NHS
United Lincolnshire Teaching Hospitals
NHS Trust

Annual report and accounts 2025/26

Contents

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 2025/26

Foreword

Welcome to the Annual Report for United Lincolnshire Teaching Hospitals NHS Trust (ULTH) for 2025/26. This document provides an overview of the activity that has taken place within our hospitals over the past year.

A key development during the year has been the continued progress of the Lincolnshire Community and Hospitals NHS Group (LCHG), which brings together Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH). By working more closely as a Group, we are actively improving the care of patients across Lincolnshire, by better coordinating care across hospital and community services. This collaboration supports more joined-up pathways, smoother transitions between services, and a stronger focus on delivering care closer to home.

Every day, our colleagues deliver care to thousands of people across Lincolnshire. We would like to begin by recognising the dedication, professionalism and compassion shown by our staff, often in the face of significant and sustained pressure across the NHS. Their commitment ensures that patients and their families receive care that is not only clinically effective but also delivered with dignity, kindness and respect.

Bringing care closer to where people live, where it makes the greatest difference, has been a key programme of work this year. Shifting care into the community helps to strengthen the focus on prevention, early detection and proactive management of illness. This approach is already making a difference, with stronger links between community, hospital and primary care leading to improved patient outcomes.

The past year has not been without challenges. We have experienced continued demand on our services; however, despite this, we have much to be proud of and celebrate. This includes improvements in the four-hour urgent and emergency care standard, ambulance handover times which has freed up ambulance service colleagues to serve our communities, reductions in 12-hour A&E waits, and progress against the 18-week referral to treatment target. We have also seen a significant reduction in the number of patients waiting more than 52 weeks from referral to treatment.

The Trust has achieved financial balance with deficit support funding, and we have been rated Amber-Green by NHS England for our overall Board capability.

Working together as a Group across LCHS and ULTH, we have delivered improvements, innovations and patient-centred service transformation in both hospital and community settings. Achievements over the past year include:

- Completing the first phase of a multi-million pound transformation of the Emergency Department at Pilgrim Hospital, Boston. The first phase is almost twice the size of the existing department. It includes eight resuscitation cubicles, 12 major cubicles for seriously ill patients, an area for children to be assessed and a relatives' room. We have also created six additional treatment cubicles as part of the new rapid assessment, intervention and treatment area designed to care for patients needing urgent assessment and care. The second phase of the development is well underway and will create a new main entrance, waiting room, triage area, Urgent Treatment Centre and dedicated paediatric area.
- Starting construction work on a new £26.5 million Endoscopy Unit at Lincoln County Hospital, which will offer a modern, accessible facility for patients and a much improved working environment for staff. It will provide state-of-the-art procedure

rooms, as well as post-procedure rooms with en-suite facilities, improving patient experience.

- Maintaining Joint Advisory Group (JAG) accreditation for our Endoscopy Service. This significant achievement is a testament to the consistently high standards of care, professionalism and dedication demonstrated by every member of the team.
- Receiving £23 million to deliver energy infrastructure improvements and clean power upgrades at Pilgrim Hospital, Boston, as part of the Public Sector Decarbonisation Scheme. This funding will support a range of measures, including an electrically powered heating and hot water system across the site, helping to reduce reliance on fossil fuels while strengthening critical infrastructure.
- Continuing to expand our Community Diagnostic Centres (CDCs). This included delivering more than 105,000 diagnostic tests to patients across Lincolnshire in our two newest CDCs in Skegness and Lincoln since they opened a year ago. We began construction work to extend facilities at Lincoln CDC. The 330 sqm single-storey extension will provide an additional 10 consultation rooms, a treatment room and a plaster room, supporting delivery of more planned care. We commenced demolition work at a former football ground in Boston to make way for a £24.9 million state-of-the-art CDC — the fourth of its kind in the county. Once complete, it will provide MRI and CT scanners, X-ray facilities, ultrasound rooms and additional consultation space, including dedicated audiology services. We also completed renovations at Grantham CDC to create three additional consultation rooms, making better use of space and enabling more clinics to take place. And finally, we won the CDC of the Year category at the Building Better Healthcare Awards 2025 for the Skegness and Lincoln centres.
- Reaching a milestone of more than 270 smokefree babies born due to support from the Stop Smoking Team Action, Advice and Refer (STAAR).
- Launching BadgerNotes, an application that allows pregnant patients to access details of their prenatal and antenatal care, alongside digitising maternity records.
- Launching the Neonatal Home Phototherapy Service, enabling clinically stable newborns with mild to moderate jaundice to receive treatment at home, reducing the need for prolonged hospital stays.
- Signing a contract and beginning to implement a new Electronic Patient Record (EPR), providing clinicians with secure, real-time access to patient information.
- Receiving Tessa Jowell Centre of Excellence status through the East Midlands Neuro-Oncology Service, recognising the high standards of treatment, care and research delivered by our Oncology team.
- Introducing the lowered threshold for home-testing kits as one of the first teams nationally. The Lincolnshire Bowel Cancer Screening Team is supporting earlier detection of potential signs of bowel cancer
- Strengthening stroke care across Lincolnshire through the CLEAR (Clinically Led Workforce and Activity Redesign) Programme, improving outcomes, reducing length of stay and enhancing community-based rehabilitation.
- Maintaining Veteran Aware Accreditation, reaffirming our commitment to delivering personalised, informed and compassionate care to veterans, serving personnel, reservists and their families.

