			2024/25 Q3 target: 75%			2024/25 Q4 target: 75%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
73.10 %	78.40 %	81.50 %	78.9 %	76.02 %	78.20 %	79.50 %	80.50 %	79.70 %	75.20 %	80.6 %	90.51 %

Snapshot

Number of patients waiting 62 days or less of referral as a percentage of total cancer pathways

Target: 85%

2024/25 Q1 target: 60%			2024/25 Q2 target: 70%			2024/25 Q3 target: 80%			2024/25 Q4 target: 85%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
58.70 %	51.30 %	66.20 %	64.00 %	61.00 %	60.50 %	62.30 %	66.40 %	68.90 %	62.00 %	52.70 %	66.10 %

Snapshot

Services objective 3f: Reduce waits for patients who require planned care and diagnostics to constitutional standards

What we will achieve in 2024/25

Meet all constitutional standards for cancer care including increasing the % of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition for 2028.

Eliminate waits of over 65 weeks for elective care by September 2024

Target: 0

2024/25 Q1 target: N/A			2024/25 Q2 target: N/A			2024/25 Q3 target: 0			2024/25 Q4 target: 0		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
306	349	507	493	560	388	201	120	53	30	29	Data not available

Reduction in 52-week wait patients

Target: 2027

2024/25 Q1 target: N/A			2024/25 Q2 target: N/A			2024/25 Q3 target: N/A			2024/25 Q4 target: 2027		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
3,033	3,105	3,259	3,182	3,280	2,949	2,181	1,944	1,543	1,552	1,461	Data not available

For our partners

- The Trust has achieved and maintained a performance of 0% for the reduction in Desflurane from 2% to 0%, from June 2024 to January 2025.
- The development of a joint research strategy is on hold, pending a Group Board development session to set strategic direction. To align with ambitions for University Teaching Hospital status, the Group must significantly enhance its research capacity, capability and culture. Progress is currently limited by a lack of investment opportunities within the Lincolnshire ICS. In the interim, the two research offices are prioritising quality, strengthening Group-wide operations and formally engaging with stakeholders to co-develop a research vision that is both aspirational and aligned with the ICS strategy

- We have been working with our partners and have drafted a partnership strategy which outlines are principles, ways of working, ensuring through our group model we build solid foundations with our community and primary care partners to transform our clinical pathways.

Partners objective 4a: Establish collaborative models of care with our partners including Primary Care Network Alliance (PCNA)

What we will achieve in 2024/25

Develop a partnership programme to drive integrated pathways of care with key partners such as the East Midlands Acute Provider Collaborative, Lincolnshire ICB, Campus for future living and LACE.

Quarterly output report, demonstrating progress against Partnership Strategy

This qualitative measurement will be reported every quarter (July/October/January/April).

Please note, that the first report will be available at the end of Q2.

Target: N/A

Quarter 1:

N/A

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Improved outcomes for our population driven by the Partnership Strategy

This qualitative measurement will be reported every quarter (July/October/January/April).

Please note, that the first report will be available at the end of Q2.

Target: N/A

Quarter 1:

N/A

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Improved delivery of equitable specialised care to our population supported through the delivery of the EMAP work programme

This qualitative measurement will be reported every quarter (July/October/January/April).

Please note, that the first report will be available at the end of Q2.

Target: N/A

Quarter 1:

N/A

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Develop and implement Phase 1 of ULTH Green Plan.

Reduction in Desflurane from 2% to 0%
This qualitative measurement will be reported every quarter Target: N/A
Quarter 1: Quarterly update submitted to FPEC in July 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Clear baseline carbon footprint measure with improvement trajectory
This qualitative measurement will be reported every quarter (July/October/January/April). Target: N/A
Quarter 1: Quarterly update submitted to FPEC in July 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Quarterly qualitative report from Sustainability Group on progress against Green Plan

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Joint working with system partners, maximising care homes, virtual wards and admission avoidance schemes, such as the frailty programme.

Total number of frail/elderly patients managed as a day case through the Frailty Assessment Unit

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Total number of non-elective admissions for frail elderly and reduction in unplanned admissions for moderate to severe frail elderly

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Working with partners to utilise alternative pathways to ED through increasing the use of UTCs, UCRs and ARIs

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Partners objective 4b: Successful delivery of the Acute Services Review

What we will achieve in 2024/25

Implement Acute Service Review: Establish a successful Integrated Stroke Service across the Group alongside UTC and Frailty Service at Grantham and District Hospital.

Improvement in Stroke Integrated Care and SNAPP performance

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Fully maximising Grantham UTC – activity trajectory

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Partners objective 4c: Grow our research and innovation through education, learning and training

What we will achieve in 2024/25

Develop and deliver the 2024/25 Joint Research Strategy objectives which will support additional research opportunities and improvements in patient.

A quarterly report from the R&I Strategy Group reporting progress against delivery of the strategy

This qualitative measurement will be reported every quarter (October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in August 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Continue to build a strong professional relationship as a Group with the University of Lincoln and the Medical School to attract and increase clinical academics and nursing opportunities to build a strong R&I.

Total number of Clinical Academics and Principal Investigators
This qualitative measurement will be reported every quarter (October/January/April). Target: N/A
Quarter 1: Quarterly update submitted to FPEC in August 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Total amount of research income generated by the Trust across research delivery, National Institute for Health and Care Research (NIHR) funding, grants and collaborations
This qualitative measurement will be reported every quarter (October/January/April). Target: N/A
Quarter 1: The first quarterly report for this measurement will be available in October 2024
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

For our population health:

- Throughout 2024/25, a population health approach has been implemented in various projects across the Trust, most noticeably in the bid around reducing DNAs (Did Not Attend) in Paediatrics as well as the recommission work around the PET scanner.
- Population Health Management (PHM) has started to be implemented in the divisions and specialties thinking with PHM information being provided at specialty reviews and cabinet meetings. We have utilised the PHM data to inform the left shift programmes of work to move care closer to home.
- A Health Inequalities Working Group has also been established within the Trust, with various work streams underway. The healthcare inequalities dashboard reports on two key performance indicators: 4-hour Emergency Department (ED) wait times and 18-week Referral to Treatment (RTT) waiting times.

Population health objective 5a: Develop a Population Health Management (PHM) and Health Inequalities (HI) approach for our Core20PLUS5 with our ICS

What we will achieve in 2024/25

Development of a Core20PLUS dashboard to enable a greater understanding of the Lincolnshire population and support a reduction in health inequalities.

Percentage of inpatients who smoke who are seen by the Tobacco Cessation Service

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Health inequalities dashboard to be developed

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Population health objective 5b: Co-create a personalised care approach to integrate services for our population that are accessible and responsive

What we will achieve in 2024/25

Introduce It's All About People Champions who will promote personalisation and strengths-based approaches across the Group.

Increase the number of Champions across the Group from 7 in ULTH and 14 in LCHS

This qualitative measurement will be reported every quarter (July/October/January/April).

Target: N/A

Quarter 1:

Quarterly update submitted to FPEC in July 2024.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Population health objective 5c: Tackle system priorities and service transformation in partnership with our population and communities

What we will achieve in 2024/25

Deliver transformational change in key pathways across the Group such as OPAT.

Development of key prioritised transformation pathways with associated KPIs

This qualitative measurement will be reported every quarter (July/October/January/April)

Target: N/A

Quarter 1:

Please refer to the paper being submitted to July's FPEC for an update on this improvement.

Quarter 2:

Quarterly update submitted to FPEC in October 2024.

Quarter 3:

Quarterly update submitted to Finance Committee in January 2025.

Quarter 4:

Quarterly update submitted to the Finance Committee in April 2025.

Population health objective 5d: Transform key clinical pathways across the group resulting in improved clinical outcomes

What we will achieve in 2024/25

We will focus on improving waiting times for frail elderly on multiple waiting lists.

Development of key prioritised transformation pathways with associated KPIs
This qualitative measurement will be reported every quarter (October/January/April) Target: N/A
Quarter 1: Quarterly update submitted to FPEC in August 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Embrace both internal and external assessments of patient experience and safety and triangulate information to drive a culture of safety and continue to improve patient experience and reduce harm through effective management of waiting times for diagnosis and treatment through improved productivity.

Improving waiting list management for patients on multiple waiting lists and reducing unplanned admissions.
This qualitative measurement will be reported every quarter (October/January/April) Target: N/A
Quarter 1: Quarterly update submitted to FPEC in August 2024.
Quarter 2: Quarterly update submitted to FPEC in October 2024.
Quarter 3: Quarterly update submitted to Finance Committee in January 2025.
Quarter 4: Quarterly update submitted to the Finance Committee in April 2025.

Maximisation of capacity and efficiencies to reduce waiting times and support discharge processes

Implementation of SAFER Bundle: Length of Stay >7 Days Pathway 0 and Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 0 patients											
Target: <10%											
2024/25 Q1 target: <10%			2024/25 Q2 target: <10%			2024/25 Q3 target: <10%			2024/25 Q4 target: <10%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
12.54 %	12.70 %	10.68 %	12.25 %	13.10 %	12.52 %	12.65 %	12.12 %	11.19 %	12.00 %	11.16 %	10.75 %

Implementation of SAFER Bundle: Length of Stay >7 Days Pathway 0 and Non-elective stranded patients with LoS over 7 days as a percentage of total non-elective LoS, just for pathway 1 – 3 patients											
Target: <50%											
2024/25 Q1 target: <50%			2024/25 Q2 target: <50%			2024/25 Q3 target: <50%			2024/25 Q4 target: <50%		
M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
66.47 %	62.79 %	66.20 %	62.30 %	63.64 %	75.11 %	75.00 %	69.73 %	71.35 %	69.14 %	71.54 %	71.16 %

Our key risks and issues

Workforce

During 2024/25, we maintained our efforts to recruit to vacant 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.

Results in the NHS National Staff Survey continue to show improvements with ULTH ranked 56 out of 62 acute trusts the highest position in the last five years. Whilst improvement could be seen key themes were identified which the Trust formulated actions in response to covering compassionate leadership, compassionate and

inclusive communications, bespoke interventions to support teams and staff engagement.

The Trust remains part of 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.

CQC Improvements

In March 2022 the Trust was delighted to announce that it was no longer considered to be in quality and financial special measures.

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.

The Trust was 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. During 2022/23 the Trust was able to demonstrate the necessary progress in addressing these issues and the notices were removed. Within the 2022 CQC report there were five "Must Do" areas for improvement identified and 38 "Should Do" areas for improvement. These improvement initiatives were built into improvement plans.

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

Domain	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.

Performance challenges

The Trust’s A&E services continue to operate under pressure with more attendances and emergency admissions. Increased acuity and demand for Emergency Care combined with delays in discharging continued to create increased waiting times. A number of schemes were put in place over the winter months which has started to show improved performance, but complexity of patients seen meant that these were not fully able to meet the underlying demand and additional growth.

Work continues with the Lincolnshire health and social care system with the aim of reducing the burden on the Emergency Departments.

There has been growing concern nationally over acute care providers ability to release ambulance crews due to high demand in Emergency Departments and lack of hospital flow. Clinical and operational leaders have worked with system leaders to ensure there is management of patient flow out of the hospital setting.

Development of the Lincolnshire Community and Hospitals NHS Group

In 2022-23, our health and care system leaders commissioned an independent review of the Lincolnshire NHS provider landscape. The intention was to identify how providers could organise health and care to better meet the considerable service and financial challenges. The review said that Lincolnshire health and care system leaders should strengthen their ability to enable shared strategic and operational decision making to improve the delivery of integrated high-quality health and care.

Greater integration between Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) was one of the key recommendations. The review recommended establishing an NHS Trust Group arrangement between LCHS and ULHT, with the close engagement of other NHS partners.

Leaders felt that moving to a Group model would most effectively address the issues of opportunity and urgency, and was the best model of provider collaboration to adopt because it would enable us to:

- Balance greater organisational integration with the potential degree of disruption.
- Maximise the potential to integrate services and resources for the benefit of patients and to do this at pace.
- Address the most pressing patient harm issues and care integration opportunities.
- Supporting better use of resources and value for money.

Through 2023/2024, work took place to progress towards a Group arrangement between the two trusts, which was formally established on 1st April 2024.

This included the establishment of a Group Board, which discharges the governance of both trusts against their own Standing Orders, but exercising their functions jointly using a single group board reporting framework (forward work plan) and a single group Board Assurance Framework (BAF).

A number of joint board committees have also been established, in the areas of Quality, Finance & Performance, People, Integration, Audit & Risk and Remuneration.

Both trusts continue to maintain legal and regulatory compliance and assurance reporting.

Coming together in a Group model has already shown benefits, including enabling reductions in integrated urgent and emergency care treatment times, increased pace through collaboration of referrals between acute and community and improved and strengthened risk identification, mitigation and management across aligned portfolios and joint executive leadership.

The future: looking ahead to our vision, ambitions and strategies for 2024/25

2024/25 was our ‘transition’ year as we integrate the two trusts more closely together, and during the year extensive work has taken place on developing a five year Group Strategy for 2025-2030.

It has been co-created with our patients, people and key external stakeholders, achieved this through several workshops and strategic thinking sessions held with our Group Board, Executive Leadership Team, Divisional Leadership Teams and our senior teams. It strategy describes the key strategic aims and objectives that we are collectively working towards, as well as a renewed vision for the Group- ‘Caring and building a healthier future for all’.

The Strategy can be found here <https://www.ulh.nhs.uk/about/trust/annual-reports/group-strategy/>

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.

The Trust, in preparing financial statements will consider their status as a “going concern” and will present accounts on that basis. The Trust is confident that it has the capacity to continue providing services while it manages the increased risk of operating at a deficit for the financial year 2024/25.

External auditors opinion is that it is rare for public bodies to cease as going concern given the essential nature of the services they provide. DHSC group organisation are, therefore, expected to prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC of the intention for dissolution without transfer of services or function to another entity.”

Performance analysis

Purpose of the performance analysis

The purpose of the performance analysis is to give a detailed view of the performance of the Trust.

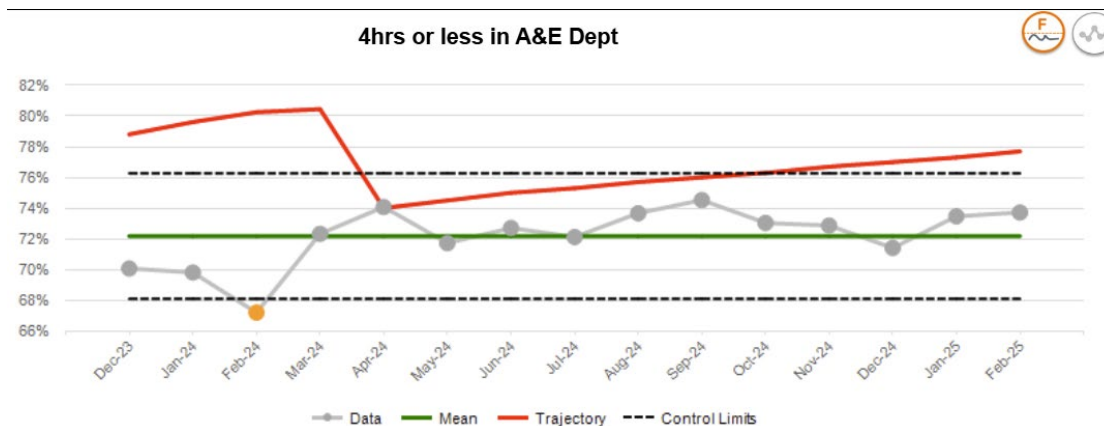
Key performance measures and how they are measured

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.

We have kept our focus on infection control and constitutional standards. During the year, compliance with infection control practices continued to be strong as evidenced by site visits and compliance with the Infection Prevention and Control Board Assurance Framework.