- Receiving a record 1,297 nominations for the LCHG Staff Awards across 13 categories, with 52 individuals and teams shortlisted.

Mrs Elaine Baylis, reached the end of her term as Group Chair on 31 March 2026. Mrs Rebecca Brown was appointed Acting Group Chair with effect from 1 April 2026. The Group is grateful for Mrs Baylis for her significant contributions to the two Trusts.

As we look ahead to the coming year, we remain committed to working with our staff, partners and communities to strengthen local services, improve patient outcomes, and ensure that high-quality care is available to the people of Lincolnshire, both now and in the future.

Rebecca Brown, Chair

Professor Karen Dunderdale, Chief Executive Officer

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 2025/26, 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 789,502 (Office of National Statistics, 2024).

As part of coming together as a Lincolnshire Community and Hospitals Group, services across the two trusts are provided by six core care groups: Family Health, Medicine, Surgery, Alliance, Planned Care and Unplanned Care with support from corporate services.

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 2025/26 of £965.6m and the main contract is with NHS Lincolnshire Integrated Care Board (ICB).

Purpose and activities of the organisation

ULTH provides acute hospital services for the people of Lincolnshire and, through the Lincolnshire Community and Hospitals NHS Group (LCHG), works alongside LCHS to deliver more integrated care across hospital, community and neighbourhood pathways. These services are delivered through four care groups and a number of clinical business units, as detailed below.

Alliance Care Group

Clinical Business Units	Services
Cancer	Haematology
	Oncology
	Radiotherapy/Radiotherapy Physics
	Specialist Palliative Care
	MacMillan Personalisation
	Blood
Diagnostics	Endoscopy
	Respiratory Physiology (inc sleep)
	Neurophysiology
	Audiology
	Radiology
	Nuclear Medicine
	Clinical Engineering
	AAA
	Breast Screening *
	DESP
	Bowel Scope
	Medical Physics
	Medical Photography
	New-Born Hearing
	Pathlinks
Outpatients	Outpatient Nursing
	Health Records
	Reception Services
	Endocrinology *
	Diabetes *
	Dermatology *
	Rheumatology *

	Neurology *
	CDC and Community Pathways
Therapies and Rehabilitation	Rehabilitation Medicine
	Occupational Therapy
	Orthotics
	Dietetics
	Physiotherapy
	S&LT Contract
	Podiatry Contract
	Harrowby *

** moving to Alliance Care Group imminently*

Family Health Care Group

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

Medicine Care Group

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

Surgical Care Group

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
	Orthopaedics
	Urology
Theatres Anaesthesia and Critical Care	Theatres
	Critical Care
	Anaesthesia

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

Strategy

Vision, ambitions and strategies for 2025-2030

During 2025/26, ULTH continued to work as part of the Lincolnshire Community and Hospitals NHS Group (LCHG), alongside LCHS. The Group model brings together acute and community services to support more integrated working, improve outcomes for patients and populations, and make best use of our collective resources across Lincolnshire.

The shared Group Strategy 2025 to 2030 provides the strategic direction for both Trusts. During 2026 the strategy was refreshed to strengthen alignment to the NHS Ten Year Health Plan, the Neighbourhood Health Framework and wider national delivery expectations, while maintaining the original strategic framework. Our shared vision is “caring and building a healthier future for all”.

The Group Strategy provides the framework for annual delivery planning and performance oversight across both Trusts. During 2025/26, this included continued focus on waiting times, pathway redesign, productivity, digital transformation, neighbourhood health, workforce development and reducing health inequalities, all supported through the Group model and system wide partnership working.

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

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

Strategic aims capture the three things we must do to deliver our vision. They are our 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 our overarching aims. Assurance ratings are assigned to each strategic objective in the Trust's Board Assurance Framework.

Strategic aim 1: Patients – *Better Care*

Provide timely, high quality, affordable care in the right place.

Objectives:

1a) Improve patient safety, patient experience and deliver clinically effective care.
1b) Reduce waiting times for our patients
1c) Improve productivity and deliver financial sustainability
1d) Provide modern, clean and fit for purpose care settings

Across the year, delivery against the *Patient - Better Care* objectives remained largely controlled, despite sustained system pressure. The focus at the beginning of the year, was on recovery with improvements in infection prevention, elective pathways and core safety arrangements. As the year progressed, several challenges became persistent rather than episodic, notably medication safety, pressure ulcers and falls, diagnostics capacity, ambulance handover delays and cancer pathway performance.

The Trust is clear that the priority is no longer new initiatives but consistency and reliability at the ward, service and pathway level.

Referral To Treatment (RTT) performance and financial balance provided important assurance. Although RTT performance was strong, the growth in long waiters and diagnostic backlogs presented a real risk.

The Trust therefore ends the year with reasonable assurance in terms of the *Patients – Better Care* strategic aim, reflecting effective control overall, but with clear need for sustained grip to convert improvement into sustained performance.

Strategic aim 2: People – *Better Opportunities*

Develop, empower and retain great people

Objectives:

2a) Enable our people to fulfil their potential through training, development, research and education.
2b) Empower our people to continuously improve and innovate.
2c) Nurture compassionate and diverse leadership.
2d) Recognise our people through thanks and celebration

Workforce performance has been a relative strength throughout the year, with consistently high compliance for mandatory training and appraisals, improving stability and sustained engagement and recognition of staff contribution. Early confidence was built on strong recruitment, leadership development and culture programmes.

However, as delivery pressures increased, capacity and resilience emerged as the critical issues, particularly sickness absence, protected time for training and medical workforce gaps. The narrative has matured from one of compliance to one focused on capability, wellbeing and leadership effectiveness as enablers of delivery.

Overall, assurance remains reasonable in terms of the *People – Better Opportunities* strategic aim. The workforce is stable and engaged, but ongoing focus is required to ensure staffing pressures do not constrain safety, productivity or transformation.

Strategic aim 3: Population – *Better Health*

Improve population health

Objectives:

3a) Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services.
3b) Move from prescription to prevention, through a population health management and health inequalities approach.
3c) Enhance our digital and research and innovation capability.
3d) Drive forward our improvement, efficiency and sustainability agenda including our Green Plan

Progress against the *Population – Better Health* objective has been directionally strong, with substantial mobilisation of transformation programmes across community pathways, estates optimisation, digital infrastructure and sustainability. Early in the year the emphasis was on programme set-up and momentum, including Left Shift initiatives, Community Diagnostic Centres and major digital investments.

By the second half of the year, attention rightly shifted to delivery risk and benefits realisation, particularly around estate utilisation and the complexity of Electronic

Patient Record (EPR) delivery. In Q4, the Trust is clear that success now depends on embedding change into business-as-usual and demonstrating measurable impact on demand, flow and outcomes.

During 2025/26, the Trust has made steady progress in strengthening Research and Innovation (R&I), moving from growth and mobilisation toward clearer governance. Changes to the National Institute for Health and Care Research (NIHR) national funding arrangements were identified as a positive opportunity for the Trust, reducing reliance on historical performance and creating greater incentive for active delivery. The R&I function was restructured into clearer operational and strategic oversight arrangements.

The focus has shifted to embedding research into business-as-usual activities supported by the development of a multidisciplinary R&I strategy and clearer integration with core corporate governance.