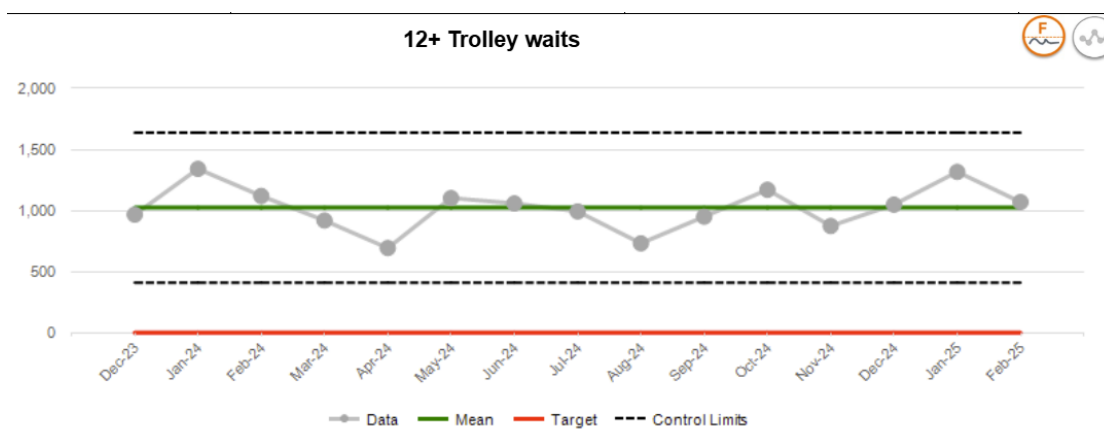
The Trust’s performance in its key national target areas of referral-to-treatment (RTT), cancer waiting times, A&E waiting times, and diagnostics have not been delivered to the standard we would expect this year. The poor position against the constitutional standards is well understood. It is driven by a number of factors including:

- growth in demand for services that has increased at a greater rate than we have been able to increase capacity,
- difficulties with recruiting sufficient numbers of staff across all parts of the urgent and elective care pathways.

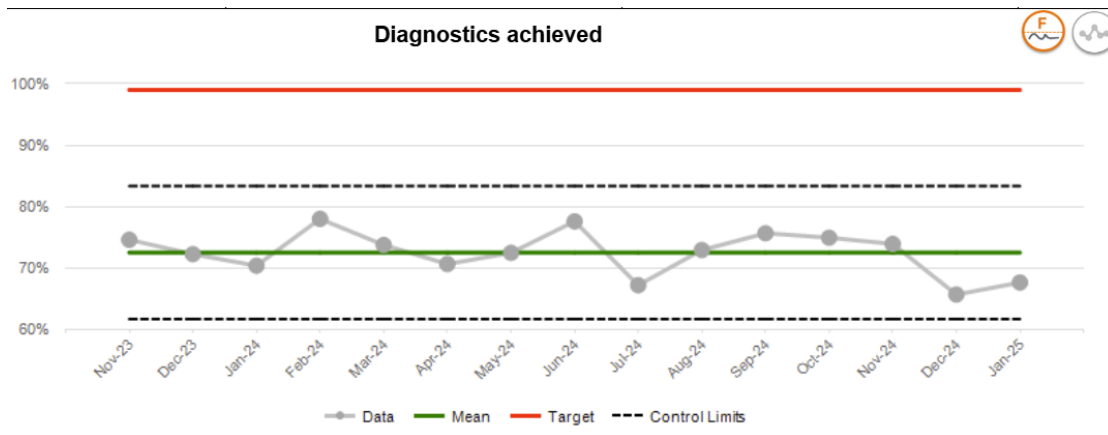


The national 4-hour standard means that we should expect to see 95% of patients in A&E within 4 hours. The agreed trajectory for compliance for ULTH is set at 78% for the end of the year.

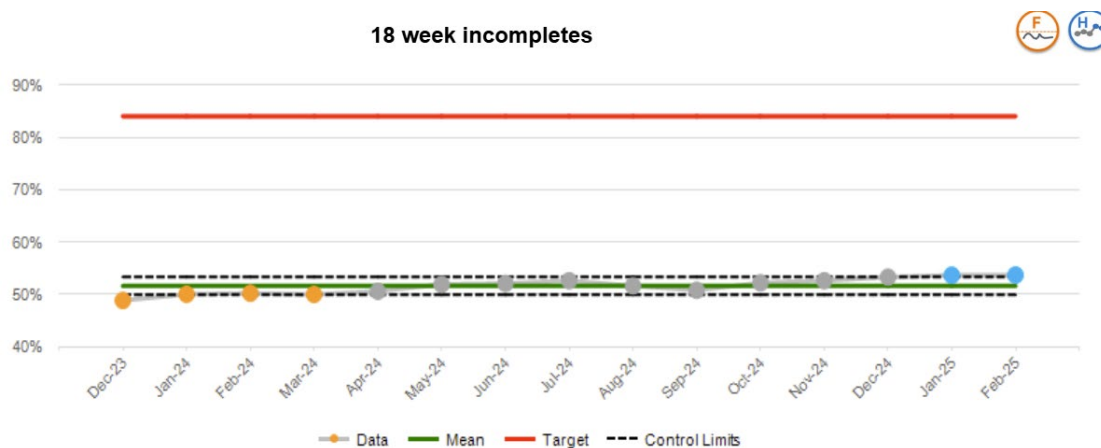
The 4-hour transit target performance for February 2025 Type 1 & 3 (24/7) ED/UTC activity was 73.72%.



There is a zero tolerance for greater than 12-hour trolley waits (time from decision to admit to admission or discharge). These events are reported locally, regionally, and nationally. In February 2025 the Trust saw 1,070 12-hr trolley wait breaches. This equates to c9% of all type 1 attendances for February.



Percentage of diagnostics tests undertaken in under six weeks. We are currently at 67.62% against the 99% target.



Percentage of patients on an incomplete pathway waiting less than 18 weeks. There is a backlog of patients on incomplete pathways.

February 2025 saw RTT performance of 53.72% against an 84.1% target.

In February 2025, the Trust had 29 patients who waited longer than 65 weeks for treatment. This represents a significant reduction from 399 in February 2024 and 2,766 in February 2023.

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.30%	0.36%	0.38%	0.29%	0.00%		
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	77.30%	72.87%	71.41%	73.47%	72.96%	75.78%		
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	874	1,049	1,317	9,941	0		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	76.22%	73.75%	74.96%	79.40%	88.50%		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	2,027	1,944	1,543		24,548	18,243		
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	120	53		2,955	0		
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	52.64%	53.32%		51.99%	84.10%		
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	70,940	70,628		N/A	N/A		
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	80.50%	79.70%		78.44%	75.00%		
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	66.40%	68.90%		62.16%	85.39%		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	75.30%	83.60%		75.70%	93.00%		

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	83.20%	29.00%		62.97%	93.00%		
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	91.80%	93.80%		91.52%	96.00%		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	96.00%	94.60%	96.40%		91.06%	98.00%		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	70.20%	81.80%		77.28%	94.00%		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	85.70%	90.00%		88.21%	94.00%		
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	66.70%	58.80%		66.90%	90.00%		
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	70.50%	78.20%		71.31%	85.00%		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	73.91%	65.66%	67.62%	71.86%	99.00%		
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.14%	1.95%	1.58%	1.78%	0.80%		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	21	24	35	318	0		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	40.45%	63.29%	58.76%	67.09%	90.00%		

3 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Nov-24	Dec-24	Jan-25	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	25.84%	41.77%	40.21%	41.09%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,645	4,687	4,556	4,666	4,657		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	670	978	1,085	555	0		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	72	85	90	645	100		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.28	2.54	2.82	2.67	2.80		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.39	4.52	4.59	4.69	4.50		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.50%	Submission suspended	Submission suspended	Submission suspended				
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	33,164	34,684	34,661	32,585	4,524		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	38.71%	38.43%	38.65%	38.90%	45.00%		

Challenges do remain as we move into 2025/26, 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.

Delivery of financial plan

The Lincolnshire system financial plan for the year 2024/25 was to deliver a breakeven outturn. The Trust delivered an agreed adjusted financial performance deficit of £18.3m. Cost improvement programme savings of £40.5m were delivered which was an over delivery against the planned savings of £40.1m.

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 £88.1m available to it in 2024/25 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 in urgent care during the 2024/25 financial year did not meet the improvement target of 78%, achieving a combined performance of 73.48%,

which was an increase from 70.74% the previous year (23/24). In March 2025, all Trusts' performances were specifically reviewed, and Lincolnshire achieved 78.33% compared to 72.55% for March 2024.

Several factors contributed to this underperformance:

- There was an increase (1.07%) in emergency services attendances at both Type 1 and Type 3 facilities
- The number of ambulance conveyances across the three acute sites rose by 5.77% compared to 23/24
- Both Pilgrim and Lincoln site ED have had building works constantly throughout the winter period which further impacted on lack of space and cubicle availability
- High acuity levels and increased demand for admissions, along with suboptimal discharges, resulted in consistently high bed occupancy rates, exceeding 95% against core stock or 90% when additional beds were opened at the expense of other resources
- Multiple exit blocks led to delayed discharges and flow issues across the hospitals: There was a particular challenge with accessing pathway 1 resource within the community to support residents within their own home who were requiring additional support. This resulting in 10% of patients being cared for within an acute bed with no criteria to reside

As a result of these factors, bed occupancy within the hospital sites remained consistently high throughout the year, often exceeding 96% during the winter. This situation caused delays within the Lincolnshire system. All pathways for community care were also impacted on and escalation resource was maximised across the system. The impact was noted within Urgent and Emergency care with overcrowding on all sites during peak periods. Impacting on patients within department for >12 hours with a DTA and on delays to ambulance handovers.

Despite the challenges faced by the ED and the Trust across ULTH we have consistently improved month on month in terms of four hour performance ending with achievement of 78.3% for March 2025.

Alongside this ambulance offloads have consistently improved with the month of March the average ambulance offload time at Boston being 21 minutes (31 mins last year) and Lincoln 25 minutes (33 mins last year). The Trust has been one of the few

acute providers who has successfully implemented the 45 minute offload dictate with ULTH the top performer in the EMAS region. This is despite both EDs having building works impeding flow and a 20% increase in Cat 2 conveyancing for ULTH.

It is noteworthy that throughout the winter we did not declare a critical incident related to lack of flow and during periods of extreme pressure, we were able to rapidly decongest and restore effective functioning.

Whilst we recognise that the four hour standard is 95%, as a Trust we have demonstrated that we can, in a sustained manner, month on month improve our four hour standard thus providing a better patient and staff experience. This has necessitated significant work across not just ED but our UTC colleagues, increase in SDEC attendances, rapid transfer to the wards to focus on pace of discharges and working with EMAS to ensure timely offloads.

There are a significant number of activities commencing in 2025/26 to further enhance our four hour performance with key areas of focus as follows:

- Enhanced collaboration with UTC
- Streaming – with no walls to SDEC and assessment areas such as gynae and surgery
- Enhancing the footprint of SDEC to increase capacity and commence with a formal surgical SDEC
- Develop virtual wards for diagnostics with UTC and ED ability to book into CDC
- Develop a CDU on Boston site
- Embed the 'lift and shift' model for rapid early morning decongestion of ED
- Continue with focus on inbound screen for ambulance offloads as opposed to waiting until ambulances were on the tarmac thereby giving a much greater lead in time for developing a plan for offloading
- Continue to develop and enhance actions that focus on limiting impact of surges and enhance rapid recovery
- Continue to promote ethos within the Trust that patients with a DTA are outliers being held in ED – thereby creating ownership and transparency around delays in ED and specialities ownership – these are not ED patients
- Continue to embed the rapid transfer process ensuring that risk is shared and does not remain within ED

Diagnostic performance

In the last year, approximately £42million has been invested in our county to develop existing and new Community Diagnostic Centres (CDCs) to increase our testing capacity and reduce waiting times for patients, each CDC being designed to consider the health needs of the local community. We now have open Grantham CDC (March 2024) which has CT and MRI scanners. The £23 million Lincoln CDC opened in August 2024 with state-of-the-art facilities that will be home to a variety of diagnostic services, including X-ray, MRI, CT and non-obstetric ultrasound as well as dedicated training facilities to support the training of future radiographers, with ULTH becoming one of the first NHS Trusts in the country to link directly with a school of radiography, through the University of Lincoln. In November 2024 Skegness CDC opened with a dedicated chemotherapy room to reduce the amount of travel necessary for cancer patients, as well as a dental X-ray. These services, along with MRI and CT scanning, have not previously been available in the town.

In terms of performance, we have seen sustained DM01 performance (which focuses on diagnostic waiting time performance standard for 10 key diagnostics tests) where up to 73% of patients had their diagnostic test within 6 weeks of referral (less than 1% of patients should wait 6 weeks or more for a diagnostics test). Strong performance (over 90%) has been sustained in Colonoscopy, CT, Flexi Sigmoidoscopy & MRI. The impact of our reducing our long waiter recovery journey of 104, 78 and 65 week waits means that patients are having to be scheduled at short notice to ensure there is capacity – this is particularly affecting audiology via ENT pathways as they continue to recover. Audiology, DEXA and Echocardiography remain the main modalities of concern and with Audiology representing the majority of 13 week waits at ULTH. Echocardiography overall performance has dipped below the 85% standard and is expected to remain at a similar level unless recruitment is resolved.

Cancer

Cancer performance within the Trust was achieved for the national 28 day Faster Diagnosis Standard month on month from May 2024. 31 day first treatments, 31-day subsequent chemotherapy and radiotherapy, 31-day subsequent surgery and 62-day performance remained below the national standard which mirrored the national picture. This was partly due to the challenges with recruiting to cancer navigator and co-ordinators posts across a number of specialties and the impact of continuing capacity challenges for outpatient appointments and theatre slots.

Actions undertaken to improve performance

During the course of 2024/25 the programme of improvement has continued within the Trust, with support from ICS colleagues, in order to improve the timeliness of assessment, diagnosis and treatment of patients on cancer pathways. Weekly meetings have established a strong colleague network within the Trust to expedite actions with immediate effect. The meetings have increased their scope to include two further patient cohorts (days 48–55 and days 21–27) to identify and address potential breaches proactively.

18 weeks referral to treatment (RTT)

- Validation programme
- Outpatient clinic utilisation
- Theatre utilisation
- Hybrid mail
- Outsourcing/Insourcing
- Use of ISPs
- Missing outcomes

Health inequalities statement

This year the Trust has established a Health Inequalities Working Group to provide focus and assurance in relation to our health inequalities programme. This group includes colleagues from across the Group and the leads for Health Inequalities and Personalisation within the ICB.

In September 2024 we completed a national health inequalities maturity matrix which demonstrated that, while we were making progress across the four key areas of focus, there was still work to do.

We have continued to develop the use of our health inequalities dashboard, which allows the Trust to monitor and record patients in the Emergency Department and open 18-week wait pathways by a multitude of health inequalities segments, including: age, gender, deprivation, and ethnicity and we are refreshing a plan that will allow us to better record the ethnicity of our patients. This data will give us further insights and understanding relating to access to our services for the CORE20Plus5 priority areas within our population that we can use to improve delivery of our services.

We have continued to actively deploy the use of population health data within our service improvement and strategy development during 2024/5 in areas such as ophthalmology and PET-CT services.

Our Trust communications and engagement leads have continued to focus on increasing the accessibility of our patient information and building the Trusts awareness of health literacy issues.

The Trust has also been working closely with to build further awareness and understanding around the personalisation agenda, by deploying training and awareness sessions across our clinical and corporate teams.

The Trust has grown the number of personalisation champions to support this agenda and more work is planned for the coming year to ensure we extend the use of shared decision-making tools and co-production within our improvement and transformation programmes. The Trust is fully committed to building on its existing population health management approach by embedding this as business as usual so that we can further improve patient experience, equity of access and clinical outcomes for the diverse communities it services.

Sustainability report

During the year the Trust's green plan actions have been reviewed. The Trust continues to seek 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.

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

The Trust's green plan will be refreshed to focus on actions for delivery across the next three years. The green plan serves as the central document for the Trust's sustainability strategy. Through this green plan, ULTH has worked with staff, patients and partners to take sustainable development and climate action as part of the Trust's commitment to offer the highest quality care to the Lincolnshire community.

Progress in year includes:

- Funding for LED lighting replacement.
- Development of decarbonisation plans for Lincoln County, Pilgrim and Grantham Hospital.
- Launch of a network of green champions
- Reduction in the use of anaesthetic gas emissions.

Task force on Climate-related Financial Disclosures (TCFD)

The Department of Health and Social Care group accounting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by HM Treasury.

Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance pillar 2023-24. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and in other external publications.

The Trust monitors climate related issues through the approved green plan. Reporting on activities, achievements, targets and developments to the Trust committee on a quarterly basis formally. Issues or updates can be raised at the Trust Leadership Team forum, held monthly.

Additionally, climate related issues are measured through the Trusts overall Integrated Improvement Plan, where the Green Plan forms a part of the overall Trust strategy. Key performance indicators are listed and monitored through the plan and is reported monthly to the Trust Board.

Additional reporting metrics, flow through to the board via Estates Return Information Collection (ERIC), Premises Assurance Model (PAM) and the greener NHS data collection which are all signed off by the Trust board annually.

Climate related issues are largely but not exclusively monitored through the Integration and Improvement directorate via the Group's Head of Sustainability and Net Zero.