The year ends with reasonable assurance in terms of the *Population – Better Health* strategic aim. Transformation is well-aligned and progressing but requires a sustained focus to translate ambition into a consistent system.

Overall Position and Future Plan

Overall, the Trust has made solid progress across all three strategic aims, underpinned by strong performance in patient safety, workforce stability, urgent care delivery and financial control.

The Trust now needs to consolidate gains, close recurring gaps and continue driving impact, particularly in safety, access, workforce resilience, transformation programmes and digital delivery. The emphasis for the next period should be on sustainable delivery.

This approach will be reflected in the Trust's strategy refresh, aligning with the NHS 10-Year Plan and the emerging neighbourhood working framework, and will be set out clearly within the 2026/27 Annual Plan.

Population Health Approach

Throughout 2025/26, ULTH continued to strengthen its population health approach as part of the Lincolnshire Community and Hospitals NHS Group (LCHG), supporting the wider shift towards more preventative, personalised and neighbourhood-based care. This has included using Population Health Management (PHM) insight to inform pathway redesign, waiting list improvement, left shift programmes and more targeted action to reduce health inequalities across Lincolnshire.

A key focus during the year has been the development of more integrated pathways across acute, community and primary care services, with particular emphasis on

reducing avoidable demand on hospital services, improving flow and supporting more care to be delivered closer to home where appropriate. This has included continued work on frailty, discharge, diagnostics, proactive care and the redesign of key clinical pathways in partnership with LCHS and wider system colleagues.

Work has also continued to strengthen our understanding of variation in access, experience and outcomes through the use of dashboards, PHM intelligence and service level insight. This has supported a more systematic approach to identifying inequalities, targeting interventions and shaping services around population need. As we move into 2026/27, this population health approach will remain central to how ULTH contributes to the Group Strategy, the development of neighbourhood health and the wider Lincolnshire ambition to deliver more coordinated, preventative and integrated care.

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. This has been reviewed and refreshed during 2025/26 with improved reports produced adopting a National Oversight Framework approach to collating and scoring metric performance.

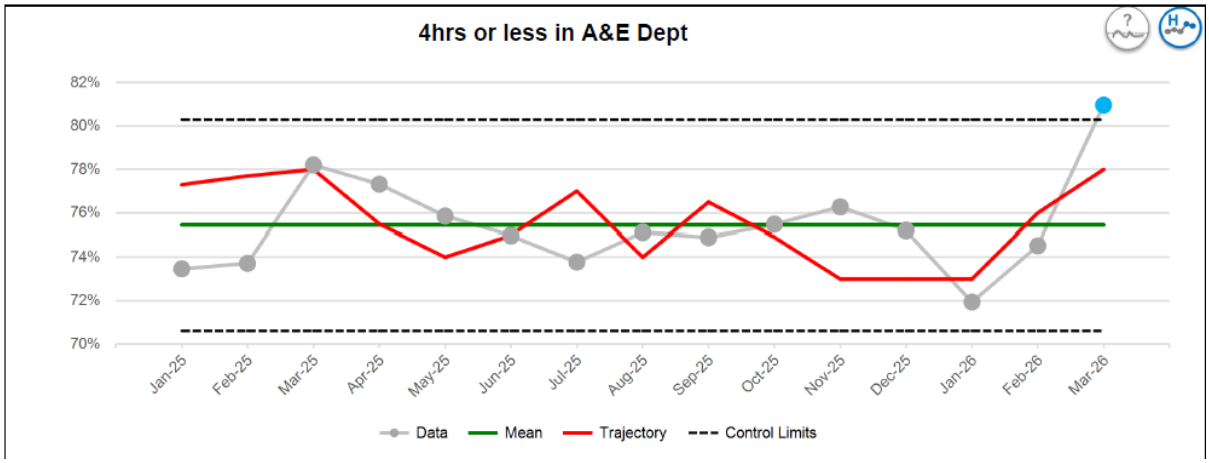
We have kept our focus on infection control and constitutional standards. During the year, compliance with infection control practices continued to be strong as evidenced by site visits and compliance with the Infection Prevention and Control Board Assurance Framework.

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:

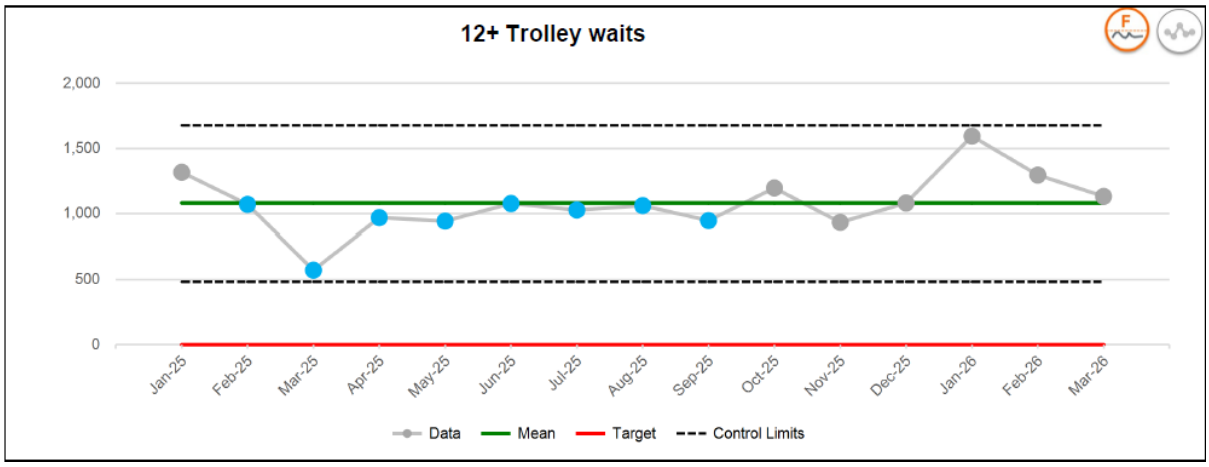
- growth in demand for services that has increased at a greater rate than we have been able to increase capacity
- difficulties with recruiting sufficient numbers of staff across all parts of the urgent and elective care pathways.

There have been some improvements in 4 hours and RTT performance as indicated below.



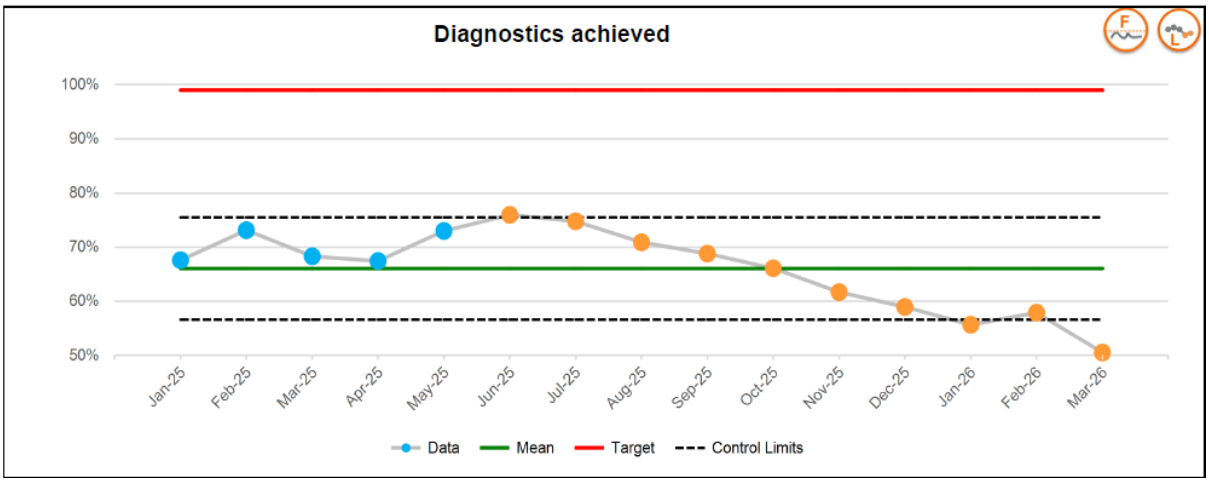
The national 4-hour standard means that we should expect to see 95% of patients in A&E within 4 hours. The agreed trajectory for compliance for ULTH is set at 78% for the end of the year.

The 4-hour transit target performance for March 2026 Type 1 & 3 (24/7) ED/UTC activity was 81.26%.