- The Integration and Improvement management structure has specific responsibility for the green plan and the sustainability strategy. The Group Head of Sustainability and Net Zero holds the responsibility under the Trust board within the Integration and Improvement directorate for all net zero related issues.
- The capital management structure incorporates the latest climate related legislation, guidance and good practice in any new build or major refurbishment within the design phases.
- The facilities management team has specific responsibility for the Trust's travel plan where a range of initiatives covering vehicular usage, EV use, cycle schemes and wider schemes such as those relating to landscaping, through natural wild gardens and tree planting for new capital schemes.

Internally the Trust has a weekly communication strategy, via email and Intranet available to all staff members which updates collectively on relevant climate related issues, progress on our net zero carbon strategy and regularly promotes energy reduction initiatives.

The Lincolnshire System Greener Board recognises that there are some areas that progress against the Trust's Sustainability ambitions is delayed. These include:

- Procurement of Green Electricity – the Trust purchases via a national framework at the best (lowest) price, this framework does not feature any green electricity tariffs.

- EV charging infrastructure – the Trust has a plan to improve the electrical infrastructure across its estate to support the drive from EV charging provision. This work needs to take place prior to installation of EV charging points.
- Reduction in use of piped nitrous oxide – the Trust has a plan to remove this but there is a national shortage of the replacement cylinder type which means the swap is delayed.
- Procurement of local food – The supply chain and regulations to protect the Trust from a food safety perspective means that although Lincolnshire is a large food production county The Trust's ability to procure local produce is limited by the point at which the produce is available to buy in the distribution process.

Emergency Preparedness, Resilience and Response (EPRR)

United Lincolnshire Teaching Hospitals NHS Trust (ULTH) has been assessed by Lincolnshire Integrated Care Board (ICB) and NHS England (Midlands) as fully compliant with 58 out of 62 core standards. This means that the Trust has an overall compliance of 94% which makes the Trust substantially compliant overall. We fully expect to retain substantial compliance for the 2025 review. The following were of note since the last report:

Training and Exercising

- Six strategic commanders were trained.
- Five tactical commanders were trained.
- The Trust mandatory major incident training (ESR) averaged 92%.
- The Trust took part in five regional exercises, delivered two table-top exercises and one live chemical decontamination exercise.

Incidents

- A business continuity incident (BCI) was declared on the 19 July 2024 for IT issues affecting the PACS systems, Health Roster and Radiology reporting.
- A BCI was declared on 16 December 2024 due to a failure of an air handling unit in the catheter lab.
- A BCI was declared on 4 and 5 March 2025 when Pilgrim Hospital, Boston's high voltage system tripped out during a planned electrical test. This resulted in many areas remaining on emergency power supplies, or in some areas (including some diagnostics) losing all power.

- A BCI was declared on the 24 March 2025 when Lincoln County Hospital experienced a loss of water supply feed to the main site.

Lessons and learning

- Structured debriefs for both CIs were delivered.
- Debriefs were undertaken for each BCI. Lessons identified were used to update business continuity plans appropriately.
- Full reports for each Incident (with associated action logs) were produced and sent to all relevant members within the Group and to the ICB and NHS England for wider learning.
- All actions within the reports were added to a lessons identified log that is scrutinised monthly by the EP Team and quarterly at EPG meetings.

Additional assurance processes

- The EPRR work plan and assurance documents were reviewed on a monthly basis.
- The risk register was reviewed via Datix for EPRR risks on a monthly basis.
- The A&E staff at Lincoln and Pilgrim and Grantham were randomly selected each quarter and given a verbal test of their knowledge for the following:
 - How to respond to a major incident
 - How to treat a self-presenting casualty that is contaminated
 - How to register an unknown patient in accordance with national guidelines
- The Chemical, Biological, Radiological, and Nuclear (CBRN) maintenance, storage and servicing of the CBRN equipment at the Lincoln, Pilgrim and Grantham sites were checked by the Emergency Planning team - The CBRN leads are maintaining excellent standards in this regard. East Midlands Ambulance Service NHS Trust (EMAS) also undertook an independent audit of the Lincoln and Pilgrim sites (with extremely positive feedback).
- Communication cascade tests were successfully undertaken quarterly at the Lincoln, Pilgrim and Grantham sites.
- The designated incident control centre areas for Lincoln, Pilgrim and Grantham hospitals were inspected quarterly to ensure that they remain fit for purpose.
- The following plans were updated and approved at the Emergency Planning Group (EPG):
 - Pandemic Infection Plan
 - Incident Response Plan
 - Incident Response Communications Plan

- VIP Policy
- Industrial Relations Action Plan
- Business Continuity Management Policy
- Emergency preparedness, resilience and response (EPRR)
- Mass Casualty Plan
- Adverse Weather Plan
- Lockdown Policy
- BC Policy
- CBRN Decontainer Plan
- Lincoln Evac Plan
- Pilgrim Evac Plan
- Grantham Evac Plan
- Incident Response Communications Plan
- Emergency Planning Group terms of reference

ULTH representatives attended the Lincolnshire Resilience Forum and Lincolnshire Health Emergency Preparedness meetings.

Business continuity

Divisional directors are challenged to provide comprehensive answers to the questions below at every EPG:

- How many plans their division require
- How many of those plans have had business continuity lead allocated to them
- How many of the required business impact analysis (BIA) have been written
- How many of the required business continuity plans (BCP) have been written
- How many of the BIAs and BCPs have been tested in the last 12 months

Progress against these metrics is tracked and reported to the board via the Finance Performance and Estates Committee via formal report post each EPG.

- The Emergency Planning Team delivered 30 tabletop exercises for business continuity plans.

Overseas visitors

The National Health Service (NHS) provides 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:

1. Identify, without discrimination, and at the earliest possible opportunity, all patients who may be liable to charges;
2. Interview patients to establish if they are ordinarily resident or not, and if not, whether they are exempt from or liable for charges;
3. 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 its 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 is 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 has access to a national support network ensuring that legislative changes and ways of working are continuously refreshed where appropriate.

Signed.....

Chief Executive

Date:

Accountability report



Corporate governance report

Directors report

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. The Trust Board met bi-monthly during 2024/25. The Assurance Committees of the Board met monthly. Further information relating to attendance at the Trust Board and these committees can be found in their annual reports on the Trust website at [Board meetings - United Lincolnshire Hospitals \(ulh.nhs.uk\)](https://www.ulh.nhs.uk/about/trust-board/).

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 strategic 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 England on behalf of the Secretary of State for Health and Social Care.

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 2024/25, this committee consisted of the chair and the non-executive directors.

An externally facilitated review of leadership and governance has been completed within the last 5 years by NHS Providers. NHS Providers has no connection with the Trust or any individual director.

Board Changes

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

Mr Andrew Morgan was Chief Executive for United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust until end of June 2024. In July 2024 Professor Karen Dunderdale was appointed as Chief Executive Officer for both United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust.

From October 2023 the Director of Finance role was covered by Mr Jonathan Young on an interim basis. From October 2024 Mr Paul Antunes Goncalves joined the Trust as Interim Director of Finance, Mr Antunes Goncalves also held the role of Interim Director of Finance for Lincolnshire Community Health Services NHS Trust. In April 2025 Mr Paul Antunes Goncalves was appointed substantively into the Chief Finance Officer role.

The Interim Chief Operating Officer Ms Michelle Harris left the Trust in March 2024 when Ms Julie Frake-Harris assumed the Interim Chief Operating Officer role. Ms Frake-Harris already held the role of Chief Operating Officer for Lincolnshire Community Health Services NHS Trust and retained this role until August 2024. In August 2024 Mrs Caroline Landon was appointed as Interim Chief Operating Officer for United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust. In April 2025 Mrs Landon was appointed substantively into the Chief Operating Officer role.

Dr Sameedha Rich-Mahadkar was substantively appointed into the role of Trust Wide Lead for Integration and Planning and covered the role of Director of Improvement and Integration on an interim basis. In September 2024 Mr Daren Fradgley was appointed Chief Integration Officer and Deputy Chief Executive across United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust.

Professor Karen Dunderdale held the role of Director of Nursing/ Deputy Chief Executive for Lincolnshire Community Health Services NHS Trust on an interim basis in addition to her role as Director of Nursing/Deputy Chief Executive at the

Trust until July 2024. In July 2024 Mrs Nerea Odongo was seconded into the organisation into the role of Chief Nursing Officer for United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust. Professor Philip Baker Non Executive Director left the Trust on the 31st March 2025.

Professor Duncan French joined the Trust in March 2025 as Teaching Hospital Non Executive Director

A full list of directors who have served during the year is shown within the remuneration report on page 51.

Audit and Risk Committee

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

For 2024/25, Audit and Risk Committee membership was as follows:

- Neil Herbert, Chair (November 2022 – ongoing)
- Philip Baker (July 2021 – March 2025)
- Daniela Cecchini (January 2022 – ongoing)
- Rebecca Brown (October 2022 – ongoing)
- Jim Connolly (October 2024 – 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/>

Code of Governance for NHS provider trusts

Statement of compliance with the Code of Governance

The Code of Governance for NHS Provider Trusts was most recently revised in October 2022, to take effect from 1 April 2023. The Audit Committee has been charged by the Board of Directors to maintain ongoing oversight of the Trust's compliance with the Code of Governance and to identify to the Board of Directors any emergent areas of significant non-compliance. A specific set of disclosures is required to meet the Code of Governance. The following table lists the disclosures and details where the relevant information can be found in the annual report.

Ref	Criteria	Compliance	Evidence
Board Leadership and Purpose			
A2	The role of the Board of Directors		
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Compliant	Annual Report – Performance Report Overview
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Compliant	Annual Report – Remuneration and Staff Report
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements	Compliant	Annual Report – Performance Overview and Remuneration and Staff Report

Ref	Criteria	Compliance	Evidence
Division of responsibilities			
B2	Appointments to the Board		
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why	Compliant	Annual Report – declarations of interest
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Compliant	Annual Report – Corporate Governance Report Directors Report – Link to website

Ref	Criteria	Compliance	Evidence
Composition, succession and evaluation			
C4	Appointments to the Board		
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Compliant	Annual Report – Corporate Governance Report – Link to Trust website
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Compliant	Annual Report - Corporate Governance Report
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Compliant	Annual Report – Corporate Governance Report and Remuneration Report – Links to Trust website

Ref	Criteria	Compliance	Evidence
Audit, Risk and Internal Control			
D2	Annual Reporting		
D2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services	Compliant	Annual Report – Financial statements
D2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Compliant	Annual Report – Statement of Accounting Officer's responsibilities
D2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report	Compliant	Annual Report – Performance Overview and Annual Governance Statement
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control	Compliant	Annual Report – Annual Governance Statement

	through the annual governance statement in the annual report.		
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	Compliant	Annual Report – Going Concern Statement in Performance Overview

Ref	Criteria	Compliance	Evidence
Remuneration			
E2	Remuneration		
E2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Compliant	Annual Report – Remuneration Report

Declaration: Audit of the Trust Annual Report and Accounts 2023/24

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 directors’ responsibilities

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

.....Date.....Chief Executive Officer
Date..... Chief Finance Officer

Statement of accounting/accountable officer's responsibilities

The NHS England, in exercise of powers delegated by the Secretary of State for Health and Social Care, 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

Karen Dunderdale
Chief Executive Officer
Date:

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 Teaching 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 Teaching Hospitals NHS Trust for the year ended 31 March 2025 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 Chief Clinical Governance Officer, as the executive lead for risk management is responsible for:

- Establishing and maintaining a Risk Register Confirm and Challenge Group authorised to monitor the consistent application of the policy throughout the Trust through supportive, multi disciplinary scrutiny of significant risks on a monthly basis
- Reporting on the effectiveness of the Risk Policy to the Audit and Risk Committee
- Retaining a suitable level of professional risk management expertise to support the effective implementation of the policy.

Members of divisional and corporate teams are responsible for:

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

All members of staff are responsible for:

- Applying this policy to any relevant risk management activity undertaken in the course of their duties
- The completion of any risk management-related mandatory Core Learning relevant to their role
- The Trust's Risk Management Policy provides staff with clear and unambiguous criteria for evaluating risks, and the essential requirements of the risk management process have been designed into the Datix Risk Management System to provide a supportive structure and guidance for those with responsibility for managing risks.

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. The Trust Board continued to consider the board assurance framework at each of its meetings.

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 most recent well led review the Care Quality Commission (CQC) recognised the effectiveness of the BAF. The Head of Internal Audit (HOIA) Opinion found that the Trust had reasonable and effective risk management, control and governance processes in place. The overall opinion was that reasonable assurance could be given that there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently. However some weaknesses in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

There are four key strategic objectives defined within the 2024/25 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 has reviewed its risk appetite statement in year during a facilitated Board Development session.

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

Risks to data security are specifically highlighted within the 2024/25 BAF. The treatment of these risks is through a cyber security plan and digital strategy which are reviewed through the Digital Hospital Group in to the Finance and Performance Committee.

The key strategic risks to the organisation during 2024/25 that were the focus of consideration by the Trust Board and Executive were:

- Reliance on paper medical records
- Reliance on manual prescribing processes
- Recovery of planned care cancer pathways
- NICE medicines reconciliation compliance
- Patient flow through emergency departments
- Quality and safety risk from inability to deliver epilepsy pathways within acute paediatrics that meet national standards
- Delivery of paediatric epilepsy pathways-community
- Removal of lift in H Block PHB affecting service delivery to patient records
- Risk of Gastro service not being viable due to current fragility of consultant workforce
- Staffing levels requiring an increase in Pharmacy to be able to provide a seven-day service.
- Pharmacy workload demands
- Consultant workforce capacity (Haematology)
- Service configuration (Haematology)
- Cancellation of elective lists due to lack of theatre staff

- Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- Failure to meet 24/25 CIP
- Reliance on agency / locum medical staff in urgent and emergency care
- Compliance with subject access requests

Managed and mitigated through:

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

And outcomes assessed through:

- Number and severity of patient safety incidents;
- Number of never events;
- Number and severity of healthcare acquired infections (HCAIs);
- Number and severity of safeguarding incidents;
- Number and severity of medication safety incidents;
- Harm free care rate;
- Hospital Standardised Mortality Ratio (HSMR);
- Number and type of complaints;
- Number and severity of health and safety incidents;
- Delivery of constitutional standards.

Reporting to the Audit and Risk Committee has been maintained 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 Policy is based on the establishment of a core set of 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 and Safety Committee) are responsible for reviewing and updating 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 leadership teams are responsible for maintaining oversight of the management of risks within their respective divisions, 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 register confirm and challenge process.

The Trust is 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 on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

In 2022 following a CQC inspection in 2021 the Trust was able to announce that it was no longer in financial special measures and as a system has exited from SoF4.

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 2025 the Trust's External Audit provider highlighted the following significant risks to the financial statements.

- Risk of fraud in revenue recognition
- Management override of controls
- Valuation of land and buildings
- Recognition of Capital expenditure and incorrect capitalisation of revenue spend

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

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 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 an annual workforce plan is completed each year, and is informed by many of the points listed above (to varying degree).

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.

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.

Information Governance

The Trust had seven Information governance data breaches which were reportable in line with the Information Commissioners Office guidance in 2024/25. The incidents mostly related to information being sent to the incorrect recipient and inappropriate use of system access. Of the cases that have been concluded to date, no case has resulted in any formal action against the Trust by the ICO and all have been fully investigated and actioned as necessary by the Trust.

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 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 Committee, Finance and Performance Committee and People and OD Committee and newly created Integration Committee as well as considering the Trust Integrated Performance Report and Board Assurance Framework. The Board have continued to direct their work to improve any identified weaknesses in the control framework and governance arrangements.

The Audit and Risk Committee

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

Clinical Audit

During 2024/25 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 2024/25 was that reasonable assurance could be given that there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently. However some weaknesses in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

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 opinions arising from risk based internal audit assignments, contained within risk based audit plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and managements progress in respect of addressing control weaknesses;

Internal Audit reported the no urgent recommendations and issued two limited assurance reports with weaknesses in a number of areas that put some system objectives at risk.

The most significant weaknesses were identified in the Planned and Preventative Estates Management and Overseas and Contracts Reviews

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, and improved its well led rating to Good however the Trust still remains assessed overall as Requires Improvement.
- The Trust exited Financial Special Measures in February 2022. The Trust has continued to face significant financial challenges. A system led financial plan was in place for 2024/25. The wider Lincolnshire health system faces a significant financial challenge, both now and in the longer term and the Trust has recognised the need to strengthen delivery of recurrent savings through its cost improvement programme. Local health and social care organisations continue to work together to identify ways in which we can collaborate to meet this challenge.

- The Trust also faces operational pressures with increasing demand. This is particularly difficult to deliver when many services have workforce or infrastructure challenges. As a result constitutional standards have not all been met.
- The Trust has recruitment and retention challenges. 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, the Trust recognises that there remain 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.....

Karen Dunderdale
Chief Executive Officer
Date:

Remuneration and staff report



Remuneration policy

Statement on Remuneration

The Trust has a Nominations and Remuneration Committee whose purpose is to develop, apply and monitor the remuneration and Terms of Service for Executive Directors. The aim of the Nominations and Remuneration Committee is to ensure that there is a transparent process for determining pay for the Chief Executive and other Executive Directors. The Committee also recommends and monitors the level and structure of remuneration for the first layer of management below Board level on a Very Senior Management contract of employment. The remit covers an annual salary review and contracted terms of employment.

Executive Directors and other Board Directors' contracts of employment include a fixed annual salary payment, which is disclosed in the Annual Report and Accounts. The Trust does not have a Performance Related Pay policy, so there are no performance-related bonuses paid out for the Trust in the financial year.

Terms and Conditions

Executive Director terms and conditions are decided by the Nominations and Remuneration Committee, taking account of benchmarking reports on NHS executive salaries and conditions, and the financial circumstances relating to the Trust. Performance is assessed against agreed Trust, team and individual objectives.

All non-medical employees of the Trust, including senior managers, are remunerated in accordance with the nationally agreed NHS terms and conditions of employment. Medical Staff are remunerated in accordance with the national terms and conditions of service for doctors and dentists.

Senior managers (executive directors) remuneration policy

The Trust is committed to ensuring that the remuneration package for its executive directors or very senior managers (VSMs) enables it 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 £150,000, 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 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 2025. These are attached to comparative figures for 2023/24.

There were no payments made to former Directors in 2024/25. There were also no performance bonuses paid to executives during the last two financial years. Benefits in kind were in respect of use of leased vehicles by senior staff.

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

					2024/25						
Name	Position	Notes	Term in post		Salary (bands of £5,000)	Expense payments - taxable (total to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension- related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total (bands of £5,000)
			Start	Finish	£000's	£00's	£000's	£000's	£000's	£00's	£000's
Elaine Baylis	Chair		Aug-21	Ongoing	50 - 55	2	-	-	-	-	50 - 55
Rebecca Brown	Deputy Chair		Aug-22	Ongoing	10 - 15	10	-	-	-	-	10 - 15
Philip Baker	Non Executive Director		Aug-21	Mar-25	10 - 15	2	-	-	-	-	10 - 15
Dani Cecchini	Non Executive Director		Jan-22	Ongoing	5 - 10	2	-	-	-	-	5 - 10
Chris Gibson	Non Executive Director		Aug-17	Jul-24	0 - 5	-	-	-	-	-	0 - 5
Neil Herbert	Non Executive Director		Aug-22	Ongoing	5 - 10	-	-	-	-	-	5 - 10
Sarah Buik	Associate Non-Executive Director		Aug-22	Ongoing	5 - 10	3	-	-	-	-	5 - 10
Vicki Wells	Associate Non-Executive Director		Aug-22	Ongoing	5 - 10	-	-	-	-	-	5 - 10
Karen Dunderdale	Group Chief Executive Officer	1, 2	Feb-20	Ongoing	135 - 140	10	-	-	-	11	135 - 140
Andrew Morgan	Chief Executive Officer	1, 2	Oct-23	Jun-24	35 - 40	-	-	-	-	-	35 - 40
Daren Fradgley	Group Chief Integration Officer	11	Aug-24	Ongoing	70 - 75	4	-	-	50 - 52.5	7	125 - 130
Paul Antunes Goncalves	Group Chief Finance Officer	5	Oct-24	Ongoing	45 - 50	1	-	-	12.5 - 15	-	60 - 65
Jonathan Young	Director of Finance		Oct-23	Sep-24	70 - 75	-	-	-	5 - 7.5	13	75 - 80
Caroline Landon	Group Chief Operating Officer	8	Aug-24	Ongoing	60 - 65	-	-	-	7.5 - 10	-	70 - 75
Colin Farquharson	Group Chief Medical Officer	6	Aug-21	Ongoing	200 - 205	-	-	-	152.5 - 155	-	355 - 360
Nerea Odongo	Group Chief Nurse	7	Jul-24	Ongoing	60 - 65	-	-	-	30 - 32.5	-	90 - 95
Angie Davies	Deputy Director of Nursing	10	Nov-23	Jul-24	40 - 45	2	-	-	-	-	40 - 45
Claire Low	Group Chief People Officer	1	Oct-22	Ongoing	110 - 115	2	-	-	-	59	120 - 125
Kathryn Helley	Group Chief Clinical Governance Officer		Nov-23	Ongoing	105 - 110	1	-	-	102.5 - 105	9	210 - 215
Jayne Warner	Group Director of Corporate Affairs		Aug-24	Ongoing	35 - 40	-	-	-	40 - 42.5	9	75 - 80
Michael Parkhill	Group Chief Estates and Facilities Officer	9	Aug-24	Ongoing	45 - 50	-	-	-	-	-	45 - 50
Sameedha Rich- Mahadkar	Director of Improvements & Integration		Jan-22	Aug-24	55 - 60	-	-	-	0 - 2.5	1	60 - 65

Name	Position	Notes	Term in post		2023/24						
					Salary (bands of £5,000)	Expense payments - taxable (total to nearest £100)	Performa nce pay and bonuses (bands of £5,000)	Long term performanc e pay and bonuses (bands of £5,000)	All pension- related benefits (bands of £2,500)	Benefits in kind total to nearest £100	Total (bands of £5,000)
			Start	Finish	£000's	£00's	£000's	£000's	£000's	£00's	£000's
Elaine Baylis	Chair		Aug-21	Ongoing	50 - 55	-	-	-	-	-	50 - 55
Philip Baker	Non-Executive Director		Aug-21	Ongoing	10 - 15	7	-	-	-	-	10 - 15
Rebecca Brown	Deputy Chair		Aug-22	Ongoing	10 - 15	12	-	-	-	-	10 - 15
Dani Cecchini	Non-Executive Director		Jan-22	Ongoing	15 - 20	11	-	-	-	-	15 - 20
Chris Gibson	Non-Executive Director		Aug-17	Jul-24	10 - 15	-	-	-	-	-	10 - 15
Neil Herbert	Non-Executive Director		Aug-22	Ongoing	10 - 15	-	-	-	-	-	10 - 15
Sarah Buik	Associate Non-Executive Director		Aug-22	Ongoing	10 - 15	6	-	-	-	-	10 - 15
Vicki Wells	Associate Non-Executive Director		Aug-22	Ongoing	10 - 15	-	-	-	-	-	10 - 15
Andrew Morgan	Chief Executive		Oct-23	Jun-24	185 - 190	-	-	-	-	23	185 - 190
Jonathan Young	Director of Finance		Oct-23	Sep-24	60 - 65	-	-	-	-	12	60 - 65
Karen Dunderdale	Director of Nursing & Deputy Chief Executive		Feb-20	Ongoing	150 - 155	8	-	-	-	8	150 - 155
Angie Davies	Deputy Director of Nursing		Nov-23	Jul-24	50 - 55	1	-	-	55 - 57.5	-	105 - 110
Colin Farquharson	Medical Director		Aug-21	Ongoing	220 - 225	-	-	-	87.5 - 90	-	310 - 315
Claire Low	Director of People and Organisational Development (OD)		Oct-22	Ongoing	120 - 125	-	-	-	62.5 - 65	25	185 - 190
Sameedha Rich-Mahadkar	Acting Director of Improvement and Integration		Jan-22	Aug-24	140 - 145	-	-	-	42.5 - 45	-	185 - 190
Kathryn Helley	Associate Director Clinical Governance		Nov-23	Ongoing	50 - 55	-	-	-	-	-	50 - 55
Julie Frake Harris	Chief Operating Officer		Dec-23	Aug-24	35 - 40	1	-	-	-	-	35 - 40
Barry Jenkins	Director of Finance & Digital		May-23	Oct-23	80 - 85	-	-	-	-	-	80 - 85
Paul Matthew	Director of Finance & Digital		Nov-18	Apr-23	15 - 20	-	-	-	-	5	15 - 20
Michelle Harris	Interim Chief Operating Officer		Dec-22	Mar-24	160 - 165	-	-	-	65 - 67.5	-	225 - 230
Paul Dunning	Acting Medical Director		Sep-22	Sep-23	95 - 100	-	-	-	-	-	95 - 100
Craig Ferris	Deputy Director of Safeguarding		Nov-23	Mar-24	50 - 55	1	-	-	15 - 17.5	-	65 - 70

Remuneration Split

Name	Position	Total Earnings	In Year Pension Adjustment	Earnings less Pension Adjustment	LCHS Contribution (Based on Earnings less Pension)	ULTH Contribution (based on Earnings less Pension)
		£000's	£000'	£000's	£000's	£000's
Elaine Baylis	Chair	51	-	51	-	51
Philip Baker	Non-Executive Director	13	-	13	-	13
Rebecca Brown	Deputy Chair	22	-	22	7	15
Dani Cecchini	Non-Executive Director	16	-	16	7	9
Chris Gibson	Non-Executive Director	4	-	4	-	4
Neil Herbert	Non-Executive Director	15	-	15	7	8
Sarah Buik	Associate Non-Executive Director	14	-	14	7	7
Vicki Wells	Associate Non-Executive Director	13	-	13	7	6
David Connolly	Non-Executive Director	15	-	15	15	-
Gail Shadlock	Non-Executive Director	13	-	13	13	-
Ian Orrell	Non-Executive Director	15	-	15	-	15
Karen Dunderdale	Group Chief Executive	249	-	249	109	140
Andrew Morgan	Chief Executive	68	-	68	29	39
Daren Fradgley	Group Chief Integration Officer	199	80	119	43	76
Paul Antunes Goncalves	Group Chief Finance Officer	112	24	88	38	50
Jonathan Young	Director of Finance	78	6	72	-	72
Samuel Wilde	Director of Finance & Business Intelligence	105	19	86	86	-
Caroline Landon	Group Chief Operating Officer	130	17	113	52	61
Julie Frake Harris	Chief Operating Officer	81	22	59	59	-
Colin Farquharson	Group Chief Medical Officer	440	189	251	47	204
Anne-Louise Schokker	Medical Director	59	-	59	59	-
Nerea Odongo	Group Chief Nurse	175	60	115	53	62
Angie Davies	Director of Nursing	43	-	43	-	43
Claire Low	Chief People Officer	196	-	196	76	120
Kathryn Helley	Group Chief Clinical Governance Officer	297	147	150	43	107
Jayne Warner	Group Director of Corporate Affairs	169	89	80	43	37
Michael Parkhill	Group Chief Estates and Facilities Officer	103	-	103	53	50
Sameedha Rich-Mahadkar	Director of Improvements & Integration	61	2	59	-	59

Notes for 2024/25

- Salary payments for Karen Dunderdale, Claire Low and Andrew Morgan (former CEO) include pension restructuring payments for pension fund performance over the year.
- Andrew Morgan left the Group in June 2024 and Karen Dunderdale was appointed Group Chief Executive. Her pay continued to be split between United

Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust.

3. With the formation of the Lincolnshire Community and Hospitals NHS Group most directors had roles overlapping the two trusts. A schedule of their split is shown above.
4. Julie Frake Harris was substantively employed as Chief Operating Officer with Lincolnshire Community Health Services NHS Trust and her costs were covered by that Trust. From August 2024 she was seconded out of the organisation until she left in December 2024.
5. Paul Antunes Goncalves was seconded to the Group from Nottingham University Hospitals NHS Trust from October 2024 as Group Chief Finance Officer. In April 2025 this appointment was made substantive.
6. Colin Farquharson was appointed Group Chief Medical Officer from 1/08/2024 from Medical Director ULTH.
7. Nerea Odongo was appointed Interim Group Chief Nurse from July 2024 – remained seconded from Northampton to end of the year.
8. Caroline Landon – Appointed Interim Group Chief Operating Officer – for 12 months from 1/08/2024.
9. Michael Parkhill appointed Interim role Group Chief Estates and Facilities Officer 01/08/2024 (still holding role of Director of Facilities and Estates
10. Angela Davies seconded to Nurse Advisor NHSE – 29/8/2024.
11. Daren Fradgley appointed Deputy Chief Executive Officer 25/09/2024
12. There are no pensionable benefits paid to non-executive directors for the year 2024/25

Definitions:

Salary

The total amount of salary, fees and allowances paid for services provided (inclusive of salary sacrifice) but excluding reimbursement of expenses and employers pension 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

Pension related benefits disclosed arise from membership of the NHS Pensions defined benefit scheme. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. The calculation applies a prescribed formula as set out within the Finance Act (2004) and is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual. Where there has been only a small increase in pension and lump sum benefits current year compared to last year, this formula can sometimes generate a negative figure. Where this is the case, Department of Health guidance states that a “zero” should be substituted for any negative figures.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits.
- A change in the pension scheme itself.
- Changes in the contribution rates.
- Changes in the wider remuneration package of an individual

Benefits in Kind

These relate to the benefit in kind associated with lease cars obtained through the Trust Salary Sacrifice Lease Car Scheme or via the Trust Standard Lease Car scheme.

There were no performance related pay or bonus payments made in 2024/25 nor 2023/24.

Pensions entitlement table

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 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2024	Cash Equivalent Transfer Value at 31 March 2025	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Karen Dunderdale	Group Chief Executive Officer	1	-	-	-	-	-	-	-	
Andrew Morgan	Chief Executive Officer	2	-	-	-	-	-	-	-	
Daren Fradgley	Group Chief Integration Officer		2.5 - 5	5 - 7.5	60 - 65	155 - 160	1,097	1,313	79	
Paul Antunes Goncalves	Group Chief Finance Officer		0 - 2.5	0 - 2.5	30 - 35	80 - 85	530	623	17	
Jonathan Young	Director of Finance	3	0 - 2.5	-	35 - 40	95 - 100	707	781	5	
Caroline Landon	Group Chief Operating Officer		0 - 2.5	-	15 - 20	-	241	318	26	
Colin Farquharson	Group Chief Medical Officer		10 - 12.5	15 - 17.5	75 - 80	190 - 195	1,433	1,753	193	
Nerea Odongo	Group Chief Nurse		2.5 - 5	-	30 - 35	-	387	485	40	
Angela Davies	Deputy Director of Nursing		-	-	50 - 55	60 - 65	1,410	1,037	-	
Claire Low	Chief People Officer	1	-	-	-	-	159	-	-	
Kathryn Helley	Group Chief Clinical Governance Officer	3	5 - 7.5	12.5 - 15	50 - 55	135 - 140	966	1,202	155	
Jayne Warner	Group Director of Corporate Affairs		2.5 - 5	10 - 12.5	30 - 35	85 - 90	563	758	90	
Michael Parkhill	Group Chief Estates and Facilities Officer	1	-	-	-	-	-	-	-	
Sameedha Rich-Mahadkar	Director of Improvements & Integration		0 - 2.5	-	25 - 30	-	322	376	-	

The Trust operates the standard NHS Pension Scheme.

Notes:

1. Dr Karen Dunderdale, Claire Low, Anne-Louise Schokker and Michael Parkhill chose not to be covered by the pension arrangements during the reporting year.
2. Andrew Morgan left his role as Chief Executive Officer during the financial year but had opted out of the pension fund in prior years.
3. Jonathan Young, Julie Frake-Harris and Kathryn Helley are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.

Negative values are not disclosed in this table but are substituted with a “zero”.

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 contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Inflation

The inflation rate used was 6.7% supplied by the Business Services Authority (Disclosure of Senior Managers Remuneration (Greenbury) 2025-20250106-(V1))

A rate of 3.10% was used for prior year in line with the published report for the Trust.

Compensation on early retirement or for loss of office

There were no directors paid for early retirement nor loss of office by the Trust in both 2024/25 and 2023/24

Payments to past directors

There were no payments made to former directors in 2024/25. There were also no performance bonuses to executives during the last two financial years. Benefits in kind were in respect of use of leased vehicles by senior staff.

Fair pay disclosure

In line with HM Treasury requirements, NHS Trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the lower quartile, median and upper quartile remuneration of the organisation's workforce. The table below shows the relationship between these quantiles.

Total remuneration comprises basic salary and allowances, non-consolidated performance-related pay and all taxable benefits. It does not include any severance payments, benefits in kind, employer pension contributions and the cash equivalent transfer value of pensions.

The Trust does not pay Performance pay and bonuses and a separate disclosure of percentile and ratio data excluding these is not enquired.