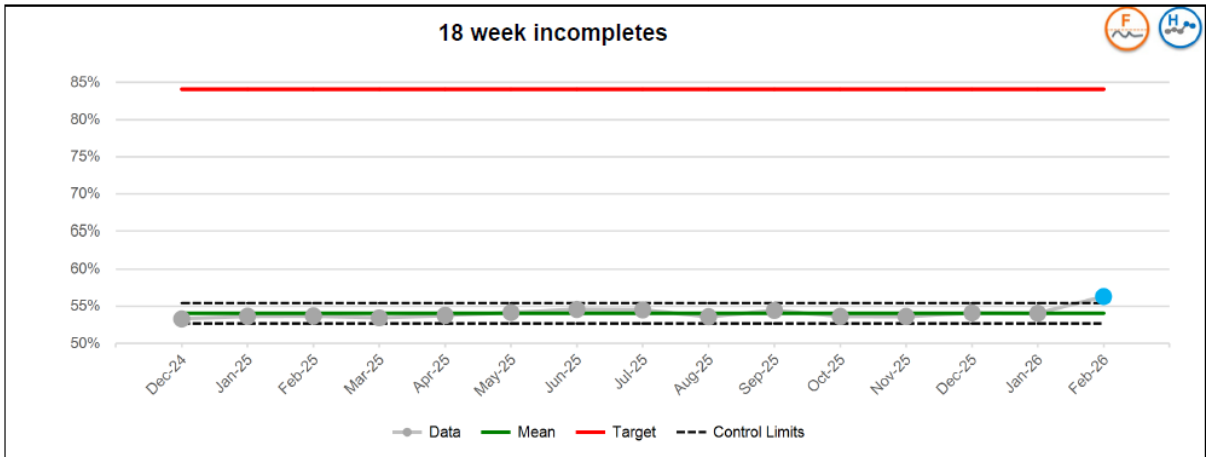


There is a zero tolerance for greater than 12-hour trolley waits (time from decision to admit to admission or discharge). These events are reported locally, regionally,

and nationally. In March 2026 the Trust saw 1,132 12-hr trolley wait breaches. This equates to c6% of all type 1 attendances for March.



Percentage of diagnostics tests undertaken in under six weeks. We are currently at 50.55% against the 99% target driven by breaches in Audiology, Ultrasound and MRI.



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

February 2026 saw RTT performance of 56.33% against an 84.1% target.
In February 2026, the Trust had 2 patients who waited longer than 65 weeks for treatment. This represents a significant reduction from 29 in February 2025 and 399 in February 2024.

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-26	Feb-26	Mar-26	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0.00%	0.41%	0.26%	0.25%	0.36%	0.00%	F	
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	78.00%	71.94%	74.53%	80.97%	75.53%	74.99%	?	H
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1,595	1,296	1,132	13,254	0	F	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.50%	77.48%	77.81%	77.83%	74.85%	88.50%	F	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	510	464		N/A	N/A	F	L
	65 Week Waiters	Responsive	Services	Chief Operating Officer	0	6	2		N/A	N/A	F	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.10%	54.08%	56.33%		54.28%	84.10%	F	H
	Waiting List Size	Responsive	Services	Chief Operating Officer	58,965	67,366	69,054		N/A	N/A	F	
	28 days faster diagnosis	Responsive	Services	Chief Operating Officer	75.00%	64.98%	73.20%		73.60%	75.00%	F	
	62 day classic	Responsive	Services	Chief Operating Officer	85.39%	64.60%	56.00%		62.36%	85.39%	F	
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.00%	71.10%	77.80%		66.65%	93.00%	F	

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-26	Feb-26	Mar-26	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.00%	7.10%	3.80%		22.19%	93.00%	F	L
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.00%	86.80%	87.40%		89.43%	96.00%	F	
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.00%	95.50%	98.80%		97.52%	98.00%	?	
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.00%	57.60%	72.70%		67.22%	94.00%	F	
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.00%	76.50%	87.20%		83.49%	94.00%	F	
	62 day screening	Responsive	Services	Chief Operating Officer	90.00%	32.50%	27.50%		53.35%	90.00%	F	L
	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.00%	72.80%	73.70%		72.86%	85.00%	F	
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.00%	55.70%	57.93%	50.55%	65.17%	99.00%	F	L
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.80%	1.82%	1.87%	1.90%	1.61%	0.80%	F	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	19	28	40	374	0	F	
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90.00%	42.11%	30.86%	37.80%	46.95%	90.00%	F	