Remuneration is calculated on the annualised full time equivalent staff in post at the Trust at the reporting date of 31st March 2025.

All Directors have been operating across United Lincolnshire Teaching Hospitals NHS Trust (ULTH) and Lincolnshire Community Health Services NHS Trust (LCHS) during part 2024/25. In compiling this note, the earnings were apportioned across the two Trusts. This apportionment was also taken into accounts in determining the highest paid director.

Percentage change in remuneration of highest paid director

Colin Farquharson, Group Medical Director, was the highest paid director for United Lincolnshire Teaching Hospitals NHS Trust in the financial year 2024/25 - £200k - £205k. In 2023/24 Colin Farquharson was the highest paid director - £220k - £225k. The reduction in costs reflects the shared cost arrangement with LCHS agreed as part of the Group.

The table below shows the average earnings for employees of the Trust at 25%, 50% and 75%. This is then compared to the highest paid director.

	Remuneration all Trust staff		
Year	25th percentile total £	Median total £	75th percentile total £
2024/25	27,691	36,329	48,526
2023/24	27,108	36,100	48,392

	Pay Remuneration Ratio		
Year	25th percentile	Median total	75th percentile total
2024/25	7:1	6:1	4:1
2023/24	8:1	6:1	5:1

In 2024/25, 210 (2023/24, 106) employees received remuneration more than the highest-paid director. Remuneration ranged from £513,047 to £13,387 (2023/24 £434,590 to £10,324).

The average employee earnings for 2024/25 was £47,482 (2023/24 was £46,835) which was 1.4% above the average for 2023/24.

Staff report



Staff numbers and costs

The tables below show the total number of employees employed by the trust – average over the two years 2024/25 and 2023/24.

			2024/25	2023/4
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	461,569	6,139	467,708	398,120
Social security costs	46,988	-	46,988	41,599
Apprenticeship levy	2,306	-	2,306	2,061
Employer's contributions to NHS pension scheme	81,593	-	81,593	61,448
Pension cost - other	137	-	137	170
Temporary staff	-	23,851	23,851	32,786
Total gross staff costs	592,593	29,990	622,583	536,184
Total staff costs	592,593	29,990	622,583	536,184
Of which				
Costs capitalised as part of assets	3,510	1,220	4,730	1,897

Staff composition

The tables below show the total number of employees employed by the Trust – average over the two years 2024/25 and 2023/24.

			2024/25	2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,128	234	1,362	1,258
Ambulance staff	10	-	10	11
Administration and estates	2,155	51	2,206	2,068
Healthcare assistants and other support staff	1,647	313	1,960	1,892
Nursing, midwifery and health visiting staff	2,670	214	2,884	2,650
Scientific, therapeutic and technical staff	741	30	771	689
Healthcare science staff	111	9	120	112
Total average numbers	8,462	851	9,313	8,680
Of which:				
Number of employees (WTE) engaged on capital projects	47	17	64	19

Gender Demographics (FTE Only)

Bands	Female	Male	Grand Total
Band 1	16.0	8.0	24.0
Band 2	887.7	294.9	1,182.6
Band 3	1,359.6	327.6	1,687.1
Band 4	418.9	129.5	548.3
Band 5	1,676.2	315.0	1,991.1
Band 6	805.3	244.7	1,050.0
Band 7	493.4	122.0	615.4
Band 8A	220.4	83.7	304.1
Band 8B	64.8	30.7	95.5
Band 8C	18.9	11.0	29.9
Band 8D	9.0	7.8	16.8
Band 9	12.2	9.0	21.2
Consultant	97.5	287.3	384.8
Executive Directors	6.0	6.0	12.0
Foundation Doctor Year 1	8.0	6.0	14.0
Foundation Doctor Year 2	68.6	73.0	141.6
Foundation Doctors Year 1	50.5	37.0	87.5
Practitioners	1.0	0.7	1.7
Specialty Doctor	71.1	159.8	230.9
Specialty Registrar	105.2	156.1	261.3
Associate Specialist	1.7	17.5	19.2
Staff Grade Practitioner		0.8	0.8

Sickness absence

The Trust is committed to maintaining and promoting the health and wellbeing of all 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 2024/25.

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Published by NHS Digital from ESR Data Warehouse		
Average FTE for 2024	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
8,676	102,685	11.8	3,166,707	166,578

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2024

Data items: ESR does not hold details of the planned working/non-working days for employees, so days lost and days available are reported based upon a 365-day year. For the annual report and accounts the following figures are used:

- The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.
- The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.
- The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Fairness and equity

As a large, public-sector employer, Lincolnshire Community and Hospitals NHS Group (LCHG) is committed to promoting equality, diversity and inclusion and to tackling any inequalities that are identified in the workforce. Whilst we are aligning our equality, diversity and inclusion work across the Group as far as possible, it is important to note that there are some statutory and contractual duties where separate reporting, as United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust respectively, is required.

The Trust has 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 staffside representatives to ensure they reflect employment law and best practice. All policies are assessed with an equality impact assessment to ensure there can be no detriment to any group of staff through their application.

The Trust believes that equality, diversity and inclusion are central to the success of our vision, just as equality, diversity and inclusion sit at the heart of the NHS Constitution.

Equality objectives are the building-blocks which turn that core principle of equality, diversity and inclusion into a reality for us all.

LCHG is fully committed to meeting its statutory and mandatory responsibilities, including implementation of the Equality Delivery System (EDS) 2022, the requirements of the Public Sector Equality Duty (PSED), the Workforce Race Equality Standard (WRES), Workforce Disability Standard (WDES), Gender Pay Gap reporting and the Accessible Information Standard (AIS).

The Trusts has delivered their equality objectives 2022-2025 with the above standards and responsibilities in mind. The Trust worked in partnership with its workforce and patient representatives to establish, check and confirm them. As we enter 2025-2026, LCHG is preparing to publish a new suite of equality objectives.

The Trust's plans and actions help to ensure compliance with equality legislation, work to eliminate unlawful discrimination experienced by those who share a protected characteristic (as defined by the Equality Act 2010) and to foster understanding and good relationships between all people.

The Trust is fully committed to caring for all patients, service users, their families and carers, and staff in a manner which embraces, respects, promotes and celebrates equality and cultural diversity. There is a range of staff networks available to help support staff and in some cases, make valuable improvements to the ways in which we work.

Staff policies applied during the financial year

The Trust has a series of policies relating to our workforce that are reviewed and updated as required and available to view upon request. Individual Trust policies are currently being reviewed with a view to harmonising into single policies to be applied across LCHG. All policies have an equality statement included in the overview as well as an equality and health inequality impact assessment. Policies are monitored to ensure that they are utilised fairly and there is no detriment to anyone with protected characteristics.

Trade union facility time reporting requirements

The Trust is committed to building strong partnerships with all stakeholders, with trade union staff representatives being key partners. 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 to participate in and to support changes which affect them. “

The policy sets out 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 their equivalents for medical staff) are the forums 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.

The Trust provides 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 for the 2024/25 financial year):

Table 1	
Relevant Union Officials	
What was the total number of your employees who were relevant union officials during the relevant period?	
Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number (based upon average monthly FTE)
11	8.72

Table 2	
Percentage of time spent on facility time	
How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?	
Percentage of time	Number of Employees
0%	0
1-50%	7
51-99%	1
100%	3

Table 3	
Percentage of pay bill spent on facility time	
Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.	
First column	Figures
Provide the total cost of facility time	£254,066
Provide the total pay bill	£493,886k
Provide the percentage of the total pay bill spent on facility time, calculated as:	0.051%

Other employee matters

Group

- Reduction in overall vacancy rate at both LCHS and ULTH
- Turnover rate across both LCHS and ULTH has seen an improved position over recent months with a stabilisation at 9.4% across both providers
- Sickness rate across both LCHS and ULTH have seen improved or stabilised position
- Core learning compliant at LCHS and ULTH and is being sustained.
- Temporary staffing for community nursing and community hospitals is reducing overall and there has been a continued downward shift in the financial year.

ULTH

- The nursing vacancy rate has continued to show over establishment reflecting the positive work undertaken for the internationally educated nurses over the last couple of years which means we are no able to support with ensuring that nurses are in the right place at the time to support patient care.
- Overall appraisal rate is outside of target, with much greater improvement needed for Agenda for Change staff. It is expected that there will be an improved position in 2025/26 as both trusts harmonise their approach to appraisals.

National Staff Survey

It is important for the Trust to know both locally and nationally where our relative improvements and declines are within the national staff survey.

Commonality of improvements seen across Group includes:

- Q11b: in the last 12 months, not experienced any musculo-skeletal problems as a result of work.
- Q12a: never/rarely find work emotionally exhausting.

Free text responses indicate the improvements are linked to the much-improved wellbeing/Employee Assistance Programme offer available across LCHG.

ULTH has improved scores for questions 25c – would recommend this organisation as a place to work and 25d if a friend needed treatment, would be happy with the standard of care.

The People Promise elements are showing relative improvements and declines and provides the contrasting view from last year's results for context, both as an overall Trust and by division/directorate.

The overall response rate for ULTH has significantly decreased this year and work will be undertaken locally with leaders to increase awareness of and promote engagement with the National Staff Survey process with their teams.

- A move to divisionally owned action plans for ULTH leaders and increased accountability as regards ensuring actions are completed is anticipated to increase engagement.
- Whilst there appears to be a number of declines and improvements across respective organisations within LCHG, it should be emphasised that any decline is marginal.
- The next step is to build the cascade mechanism for this information across LCHG using a hybrid of both ULTH and LCHS previous approaches.
- Organisational development teams will offer support in terms of interpreting data and guidance as regards how to use this, specifically around building directorate level action plans.
- Divisional level action plans to be built and presented to Group Leadership Team (GLT) by respective leaders in June 2025.

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

Recruitment and Retention

There is an improved position in relation to recruitment and retention across both trusts within the Group.

- The attrition rate for ULTH has reduced from 10.3% in April 2024 to 9.47% as at the end of February 2025.
- The vacancy rate for ULTH has reduced from 6.18% in April 2024 to 5.97% in February 2025.

The recruitment market for medical staff remains a challenge. The Trust has seen a significant improvement in vacancy rate for this staff group during 24/25. Allied health professionals remains a challenge, however, the Trust has successfully

recruited international candidates as part of an NHS England scheme to introduce community diagnostic centres in Lincolnshire.

The Trust is looking at its overall workforce model with the introduction of new roles, to reduce the reliance on roles that are hard to recruit and an increased focus on increasing retention levels.

Developing workforce safeguards

An initial assessment of the maturity of workforce planning has been undertaken using the associated NHS Improvement operational workforce planning toolkit. An annual workforce plan is informed by many of the points listed above (to varying degree). The Trust has begun to embed a strategic workforce planning to support leaders to manage their services and resources in line with national planning guidance. This includes rolling out a new plan for every post process within medical and dental which further supports a reduction in reliance on temporary staff.

Freedom to speak up

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. ULTH 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's freedom to speak up guardian in 2024/25:

	Total Cases	Cases received anonymously	Cases with element of patient safety	Cases with element of bullying/ harassment	Behaviour and Relationships	Cases where detriment reported
Q1	91	3	6	19	55	0
Q2	109	2	14	10	43	0
Q3	118	4	17	10	36	5

Q4	115	9	8	11	52	0
----	-----	---	---	----	----	---

The Trust has a Freedom to Speak Up Policy in place, which aligns to the NHS policy. The group has two guardians working flexibly to cover the services. They are supported by a team of National Guardian's Office trained champions, who promote speak up and signpost issues to the guardians or appropriate channels. Both guardians are linked into regional and national networks and compliant with their training requirements.

ULTH continues on an upward trajectory with an increase in staff feeling confident to speak up about any concerns and confident they will be addressed by the organisation. The freedom to speak up guardian continuously works with staff on raising awareness of speaking up and Speak Up training is now on all staff compliance.

Consultancy expenditure

Consultancy is the provision to management of objective advice and assistance relating to strategy, structure, management or operations in pursuit of Trust policies and objectives. Such assistance is normally provided outside 'business-as-usual' where in-house skills are limited and may impact delivery schedules. Consultancy may include the identification of options with recommendations, or assistance with the implementation of solutions.

In 2024/25 the Trust spend £16,353 on the following consultations:

- a) Refurbishment evaluations £6,892
- b) Surveys £1,350
- c) Framework £8,111

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 bodies to publish information on highly paid off-payroll engagements. this disclosure was to cover payments of £245 per day. This was set at the minimum pay scale for a senior civil employee.

In April 2017 the Secretary of state public instruction for public bodies to follow a reformed off-payroll tax rule (IR35). Public bodies were to determine whether the rules apply when engaging a worker through a Personal Service Company (PSC).

The worker (or contractor) was 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 where individuals are paid through their own companies and, therefore, responsible for their own tax and NI arrangements.

Highly paid off-payroll worker engagements still working at the Trust on 31 March 2025, earning £245 or more per day:

No. of existing engagements as of 31 March 2025 *	20
Of which the number that have existed:	
for less than one year at time of reporting	14
for between one and two years at time of reporting	2
for between two and three years at time of reporting	4
for between three and four years at time of reporting	
for four years or more at time of reporting	

The table below represents all off-payroll engagements between 1 April 2024 and 31 March 2025.

**No. of off-payroll workers engaged between 1 April 2024 and 31 March 2025	45
Of which	
Not Subject to off-payroll legislation	3
Subject to off payroll legislation and determined as in the scope of IR35	31

Subject to off payroll legislation and determined as out of scope of IR35	11
No of engagements reassessed for compliance or assurance purposes during the year	1
Of which: Number of engagements that saw a change to IR35 status following review	0

** The table includes agency nursing staff engaged for more than four weeks during the financial year at an average cost exceeding £245.

Off-payroll board member/senior official engagements

The following table shows off-payroll engagements of board members, and/or senior officials with significant financial responsibility between 1 April 2024 and 31 March 2025.

No of off-payroll engagements 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.	19

Exit packages

The Trust is required to disclose details of exit packages agreed in the year. The following tables show the number of exit packages agreed and amounts paid out in relation to these.

Table 1: Exit Packages

Reporting of compensation schemes - exit packages 2024/25

	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 - £25,000	-	1	1
£25,001 - 50,000	-	1	1
Total number of exit packages by type	-	2	2
Total resource cost (£)	£0	£61,000	£61,000

Reporting of compensation schemes - exit packages 2023/24

	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	-	4	4
£10,000 - £25,000	-	2	2
£25,001 - 50,000	1	-	1
Total number of exit packages by type	1	6	7
Total resource cost (£)	£46,000	£38,000	£84,000

Redundancy and other departure costs are paid in accordance with 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 and not NHS

Pensions Scheme. Ill-health retirement costs are paid fully by NHS Pensions Scheme and are not included in the tables presented with this report.

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

Table 2: Analysis of Other Departures

Exit packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000		
Contractual payments in lieu of notice	-	-	6	38
Non-contractual payments requiring HMT approval	2	61	-	-
Total	2	61	6	38
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

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.

Financial statements



Statement of Comprehensive Income

		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	846,199	740,456
Other operating income	4	53,359	48,133
Operating expenses	7,9	(920,042)	(809,543)
Operating surplus/(deficit) from continuing operations		(20,484)	(20,954)
Finance income	11	1,816	2,554
Finance expenses	12	(310)	(198)
PDC dividends payable		(9,928)	(8,277)
Net finance costs		(8,422)	(5,921)
Other gains / (losses)	13	346	(1,189)
Surplus / (deficit) for the year from continuing operations		(28,560)	(28,064)
Surplus / (deficit) for the year		(28,560)	(28,064)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	16	(521)	(1,719)
Revaluations	16	5,290	8,731
Total comprehensive income / (expense) for the period		(23,791)	(21,052)

Statement of Financial Position

		31 March 2025 £000	31 March 2024 £000
	Note		
Non-current assets			
Intangible assets	14	11,958	10,924
Property, plant and equipment	15	384,195	333,031
Right of use assets	18	13,686	13,956
Receivables	20	2,084	2,022
Total non-current assets		411,923	359,933
Current assets			
Inventories	19	6,362	6,581
Receivables	20	24,167	19,781
Cash and cash equivalents	22	19,146	50,858
Total current assets		49,675	77,220
Current liabilities			
Trade and other payables	23	(81,341)	(95,425)
Borrowings	25	(3,080)	(3,167)
Provisions	27	(12,594)	(12,154)
Other liabilities	24	(1,259)	(1,195)
Total current liabilities		(98,274)	(111,941)
Total assets less current liabilities		363,324	325,212
Non-current liabilities			
Borrowings	25	(12,922)	(13,557)
Provisions	27	(5,371)	(5,271)
Other liabilities	24	(10,063)	(10,566)
Total non-current liabilities		(28,356)	(29,394)
Total assets employed		334,968	295,818
Financed by			
Public dividend capital		819,701	756,760
Revaluation reserve		52,015	48,454
Other reserves		190	190
Income and expenditure reserve		(536,938)	(509,586)
Total taxpayers' equity		334,968	295,818

The notes on pages 131 to 203 form part of these accounts.

Name	Karen Dunderdale
Position	Group Chief Executive Officer
Date	27 June 2025

Statement of Cash Flows

		2024/25	2023/24
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		(20,484)	(20,954)
Non-cash income and expense:			
Depreciation and amortisation	7.1	33,029	25,768
Net impairments	8.1	8,079	6,580
Income recognised in respect of capital donations	4	(147)	(114)
Amortisation of PFI deferred credit		(503)	(503)
(Increase) / decrease in receivables and other assets		(4,372)	33,556
(Increase) / decrease in inventories		219	(448)
Increase / (decrease) in payables and other liabilities		(3,476)	293
Increase / (decrease) in provisions		490	(5,390)
Other movements in operating cash flows		-	(4)
Net cash flows from / (used in) operating activities		12,835	38,784
Cash flows from investing activities			
Interest received		1,828	2,551
Purchase of intangible assets		(7,107)	(7,132)
Purchase of PPE and investment property		(89,050)	(44,652)
Sales of PPE and investment property		353	59
Initial direct costs or up front payments in respect of new right of use assets (lessee)		-	(53)
Net cash flows from / (used in) investing activities		(93,976)	(49,227)
Cash flows from financing activities			
Public dividend capital received		62,941	32,718
Movement on other loans		(805)	(805)
Capital element of lease rental payments		(2,431)	(2,393)
Other interest		(10)	(9)
Interest paid on lease liability repayments		(241)	(142)
PDC dividend (paid) / refunded		(10,016)	(9,328)
Cash flows from (used in) other financing activities		(9)	(9)
Net cash flows from / (used in) financing activities		49,429	20,032
Increase / (decrease) in cash and cash equivalents		(31,712)	9,589
Cash and cash equivalents at 1 April - brought forward		50,858	41,269
Cash and cash equivalents at 1 April - restated		50,858	41,269
Cash and cash equivalents at 31 March	22.1	19,146	50,858

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	756,760	48,454	-	190	-	(509,586)	295,818
Surplus/(deficit) for the year	-	-	-	-	-	(28,560)	(28,560)
Other transfers between reserves	-	(1,208)	-	-	-	1,208	-
Impairments	-	(521)	-	-	-	-	(521)
Revaluations	-	5,290	-	-	-	-	5,290
Public dividend capital received	62,941	-	-	-	-	-	62,941
Taxpayers' and others' equity at 31 March 2025	819,701	52,015	-	190	-	(536,938)	334,968

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	724,042	42,584	-	190	-	(482,664)	284,152
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2023 - restated	724,042	42,584	-	190	-	(482,664)	284,152
Surplus/(deficit) for the year	-	-	-	-	-	(28,064)	(28,064)
Other transfers between reserves	-	(1,139)	-	-	-	1,139	-
Impairments	-	(1,719)	-	-	-	-	(1,719)
Revaluations	-	8,731	-	-	-	-	8,731
Transfer to retained earnings on disposal of assets	-	(3)	-	-	-	3	-
Public dividend capital received	32,718	-	-	-	-	-	32,718
Taxpayers' and others' equity at 31 March 2024	756,760	48,454	-	190	-	(509,586)	295,818

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 and Social Care 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 (previously the NHS Litigation Authority) on 1st April 2000 have been recorded as 'other reserves'.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Notes to the Accounts

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 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 circumstances of the Trust for the purpose of giving a true and fair view has been selected. The 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 Consolidation

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 to obtain economic benefits. The transactions are, however, 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 any other entities or organisations.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The DHSC Group Accounting Manual's (GAM) extended definition of a contracts include legislation and regulations which enables an entity to receive cash or other financial assets that are 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 financial year end, the Trust accrues income relating to performance obligations satisfied in that year but not yet paid for. 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 through provider contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain fixed and variable elements. Under the variable element, providers earn income for elective activity (both ordinary and day cases), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear

medicine, and chemotherapy delivery activities. The precise definition of these activities is given in the NHSPS.

Income is earned at NHSPS tariffs based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below. Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2024/25, The Trust was operating under a gainshare agreement where marginal costs were paid upfront as part of the main contract and underperformance anticipated to clawed back.

High costs drugs and devices that are excluded from the calculation of national tariffs are reimbursed by Commissioner based on actual usage or at a fixed baseline in addition to the price of the related service. In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts

Income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes was paused for 2024/25. The Trust receives income from a number of provider-to-provider contracts in the year.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. From 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners. In 2022/23 elective recovery funding for providers was identified within the aligned payment and incentive contracts.

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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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. 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 grant is used to fund capital expenditure, it is credited to the 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 apprenticeship service 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 financial year.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, 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 assets and liabilities. Therefore, the schemes are accounted for as though they are 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 they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to 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 those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

Note 1.9 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 in use for more than one fiscal year.
- the cost of the item is measurable reliably.
- the items:
 - have cost of £5,000 and above.
 - collectively, items with a cost of £250 and above each have a total cost of at least £5,000 where the assets are functionally interdependent, have broadly simultaneous purchase dates, expected to have similar disposal dates and are under single managerial control.

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

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 during construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets under construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

The Trust checks at the end of each financial year whether 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 the magnitude of the loss.

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

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition subject only to terms which are usual and customary for such sales.

The sale must be considered highly likely after the following considerations:

- management are committed to a plan to sell the asset an active programme has begun to find a buyer to 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 measures required to complete the sale are unlikely to be altered or abandoned.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged, and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met and sale complete.

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

Property, plant and equipment 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition is complete.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has stipulated conditions 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 and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-

Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

The nature of the PFI held by United Lincolnshire Teaching Hospitals NHS Trust is such that no unitary payment is included within operating expenses, and the operator derives income from charges made to users rather than from payments by the Trust. The Trust guarantees certain levels of usage of the asset over a given period.

Further description of the scheme is set out in Note 31.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in income and expenditure reserves.

IFRS16 principles are not applicable to the Trust's PFI as there is no unitary payment and no lease liability for the PFI assets held by the Trust.

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 is shown in the table below:

	Min life	Max life
	Years	Years
Land	-	-
Buildings, excluding dwellings	10	90
Dwellings	60	90
Plant & machinery	3	20
Transport equipment	5	15
Information technology	2	10
Furniture & fittings	5	15

Note 1.10 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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 is shown in the table below:

	Min life	Max life
	Years	Years
Intangible assets - internally generated		
Information technology	2	15
Development expenditure	2	10
Intangible assets - purchased		

Software	2	15
Licences & trademarks	2	5
Websites	2	10

Note 1.11 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.

Between 2020/21 and 2023/24 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 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 DHSC. Distribution of these inventories stopped in March 2024. The Trust had some of these stocks at the beginning of 2024/25.

Note 1.12 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 1.13 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 the Office of National Statistics (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, that is, 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. 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 leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

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

In line with the GAM (Paragraph 4.280&4.281) balances with core central government departments (including their executive agencies), the Government's Exchequer Funds, Bank of England and Government Banking Service are excluded from recognising stage-1 and stage-2 impairments. In addition, any Government Exchequer Funds' assets where repayment is ensured by primary legislation are also excluded from recognising stage-1 and stage-2 impairments. ALBs are excluded from the exemption unless they are explicitly covered by a guarantee given by their parent department.

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

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are made up of three elements:

- Compensation Recovery Unit, where a provision of 23.07% 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.

De-recognition

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

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

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability (IFRS 16).

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

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

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%

Very long-term	Exceeding 40 years	4.55%	4.40%
----------------	--------------------	-------	-------

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 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note XX 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 claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 34 of the Annual Report, where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital (PDC)

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 in the PDC dividend policy issued 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 the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

The Trust has determined that it has no corporation tax liability due to its status as a provider of public health and a non-profit making organisation.

Note 1.20 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.

Note 1.21 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

The Trust does not hold any assets or liabilities denominated in foreign currency. The Trust, from time to time, receive payments from Overseas Patients in other currencies. These are converted at the rate applicable on the date the payment is received.

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

Note 1.22 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 1.23 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 except for provisions for future losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value. Gifts in the Trust are handled through an independent Charitable organisation and donated to the trust as in Note 1.2 above.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted.

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of

insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The Department of Health and Social Care GAM have recommended the following changes for 2025/26:

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5-year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £263 million as at 31 March 2025.

Note 1.27 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's 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 specialised usage land and buildings should be valued based on 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 or similar usage and productive capacity as the property being valued'. 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 would need to spend 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 made 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 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 the main roads into the city.
- Grantham District General Hospital site could theoretically be provided from a location on the outskirts of Grantham with access to the main road around Grantham.
- Boston Pilgrim Hospital would not be re-sited.
- All Dwellings under the Trust

Further details concerning the valuation of Property, Plant and Equipment are provided in Note 1.9 above and note 15 of the Annual Accounts.

Note 1.28 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 2025: £442.6 million (2023/24 £385.6 m)

A revaluation of Trust Property is conducted by Cushman & Wakefield before the end of each financial year. The value of land, buildings and dwellings post revaluation was £442.6million and is detailed on 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 1.9.

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 several different ways such as valuations (external professional

opinion), internal review and profession assessment (equipment and IT assets predominantly).

Progress Housing (value 31 March 2025 £48.3 million (2023/24 was £44.7 million)
The Trust entered a contract with Progress Living in 2006, in which they provide accommodation to Trust employees. Under the terms of the contract the Trust guarantees minimum occupancy where the Trust meets the costs of underoccupancy.

Future occupancy levels are estimated based on average occupancy levels over the preceding 12 months from November 2024. 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 considers 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 12 months as a basis for future occupancy is therefore a key source of estimation uncertainty

Note 1.29 Adjusted performance results

	2024/25	2023/24
Adjusted financial performance (control total basis):	£000	£000
Surplus / (deficit) for the period	(28,560)	(28,064)
Remove net impairments not scoring to the Departmental expenditure limit	8,079	6,580
Remove I&E impact of capital grants and donations	718	652
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	1,481	1,132
Remove net impact of DHSC centrally procured inventories	28	56
Adjusted financial performance surplus / (deficit)	(18,254)	(19,644)

Note 2 Operating Segments

"The Trusts prepares reporting disclosures in accordance with IFRS 8 and paragraphs 5.45 to 5.53 of the GAM. The Trust operates in one business segment, the provision of healthcare services. The performance of the Trust is reviewed regularly by the Trust Board.

The financial results reported on the Financial Statement below are for operations within this one segment.

The Trust provides medical treatment, related research, training and education within the United Kingdom as directed by Departments of HM Government.

The main revenue source is from the provision of medical treatment to patients as analysed on Note 3 of the Financial Statement by patient type.

Other streams of revenue come from education and training, research, non-patient care services to other organisation within the healthcare service sector and other income generated from healthcare related activities. This income is analysed on Note 4 of the Financial Statement."

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

	2024/25		2023/24	
	£000s	%	£000s	%
Revenue from HM Government sources	848,979	94.4	754,968	95.7
Revenue from non HM Government sources	50,579	5.6	33,621	4.3
Total	899,558	100.0	788,589	100.0

Interest Yield for the year shown below

	2024/25	2023/24
	£000s	£000s
Interest Income	1,816	2,554
Income Expense	(310)	(198)
Total	1,506	2,356

Revaluation and Impairment

	2024/25	2023/24
	£000s	£000s
Revaluation Reserve Adjustments	5,290	8,731
Impairments	(521)	(1,719)
	4,769	7,012

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)

	2024/25	2023/24
	£000	£000
Income from commissioners under API contracts - variable element*	137,234	127,550
Income from commissioners under API contracts - fixed element*	602,716	526,170
High cost drugs income from commissioners	67,296	58,420
Other NHS clinical income	5,216	4,392
All services		
Private patient income	123	188
National pay award central funding***	1,380	328
Additional pension contribution central funding**	32,234	18,624
Other clinical income	-	4,784
Total income from activities	846,199	740,456

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where

government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2024/25	2023/24
	£000	£000
Income from patient care activities received from:		
NHS England	91,823	122,577
Integrated care boards	751,493	614,516
Department of Health and Social Care	23	104
Other NHS providers	316	366
Local authorities	115	117
Non-NHS: private patients	123	188
Non-NHS: overseas patients (chargeable to patient)	506	1,084
Injury cost recovery scheme	1,239	1,063
Non NHS: other	561	441
Total income from activities	846,199	740,456
Of which:		
Related to continuing operations	846,199	740,456
Related to discontinued operations	-	-

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

	2024/25	2023/24
	£000	£000
Income recognised this year	506	1,084
Cash payments received in-year	530	262
Amounts added to provision for impairment of receivables	631	1,164
Amounts written off in-year	343	225

Note 4 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,940	-	1,940	1,688	-	1,688
Education and training	28,035	2,576	30,611	23,229	1,727	24,956
Non-patient care services to other bodies	6,081		6,081	5,265		5,265
Income in respect of employee benefits accounted on a gross basis	5,127		5,127	6,806		6,806
Receipt of capital grants and donations and peppercorn leases		147	147		114	114
Charitable and other contributions to expenditure		56	56		235	235
Revenue from operating leases		1,257	1,257		1,214	1,214
Amortisation of PFI deferred income / credits		503	503		503	503
Other income	7,637	-	7,637	7,352	-	7,352
Total other operating income	48,820	4,539	53,359	44,340	3,793	48,133
Of which:						
Related to continuing operations			53,359			48,133
Related to discontinued operations			-			-

Note 5 Fees and charges

The following disclosure is of income from charges to service users where the full cost of providing 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 disclosed.

	2024/25	2023/24
	£000	£000
Income	5,481	4,723
Full cost	(5,007)	(3,916)
Surplus / (deficit)	474	807

Note 5.1 Other Schemes

This note addresses and aggregates schemes that, individually, have a cost exceeding £1m.

This comprises catering and car parking income and from 2024/25 retail sales from the public and staff.

Catering	2024/25	2023/24
	£000s	£000s
Income	3,091	2,513
Full cost	(3,418)	(2,778)
Surplus / (deficit)	(327)	(265)

Car Parking	2024/25	2023/24
	£000s	£000s
Income	1,073	1,187
Full cost	(226)	(284)
Surplus / (deficit)	847	903

Retail Sales	2024/25	2023/24
	£000s	£000s
Income	1,317	1,023
Full cost	(1,363)	(854)
Surplus / (deficit)	(46)	169

Note 6 Operating leases - United Lincolnshire Teaching Hospitals NHS Trust as lessor

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

The Trust has leased buildings to other organisations that provide ancillary services to patients.

Note 6.1 Operating lease income

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,112	1,132
Variable lease receipts / contingent rents	145	82
Total in-year operating lease income	1,257	1,214

Note 6.2 Future lease receipts

	31 March	31 March
	2025	2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	241	275
- later than one year and not later than two years	230	248
- later than two years and not later than three years	195	236
- later than three years and not later than four years	19	203
- later than four years and not later than five years	19	36
- later than five years	6	115
Total	710	1,113

Note 7 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	37	141
Purchase of healthcare from non-NHS and non-DHSC bodies	8,573	7,144
Purchase of social care	5	3
Staff and executive directors costs	609,208	526,911
Remuneration of non-executive directors	160	154
Supplies and services - clinical (excluding drugs costs)	83,272	74,098
Supplies and services - general	12,800	11,547
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	74,632	71,205
Inventories written down	261	209
Consultancy costs	12	4
Establishment	8,862	8,314
Premises	34,334	29,591
Transport (including patient travel)	2,095	1,954
Depreciation on property, plant and equipment	27,359	21,085
Amortisation on intangible assets	5,670	4,683
Net impairments	8,079	6,580
Movement in credit loss allowance: contract receivables / contract assets	385	732
Change in provisions discount rate(s)	9	(139)
audit services- statutory audit	182	176
Internal audit costs	238	221
Clinical negligence	24,185	22,967
Legal fees	382	716
Insurance	36	23
Research and development	2,277	1,974
Education and training	11,979	10,101
Expenditure on short term leases	228	61
Redundancy	-	48
Car parking & security	68	25
Hospitality	1	2
Losses, ex gratia & special payments	(1,053)	1,128
Other services, eg external payroll	3,907	3,168
Other	1,859	4,717
Total	920,042	809,543
Of which:		
Related to continuing operations	920,042	809,543
Related to discontinued operations	-	-

Note 7.1 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2024/25 or 2023/24.