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jan-26	Feb-26	Mar-26	YTD	YTD Trajectory	Pass/Fail	Trend Variation
Improve Clinical Outcomes	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	34.21%	16.05%	25.61%	28.58%			
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,890	4,322	4,805	4,695	4,657		
	% EMAS Conveyances Delayed <45 mins	Responsive	Services	Chief Operating Officer	95.00%	66.70%	78.91%	85.21%	82.72%	95.00%		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	126	118	131	N/A	N/A		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.41	2.41	3.41	2.88	2.80		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.32	3.91	4.34	4.32	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	47,713	47,446	49,241	43,951	4,524		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.00%	38.54%	38.53%	38.73%	37.60%	45.00%		
	31-day Treatment (Combined)	Responsive	Services	Chief Operating Officer	96.00%	84.65%	88.90%		88.32%	96.00%		
	62-day Treatment (Combined)	Responsive	Services	Chief Operating Officer	85.00%	63.84%	58.90%		64.75%	85.00%		

Challenges do remain as we move into 2026/27, with a strong continued focus on recovery of 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.

CQC Improvements

The Trust is registered with the Care Quality Commission (CQC) and has no conditions on its registration. Since the Trust's last comprehensive inspection by CQC in October 2021, CQC has revised its approach to inspection. This change in approach has resulted in several focussed inspections during 2025/26 of services run by the Trust, instead of a comprehensive inspection of the organisation as a whole. The following inspections have taken place during 2025/26:

- July 2025: Lincoln County Hospital Emergency Department (ED). Report published September 2025. Outcome: Rated 'Requires Improvement'.
- January 2026: Boston Pilgrim Hospital Medical Wards and Discharge Lounge. Report published May 2026. Outcome: Rated 'Good'.
- March 2026: Grantham District Hospital End of Life Care. Report not yet published.

The CQC inspection reports following these visits are available at the following link:

All inspections: United Lincolnshire Teaching Hospitals NHS Trust - Care Quality Commission

The Trust continues to work closely with CQC recognising the value of external assessment against a recognised quality framework.

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 2025/26.

External auditors' opinion is that it is rare for public bodies to cease as going concerns given the essential nature of the services they provide. DHSC group organisations 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."

Delivery of financial plan

The Lincolnshire system financial plan for the year 2025/26 was to deliver a breakeven outturn. The Trust delivered an agreed adjusted financial performance surplus of £4.9m assisted by deficit support funding received at year end. Cost improvement programme savings of £62.7m were delivered against a plan of £69.8m

The financial performance of the Trust is reviewed every month by the Finance and Performance Committee to gain assurance in respect of financial delivery.

The Trust fully utilised its Capital Expenditure Reserve spending £124.8m against a plan of £113.5m. The bulk of capital spend was in Estate infrastructure and improving and modernising Digital and Equipment assets.

Health inequalities statement

Over the past 12 months, United Lincolnshire Teaching Hospitals NHS Trust (ULTH) has continued to make positive progress in reducing health inequalities and strengthening personalised, equitable care.

Governance and oversight

The Health Inequalities and Personalisation Working Group meets monthly and reports into a Board-level Integration Committee, providing senior oversight and assurance. Working across the Acute and Community Trusts, health inequalities activity is progressed through established governance and reporting routes, with increasing emphasis on embedding health inequalities into “business as usual” planning, transformation and assurance.

Understanding and targeting population disadvantage

Our reporting aligns with NHS England’s expectation that “core” population disadvantage is understood through the Index of Multiple Deprivation (IMD), the official measure of relative deprivation in England. The IMD comprises seven domains of deprivation:

- Income (22.5%)
- Employment (22.5%)
- Education, Skills & Training (13.5%)
- Health Deprivation & Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing & Services (9.3%)
- Living Environment (9.3%)

Together, these domains help to define and understand the Core20PLUS5 approach (a national approach to reducing healthcare inequalities by focusing support on the most deprived 20% of the population, underserved groups, and five key clinical areas).

Maturity, assurance and improvement

The combined Acute and Community Trusts completed health inequalities maturity matrix submissions to the Lincolnshire ICB in March and October 2025, demonstrating positive improvement across all four domains (Figure 1).