Note 8 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	8,079	6,580
Total net impairments charged to operating surplus / deficit	8,079	6,580
Impairments charged to the revaluation reserve	521	1,719
Total net impairments	8,600	8,299

Note 8.1 Material Impairment losses / (reversals)

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

	2024/25	2023/24
	£000	£000
Reversals of impairments charged to SOCI in previous years:		
A&E/X-ray Pilgrim Hospital		(11)
Endoscopy Lincoln County Hospital		(5)
PARU Modular Building	(1,766)	(444)
New Resus Building-Lincoln	(2,594)	
Other - buildings*	(1,437)	

	2024/25	2023/24
Impairments charged to SOCI in current year:	£000	£000
Tower Block Pilgrim Hospital	218	57
Generator House Lincoln County Hospital	47	1,218
Maternity Unit Pilgrim	107	2,135
New Resus building	-	132
Maternity Unit Lincoln County Hospital	-	572
Data Centre 3 new Build	399	910
Phase II	2,472	
A & E Building Pilgrim	737	
external Areas, Pilgrim	820	
Skegness Community Diagnostic Centre	3,223	
Lincoln Community Diagnostic Centre	3,364	
Other - buildings a	2,489	2,016
	8,079	6,580

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

Note 8.2 Property, Plant and Equipment impairments and reversals charged to the revaluation reserve

	2024/25	2023/2202 4
	£000	£000
Other	-	
Changes in market price	521	1,719
Total impairments for PPE charged to reserves	521	1,719

Note 9 Employee benefits

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	467,708	398,120
Social security costs	46,988	41,599
Apprenticeship levy	2,306	2,061
Employer's contributions to NHS pensions	81,593	61,448
Pension cost - other	137	170
Temporary staff (including agency)	23,851	32,786
Total gross staff costs	622,583	536,184
Recoveries in respect of seconded staff	-	-
Total staff costs	622,583	536,184
Of which		
Costs capitalised as part of assets	4,730	1,897

Note 9.1 Retirements due to ill-health

During 2024/25 there were 4 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £63k (£253k in 2023/24).

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

Note 10 Pension Costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of

participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

An outline of these follows:

a) **Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was considered through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

The estimated cost of Pension for 2025/26 is £32,234k

Note 11 Finance income

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	1,816	2,554
Total finance income	1,816	2,554

Note 12 Finance expenditure

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on lease obligations	241	142
Interest on late payment of commercial debt	10	9
Total interest expense	251	151
Unwinding of discount on provisions	51	37
Other finance costs	8	10
Total finance costs	310	198

Note 12.1 The late payment of commercial debts (interest) Act 1998

	2024/25	2023/24
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	1,483	883
Amounts included within interest payable arising from claims made under this legislation	10	9

Note 13 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	350	104
Losses on disposal of assets	(4)	(1,293)
Total gains / (losses) on disposal of assets	346	(1,189)
Total other gains / (losses)	346	(1,189)

Note 14 Intangible assets - 2024/25

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	25,808	-	-	20	-	-	15	597	-	26,440
Additions	3,933	-	-	-	-	-	-	2,043	-	5,976
Reclassifications	1,409	-	-	-	-	-	-	(681)	-	728
Disposals / derecognition	(3,023)	-	-	-	-	-	-	-	-	(3,023)
Valuation / gross cost at 31 March 2025	28,127	-	-	20	-	-	15	1,959	-	30,121
Amortisation at 1 April 2024 - brought forward	15,481	-	-	20	-	-	15	-	-	15,516
Provided during the year	5,670	-	-	-	-	-	-	-	-	5,670
Disposals / derecognition	(3,023)	-	-	-	-	-	-	-	-	(3,023)
Amortisation at 31 March 2025	18,128	-	-	20	-	-	15	-	-	18,163
Net book value at 31 March 2025	9,999	-	-	-	-	-	-	1,959	-	11,958
Net book value at 1 April 2024	10,327	-	-	-	-	-	-	597	-	10,924

Note 14.1 Intangible assets - 2023/24

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	22,096	-	-	20	-	-	15	3,653	-	25,784
Valuation / gross cost at 1 April 2023 - restated	22,096	-	-	20	-	-	15	3,653	-	25,784
Additions	3,254	-	-	-	-	-	-	597	-	3,851
Reclassifications	4,026	-	-	-	-	-	-	(3,653)	-	373
Disposals / derecognition	(3,568)	-	-	-	-	-	-	-	-	(3,568)
Valuation / gross cost at 31 March 2024	25,808	-	-	20	-	-	15	597	-	26,440
Amortisation at 1 April 2023 - as previously stated	14,366	-	-	20	-	-	15	-	-	14,401
Amortisation at 1 April 2023 - restated	14,366	-	-	20	-	-	15	-	-	14,401
Provided during the year	4,683	-	-	-	-	-	-	-	-	4,683
Disposals / derecognition	(3,568)	-	-	-	-	-	-	-	-	(3,568)
Amortisation at 31 March 2024	15,481	-	-	20	-	-	15	-	-	15,516
Net book value at 31 March 2024	10,327	-	-	-	-	-	-	597	-	10,924
Net book value at 1 April 2023	7,730	-	-	-	-	-	-	3,653	-	11,383

Note 15 Property, plant and equipment - 2024/25

	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 2024 - brought forward	11,800	177,901	44,709	47,460	85,082	604	16,481	1,402	385,439
Additions	-	9,385	-	60,969	7,461	-	1,826	137	79,778
Impairments	-	(20,206)	-	-	-	-	-	-	(20,206)
Reversals of impairments	-	5,221	-	-	-	-	-	-	5,221
Revaluations	-	354	3,550	-	-	-	-	-	3,904
Reclassifications	-	31,201	-	(51,687)	11,803	-	7,955	-	(728)
Transfers to / from assets held for sale	-	-	-	-	(1,455)	-	-	(38)	(1,493)
Disposals / derecognition	-	-	-	-	(5,315)	-	(3,895)	(83)	(9,293)
Valuation/gross cost at 31 March 2025	11,800	203,856	48,259	56,742	97,576	604	22,367	1,418	442,622
Accumulated depreciation at 1 April 2024 - brought forward	-	-	-	-	44,988	495	6,232	693	52,408
Provided during the year	-	7,035	736	-	10,673	22	5,935	172	24,573
Impairments	-	(4,134)	-	-	-	-	-	-	(4,134)
Reversals of impairments	-	(2,251)	-	-	-	-	-	-	(2,251)
Revaluations	-	(650)	(736)	-	-	-	-	-	(1,386)
Transfers to / from assets held for sale	-	-	-	-	(1,452)	-	-	(38)	(1,490)
Disposals / derecognition	-	-	-	-	(5,315)	-	(3,895)	(83)	(9,293)
Accumulated depreciation at 31 March 2025	-	-	-	-	48,894	517	8,272	744	58,427
Net book value at 31 March 2025	11,800	203,856	48,259	56,742	48,682	87	14,095	674	384,195
Net book value at 1 April 2024	11,800	177,901	44,709	47,460	40,094	109	10,249	709	333,031

Note 15.1 Property, plant and equipment - 2023/24

	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 2023 - as previously stated	11,800	181,022	37,113	18,742	79,675	593	16,478	1,127	346,550
Valuation / gross cost at 1 April 2023 - restated	11,800	181,022	37,113	18,742	79,675	593	16,478	1,127	346,550
Additions	-	5,770	-	42,992	4,151	-	722	302	53,937
Impairments	-	(12,550)	-	(1,267)	-	-	-	-	(13,817)
Reversals of impairments	-	(499)	-	-	-	-	-	-	(499)
Revaluations	-	41	7,596	-	-	-	-	-	7,637
Reclassifications	-	5,346	-	(13,007)	4,558	57	2,673	-	(373)
Transfers to / from assets held for sale	-	-	-	-	(1,019)	(17)	-	-	(1,036)
Disposals / derecognition	-	(1,229)	-	-	(2,283)	(29)	(3,392)	(27)	(6,960)
Valuation/gross cost at 31 March 2024	11,800	177,901	44,709	47,460	85,082	604	16,481	1,402	385,439
Accumulated depreciation at 1 April 2023 - as previously stated	-	-	-	-	40,504	516	6,078	593	47,691
Accumulated depreciation at 1 April 2023 - restated	-	-	-	-	40,504	516	6,078	593	47,691
Provided during the year	-	6,538	599	-	7,698	25	3,546	127	18,533
Impairments	-	(4,964)	-	-	-	-	-	-	(4,964)
Reversals of impairments	-	(1,053)	-	-	-	-	-	-	(1,053)
Revaluations	-	(495)	(599)	-	-	-	-	-	(1,094)
Transfers to / from assets held for sale	-	-	-	-	(942)	(17)	-	-	(959)
Disposals / derecognition	-	(26)	-	-	(2,272)	(29)	(3,392)	(27)	(5,746)
Accumulated depreciation at 31 March 2024	-	-	-	-	44,988	495	6,232	693	52,408
Net book value at 31 March 2024	11,800	177,901	44,709	47,460	40,094	109	10,249	709	333,031
Net book value at 1 April 2023	11,800	181,022	37,113	18,742	39,171	77	10,400	534	298,859

Note 15.2 Property, plant and equipment financing - 31 March 2025

	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
Owned - purchased	11,800	203,297	-	56,742	47,043	87	14,072	674	333,715
On-SoFP PFI contracts and other service concession arrangements	-	-	48,259	-	-	-	-	-	48,259
Owned - donated/granted	-	559	-	-	1,639	-	23	-	2,221
Total net book value at 31 March 2025	11,800	203,856	48,259	56,742	48,682	87	14,095	674	384,195

Note 15.3 Property, plant and equipment financing - 31 March 2024

	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
Owned - purchased	11,800	177,342	-	47,460	37,737	109	10,249	709	285,406
On-SoFP PFI contracts and other service concession arrangements	-	-	44,709	-	-	-	-	-	44,709
Owned - donated/granted	-	559	-	-	2,357	-	-	-	2,916
Total net book value at 31 March 2024	11,800	177,901	44,709	47,460	40,094	109	10,249	709	333,031

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

	Plant & machinery	Fair value of asset
Asset Description - Donation of physical asset	£000	£000
Opmaster 506P Operating Trolley	7	7
DP-50 Handheld Ultrasound System	5	5
Trios 3 System	19	19
Novux E4 Red Scan	19	19
Chargebox Fast6 Mobile Device Charger *3	27	27
Opmaster 506P Ophthal Operating Trolley	8	8
Criticool Cooling System	17	17
Criticool Cooling System	17	17
QA4 Powered Mobile Surgery System	10	10
Lucas 3.1 Chest Compression System	12	12
Total value of physical assets donated	141	141

Note 17 Revaluations of property, plant and equipment

The Trust commissioned a desktop revaluation of land, buildings and dwellings with a valuation date of 31 March 2025. This revaluation was conducted by Cushman & Wakefield Debenham Tie Leung Limited.

This desktop revaluation has been undertaken on the following basis:

- 1) 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 may

require a smaller footprint and may be sited at alternative locations to serve the populations of Lincoln, Boston Grantham and surrounding towns.

- 2) Land and Buildings no longer in operational use are classified as 'surplus' and valued at Fair Value. The carrying value of assets not in active use but not classified as held for sale is £1.0m (31 March 2024: £1.0m)
- 3) Dwellings are valued on an Existing Use Value (EUV) at 31 March 2025

The table below summarises the desktop valuation carried out for 31 March 2025

	2024/25	2023/24
	£000s	£000s
Land	11,800	-
Dwellings*	48,259	44,709
Buildings	203,856	-
	263,915	44,709

	2024/25	2023/24
	£000s	£000s
Revaluation Reserves Movement		
Revaluation reserve at 1 April 2024 - brought forward	48,454	42,584
Net impairments	(521)	(1,719)
Revaluations	5,290	8,731
Transfers to other reserves	(1,208)	(1,142)
Revaluation reserve at 31 March 2025	52,015	48,454

* Dwellings relate Progress Care Housing Association Ltd accommodation units (non-specialised - dwellings) - see also notes 1.9.

Accounting policies note 1.9 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 purchased or capitalised. 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 qualified valuers and based on prevailing economic environment and factors.

The gross value of fully depreciated assets still in use is £6.2m (31 March 2024: £5.47m).

The value of buildings owned by the Trust that are leased out under operating leases is shown below.

	2024/25	2023/24
	£000s	£000s
Net book value 1 April	10,842	10,915
New leases	16	16
Additions	372	372
Depreciation	(317)	(317)
Increase in valuation 31 March	6	6
Impairments/Reversals	(150)	(150)
Net book value 31 March	10,769	10,842

Pathlincs, Thames Amb, St Barnabas, Synergy, Rowlands, Growing Wild, Nursery Sports & Social & Hair Salon, EMAS

Note 18 Leases - United Lincolnshire Teaching Hospitals NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust is the lessee for a number of properties: Buildings 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 are leased through NHS Property Services with a collective annual lease cost of £0.8m (2023/24: £0.8m)

Other Properties where the Trust is lessee include: Beach House and Car Parks at Lincoln County Hospital. These have a collective annual lease cost of £0.2m (2023/24: £0.2m).

The Trust's arrangements relating to the lease of plant and equipment are supplied under normal commercial terms by non-NHS suppliers.

These incorporate lease cars, MRI scanners and other smaller items of medical equipment and photocopiers.

Note 18.1 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Intangible assets	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	12,005	6,037	605	-	-	-	18,647	9,159
Additions	2,160	97	105	-	-	-	2,362	-
Remeasurements of the lease liability	158	-	-	-	-	-	158	158
Movements in provisions for restoration / removal costs	(1)	-	-	-	-	-	(1)	-
Disposals / derecognition	(315)	(8)	(349)	-	-	-	(672)	-
Valuation/gross cost at 31 March 2025	14,007	6,126	361	-	-	-	20,494	9,317
Accumulated depreciation at 1 April 2024 - brought forward	1,782	2,549	360	-	-	-	4,691	1,461
Provided during the year	1,307	1,330	149	-	-	-	2,786	985
Disposals / derecognition	(315)	(8)	(346)	-	-	-	(669)	-
Accumulated depreciation at 31 March 2025	2,774	3,871	163	-	-	-	6,808	2,446
Net book value at 31 March 2025	11,233	2,255	198	-	-	-	13,686	6,871
Net book value at 1 April 2024	10,223	3,488	245	-	-	-	13,956	7,698
Net book value of right of use assets leased from other NHS providers								159
Net book value of right of use assets leased from other DHSC group bodies								6,712

Note 18.2 Right of use assets - 2023/24

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Intangible assets	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	7,423	6,315	487	-	-	-	14,225	6,917
Valuation / gross cost at 1 April 2023 - restated	7,423	6,315	487	-	-	-	14,225	6,917
Additions	2,377	-	159	-	-	-	2,536	-
Remeasurements of the lease liability	2,242	-	-	-	-	-	2,242	2,242
Disposals / derecognition	(37)	(278)	(41)	-	-	-	(356)	-
Valuation/gross cost at 31 March 2024	12,005	6,037	605	-	-	-	18,647	9,159
Accumulated depreciation at 1 April 2023 - brought forward	830	1,402	186	-	-	-	2,418	698
Accumulated depreciation at 1 April 2023 - restated	830	1,402	186	-	-	-	2,418	698
Provided during the year	975	1,379	198	-	-	-	2,552	763
Disposals / derecognition	(23)	(232)	(24)	-	-	-	(279)	-
Accumulated depreciation at 31 March 2024	1,782	2,549	360	-	-	-	4,691	1,461
Net book value at 31 March 2024	10,223	3,488	245	-	-	-	13,956	7,698
Net book value at 1 April 2023	6,593	4,913	301	-	-	-	11,807	6,219
Net book value of right of use assets leased from other NHS providers								187
Net book value of right of use assets leased from other DHSC group bodies								7,511

Note 18.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 25.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	13,906	11,695
Carrying value at 1 April - restated	13,906	11,695
Lease additions	2,356	2,483
Lease liability remeasurements	158	2,242
Interest charge arising in year	241	142
Early terminations	-	(121)
Lease payments (cash outflows)	(2,672)	(2,535)
Carrying value at 31 March	13,989	13,906

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets is £0k and is included within revenue from operating leases in note 4.

Note 18.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,555	809	2,563	798
- later than one year and not later than five years;	5,787	3,233	6,040	3,189
- later than five years.	7,808	3,516	6,795	4,210
Total gross future lease payments	16,150	7,558	15,398	8,197
Finance charges allocated to future periods	(2,161)	(364)	(1,492)	(424)
Net lease liabilities at 31 March 2025	13,989	7,194	13,906	7,773
Of which:				
Leased from other NHS providers		161		189
Leased from other DHSC group bodies		7,033		7,584

Note 19 Inventories

	31 March 2025	31 March 2024
	£000	£000
Drugs	3,185	3,114
Consumables	3,177	3,467
Total inventories	6,362	6,581
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £77,582k (2023/24: £76,663k). Write-down of inventories recognised as expenses for the year were £261k (2023/24: £209k).

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 2023/24 the Trust received £166k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

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 20 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	14,181	8,286
Allowance for impaired contract receivables / assets	(1,338)	(1,383)
Prepayments (non-PFI)	8,472	10,060
Interest receivable	131	143
PDC dividend receivable	411	323
VAT receivable	263	1,852
Other receivables	2,047	500
Total current receivables	24,167	19,781
Non-current		
Contract receivables	2,073	1,963
Allowance for impaired contract receivables / assets	(507)	(453)
Other receivables	518	512
Total non-current receivables	2,084	2,022
Of which receivable from NHS and DHSC group bodies:		
Current	9,903	4,786
Non-current	518	512

Note 20.1 Allowances for credit losses

	2024/25		2023/24	
	Contract receivable s and contract assets	All other receivable s	Contract receivable s and contract assets	All other receivable s
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	1,836	-	1,347	-
Allowances as at 1 April - restated	1,836	-	1,347	-
New allowances arising	1,727	-	2,438	-
Reversals of allowances	(1,342)	-	(1,706)	-
Utilisation of allowances (write offs)	(376)	-	(243)	-
Allowances as at 31 Mar 2025	1,845	-	1,836	-

Note 20.2 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 2025	31 March 2024
	£000	£000
0 - 30 days	-	-
30-60 Days	-	-
60-90 days	-	-
90- 120 days	52	217
Over 120 days	746	703
Total	798	920

Ageing of non-impaired financial assets past their due date

	31 March 2025	31 March 2024
	£000	£000
0 - 30 days	3,857	2,561
30-60 Days	255	43
60-90 days	82	85
90- 120 days	43	22
Over 120 days	85	43
Total	4,322	2,754

In addition to providing against specific invoiced debt £0.8m (2023/24: £0.9m), the Trust also makes general provision for impairment based upon expected recovery rates.

This covers both invoiced debt £0.2m (2023/24: £0.2m) and income from the Compensation recovery unit £0.8m (2023/24: £0.7m).

Note 21 Finance leases (United Lincolnshire Teaching Hospitals NHS Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the United Lincolnshire Teaching Hospitals NHS Trust is the lessor.

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

Note 22 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.

	2024/25	2023/24
	£000	£000
At 1 April	50,858	41,269
At 1 April (restated)	50,858	41,269
Net change in year	(31,712)	9,589
At 31 March	19,146	50,858
Broken down into:		
Cash at commercial banks and in hand	13	11
Cash with the Government Banking Service	19,133	50,847
Total cash and cash equivalents as in SoFP	19,146	50,858
Total cash and cash equivalents as in SoCF	19,146	50,858

Note 22.1 Third party assets held by the trust

United Lincolnshire Teaching 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.

Note 23 Trade and other payables

	31 March 2025	31 March 2024
	£000	£000
Current		
Trade payables	11,531	16,097
Capital payables	16,551	27,095
Accruals	33,245	32,915
Social security costs	6,119	6,061
Other taxes payable	6,814	6,928
Pension contributions payable	6,823	6,116
Other payables	258	213
Total current trade and other payables	81,341	95,425
Of which payables from NHS and DHSC group bodies:		
Current	4,410	10,363
Non-current		

Note 24 Other liabilities

	31 March 2025	31 March 2024
	£000	£000
Current		
Deferred income: contract liabilities	756	692
Deferred PFI credits / income ¹	479	479
Other deferred income	24	24
Total other current liabilities	1,259	1,195
Non-current		
Deferred PFI credits / income 1	9,578	10,056
Other deferred income	485	510
Total other non-current liabilities	10,063	10,566

¹ 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 25 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Other loans	805	805
Lease liabilities	2,275	2,362
Total current borrowings	<u>3,080</u>	<u>3,167</u>
Non-current		
Other loans	1,208	2,013
Lease liabilities	11,714	11,544
Total non-current borrowings	<u>12,922</u>	<u>13,557</u>

Note 26 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Lease Liabilities £000	Total £000
Carrying value at 1 April 2024	-	2,818	13,906	16,724
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(805)	(2,431)	(3,236)
Financing cash flows - payments of interest	-	-	(241)	(241)
Non-cash movements:				
Additions	-	-	2,356	2,356
Lease liability remeasurements	-	-	158	158
Application of effective interest rate	-	-	241	241
Carrying value at 31 March 2025	<u>-</u>	<u>2,013</u>	<u>13,989</u>	<u>16,002</u>

	Loans from DHSC	Other loans	Lease Liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	-	3,623	11,695	15,318
Carrying value at 1 April 2023 - restated	-	3,623	11,695	15,318
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(805)	(2,393)	(3,198)
Financing cash flows - payments of interest	-	-	(142)	(142)
Non-cash movements:				
Additions	-	-	2,483	2,483
Lease liability remeasurements	-	-	2,242	2,242
Application of effective interest rate	-	-	142	142
Early terminations	-	-	(121)	(121)
Carrying value at 31 March 2024	-	2,818	13,906	16,724

Note 27 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re- structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2024	669	1,439	3,608	-	-	-	11,709	17,425
Change in the discount rate	1	7	-	-	-	-	(5)	3
Arising during the year	49	116	302	-	-	-	5,537	6,004
Utilised during the year	(96)	(105)	(390)	-	-	-	(2,049)	(2,640)
Reversed unused	(49)	-	(2,509)	-	-	-	(346)	(2,904)
Unwinding of discount	16	35	-	-	-	-	26	77
At 31 March 2025	590	1,492	1,011	-	-	-	14,872	17,965
Expected timing of cash flows:								
- not later than one year;	95	103	1,011	-	-	-	11,385	12,594
- later than one year and not later than five years;	340	388	-	-	-	-	3,019	3,747
- later than five years.	155	1,001	-	-	-	-	468	1,624
Total	590	1,492	1,011	-	-	-	14,872	17,965

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.

1. 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.

Pension and Early departure provisions went down from £669k to £590k due to low arisings and also the value of unused provision within the year.

2. The provision for legal claims are made up of two component elements:
 - (a) Third party liability and property expense claims as notified by NHS Resolution £303 K (2023/24: £300 k)
 - (b) Projected liabilities in relation to claims made against the Trust for employment, commercial and other litigation issues £708k (2023/24: £3,300k).

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. The estimated costs are included with the provisions above.

3. Other provisions:
 - a) Clinicians Pension provision £538k (2023/24 £500k) (supplied from NHSE)
 - b) Medical Staff Bank Annual leave (Flowers) £7,450k
 - c) Restore Contract Cost provision £2,940k (2024/24 £2,800k) (cost of destroying and releasing records)
 - d) Job Planning £1,113k
 - e) Dilapidation Provision £30 k (providing for restoring leased properties to original state)
 - f) Anaesthetists Annual Leave Provision £966k
 - g) Brokenhurst VAT Claim £1,720k (this provision reverses other income)

Note 27.1 Clinical negligence liabilities

At 31 March 2025, £325.1k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of United Lincolnshire Teaching Hospitals NHS Trust (31 March 2024: £281,830k).

Note 28 Contingent assets and liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	(61)
Net value of contingent liabilities	-	(61)
Net value of contingent assets	-	-

Note 29 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	8,125	38,991
Intangible assets	428	70
Total	8,553	39,061

Note 30 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 to the Trust. In addition, the contract includes a 20-year occupancy guarantee at 85.3%. If 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.

Note 30.1 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities

Initial application of IFRS 16 liability measurement principles to PFI liabilities found that IFRS16 principles are not applicable under the Trust's PFI as there is no unitary payment and therefore no imputed lease liability."

Note 31 Financial instruments

Note 31.1 Financial risk management

IFRS 7 directs disclosure of the role financial instruments have had during the period in creating or changing the risks organisation face when undertaking operations. The Trust has a standing service agreement with Lincolnshire Integrated Care Board (LICB) and NHS England. The two organisations are financed through public funds and this, to some extent, mitigates the financial risk the Trust faces. The Trust, therefore, mainly relies on public finance and so has limited opportunities to borrow or invest funds and financial assets and liabilities are generated by day-to-day operations and cannot be used to mitigate financial risk.

The Trust's finances are managed through stringent financial instructions and policies agreed by its board of directors. The finances are also subject to review and checks by internal and external auditors.

Currency risk

The Trust UK based with a greater proportion of its transactions, assets and liabilities based in the UK and transacted in pound sterling. The Trust has no overseas operations and has low exposure to currency rate fluctuations. The small number of overseas patients are asked to pay for services in sterling by converting their currencies at the day rates when payment is cleared.

The Trust has one interest free loan from Salix Finance obtained to support the purchase of the generator at Grantham Hospital.

The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk

A large proportion of the Trust's revenue comes from contracts other public sector related organisations, their exposure to credit risk is minimal. Areas of credit risk are from overseas client accounts.

Income from the public financiers are on the basis 'Aligned payment and incentive contracts' comprising fixed and variable elements. Payments are normally received on schedule with minimum adjustments based on service delivery.

The Trust has, therefore minimal exposure to credit risk.

Liquidity Risk

The Trust finances are supported by funding from NHS England through the Lincolnshire Integrated Care Board. The funding is normally based on resource allocations based on Trust service delivery plans. The Trust receives cash resources to cover all the costs for delivering their services over a financial year. Capital programmes are funded through the Department of Health and Social Care capital funding. The Trust has avenues to apply for additional liquidity support through the ICB system or direct to NHS England.

Liquidity risk is minimum for the Trust because of the open avenues for support available.

Note 31.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	17,105	17,105
Cash and cash equivalents	19,146	19,146
Total at 31 March 2025	36,251	36,251
Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non- financial assets	9,568	9,568
Cash and cash equivalents	50,858	50,858
Total at 31 March 2024	60,426	60,426

Note 31.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	13,989	13,989
Other borrowings	2,013	2,013
Trade and other payables excluding non-financial liabilities	59,773	59,773
Provisions under contract	13,122	13,122
Total at 31 March 2025	88,897	88,897

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	13,906	13,906
Other borrowings	2,818	2,818
Trade and other payables excluding non financial liabilities	79,751	79,751
Provisions under contract	11,679	11,679
Total at 31 March 2024	108,154	108,154

Note 31.4 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 2025	31 March 2024
	£000	£000
In one year or less	72,798	91,469
In more than one year but not more than five years	7,075	8,101
In more than five years	11,185	10,076
Total	91,058	109,646

Note 31.5 Fair values of financial assets and liabilities

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

Note 32 Losses and special payments

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	26	31	23	9
Fruitless payments and constructive losses	1	303	1	21
Bad debts and claims abandoned	242	367	289	249
Stores losses and damage to property	3	261	2	207
Total losses	272	962	315	486
Special payments				
Compensation under court order or legally binding arbitration award	16	714	21	262
Ex-gratia payments	73	38	61	46
Special severance payments	2	61	-	-
Total special payments	91	813	82	308
Total losses and special payments	363	1,775	397	794

Note 33 Gifts

No gifts were made or received by the Trust in 2024/25 (Nil in 2023/24)

Note 34 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 2024/25 between the Trust and Organisations with whom Trust Senior Executives / Management hold positions of influence.

All Trust Board members of the Trust are also Trust Board members for Lincolnshire Community Health Services NHS Trust. Apart from Lincolnshire Community Health Services, other directors had interest in the following organisations:

- a. Philip Baker – University of Leicester (Pro-Vice Chancellor Research and Enterprise) – value of trade with Trust £2k income (2023/24 - £3k income)
- b. Colin Farquharson - University of Lincoln (Honorary Clinical Professor of Cardiology) – value of trade with Trust - £267k income and £323k expenditure (2023/24 - £340k income, £242k expenditure)

The Department of Health and Social Care is the Trust's 'Parent body' and is regarded as a related party.

During the year the Trust 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 2024/25 are listed below.

- Lincolnshire Partnership NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Lincolnshire Community Health Services NHS Trust
- University Hospitals of Leicester NHS Trust
- NHS Humber and North Yorkshire ICB
- NHS Leicester, Leicestershire and Rutland ICB
- NHS Lincolnshire ICB
- NHS Nottingham and Nottinghamshire ICB
- NHS South Yorkshire ICB
- NHS England - Core (including expenditure and payables for all regions and central specialised commissioning)
- NHS England - Central Specialised Commissioning Hub
- Midlands Regional Office

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. At the end of the financial year the Charity owed the Trust £133k (2023/24 £180k (total transactions of £387k (2023/24 - £242k))

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 2024/25 including the purchase / donation of various capital assets to the Trust as detailed at note 16.

2023/24 Related Party Disclosures

Elaine Baylis -Trust Chair	Trust Chair	Lincolnshire Community Health Services NHS Trust
Andrew Morgan - Chief Executive	Chief Executive	Lincolnshire Community Health Services NHS Trust
Karen Dunderdale - Deputy Chief Executive and Director of Nursing	Executive Chief Nurse	Lincolnshire Community Health Services NHS Trust
Claire Low - Director of People and Organisational Development	Director of People	Lincolnshire Community Health Services NHS Trust
Julie Frake-Harris - Chief Operating Officer	Chief Operating Officer	Lincolnshire Community Health Services NHS Trust
Rebecca Brown - Non Executive Director	Non Executive Director	Lincolnshire Community Health Services NHS Trust

NHS Cambridgeshire and Peterborough ICB	NHS Lincolnshire ICB
Nottingham University Hospitals NHS Trust	NHS Derby and Derbyshire ICB
Northern Lincolnshire and Goole NHS Foundation Trust	NHS Lancashire and South Cumbria ICB
Lincolnshire Community Health Services NHS Trust	NHS Humber and North Yorkshire ICB
NHS Nottingham and Nottinghamshire ICB	NHS West Yorkshire ICB
NHS Leicester, Leicestershire and Rutland ICB	NHS England
Lincolnshire Partnership NHS Foundation Trust	NHS Resolution
University Hospitals of Leicester NHS Trust	NHS Property Services
Sheffield Teaching Hospitals NHS Foundation Trust	Care Quality Commission
NHS Cambridgeshire and Peterborough ICB	NHS Blood and Transport

Note 35 Better Payment Practice code

	2024/25	2024/25	2023/24	2023/24
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	108,610	311,061	111,386	272,033
Total non-NHS trade invoices paid within target	98,793	279,892	92,285	236,483
Percentage of non-NHS trade invoices paid within target	91.0%	90.0%	82.9%	86.9%
NHS Payables				
Total NHS trade invoices paid in the year	2,716	56,709	2,384	50,001
Total NHS trade invoices paid within target	2,260	50,974	2,100	47,010
Percentage of NHS trade invoices paid within target	83.2%	89.9%	88.1%	94.0%

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

Note 36 Capital Resource Limit

	2024/25	2023/24
	£000	£000
Gross capital expenditure	88,274	62,566
Less: Disposals	(6)	(1,368)
Less: Donated and granted capital additions	(147)	(114)
Charge against Capital Resource Limit	88,121	61,084
Capital Resource Limit	88,121	61,084
Under / (over) spend against CRL	-	-

Note 37 Breakeven duty financial performance

	2024/25
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(18,254)
Breakeven duty financial performance surplus / (deficit)	(18,254)

Note 38 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,282	(13,880)	320	124	(25,813)	(15,161)	(56,917)	(56,891)
Breakeven duty cumulative position	4,071	5,353	(8,527)	(8,207)	(8,083)	(33,896)	(49,057)	(105,974)	(162,865)
Operating income		391,141	392,202	407,975	422,802	425,524	433,250	423,428	437,324
Cumulative breakeven position as a percentage of operating income		1.4%	(2.2%)	(2.0%)	(1.9%)	(8.0%)	(11.3%)	(25.0%)	(37.2%)
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
		£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(79,664)	(87,945)	(41,876)	3,149	2,665	(13,037)	(19,644)	(18,254)
Breakeven duty cumulative position		(242,529)	(330,474)	(372,350)	(369,201)	(366,536)	(379,573)	(399,217)	(417,471)
Operating income		433,161	447,492	539,248	643,878	680,194	757,678	788,589	899,558
Cumulative breakeven position as a percentage of operating income		(56.0%)	(73.9%)	(69.0%)	(57.3%)	(53.9%)	(50.1%)	(50.6%)	(46.4%)

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