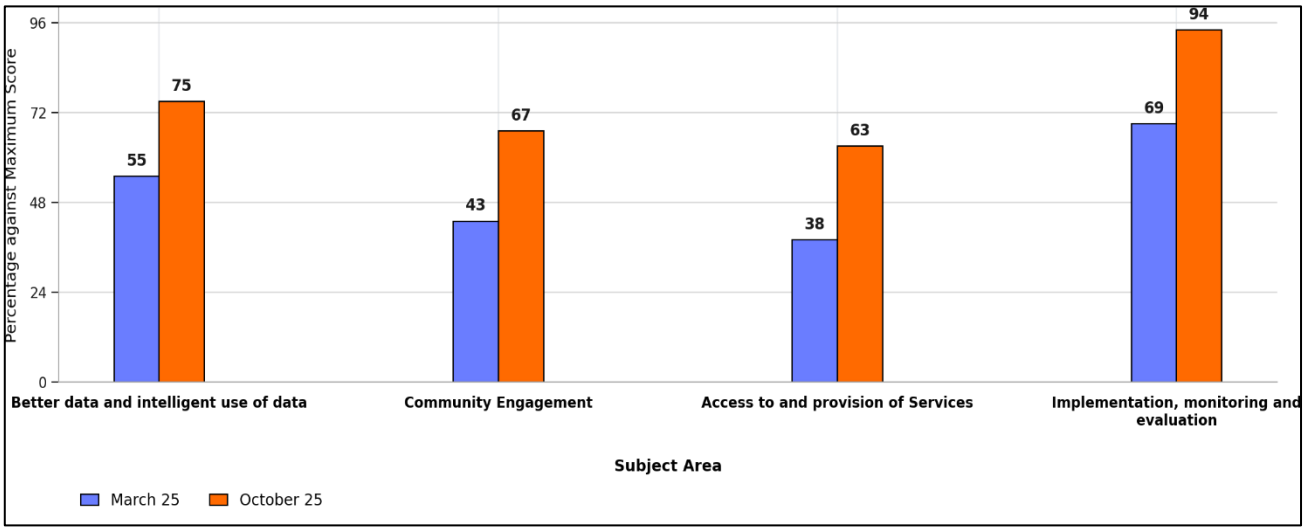


Figure 1: Health Inequalities Maturity Matrix – progress (March and October 2025)

In addition, the Trust completed an assurance review audit of Health Inequalities and Population Health Management in October 2025, delivered by TIAA Ltd (Transforming. Inspiring. Advising. Assuring). ULTH received an overall positive first audit outcome of **'Reasonable Assurance'**, and the associated actions have now been addressed to support further development.

Strengthening data and reporting

Progress has been made towards a joint Lincolnshire Community and Hospitals NHS Group (LCHG) automated reporting dashboard to support readily accessible health inequalities data, meeting system requirements and legal duties. Work is continuing to strengthen joint reporting and address data sharing challenges across differing systems. This will enable staff to access timely information on health inequalities, identify priority areas, and support delivery across workstreams. The joint dashboard is anticipated to be completed within Q1 and will be shared across the Group.

The dashboard will support consistent reporting and assurance by providing a single view of priority measures aligned to Core20PLUS5, enabling teams to monitor variation, identify gaps, and target improvement activity. It will also support governance by strengthening routine reporting into Group and Trust-level committees and informing Care Group planning and performance review.

It's All About People (IAAP) Personalisation Team

The importance and intrinsic links between health inequalities and personalised care have been fully recognised. As a result, the LCHG Health Inequalities Working Group has extended its scope to include the It's All About People (IAAP) Personalisation team and has been renamed the LCHG Health Inequalities and Personalisation Working Group.

IAAP is jointly funded by health and social care organisations. It comprises a small team of colleagues drawn from the NHS, Adult Social Care, and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, alongside individuals with lived experience who play an essential role in shaping and informing the work.

The Trust has begun working more closely with the programme to strategically embed personalised, strengths-based approaches across our organisations, with a strong focus on relationship-building and promoting a culture of intelligent kindness. There is clear recognition that adopting a more personalised approach—one that seeks to understand what matters most to individuals and their communities—can have a meaningful impact on reducing health inequalities.

The IAAP model below illustrates the positive impact a personalised approach can have on health inequalities (Figure 2).

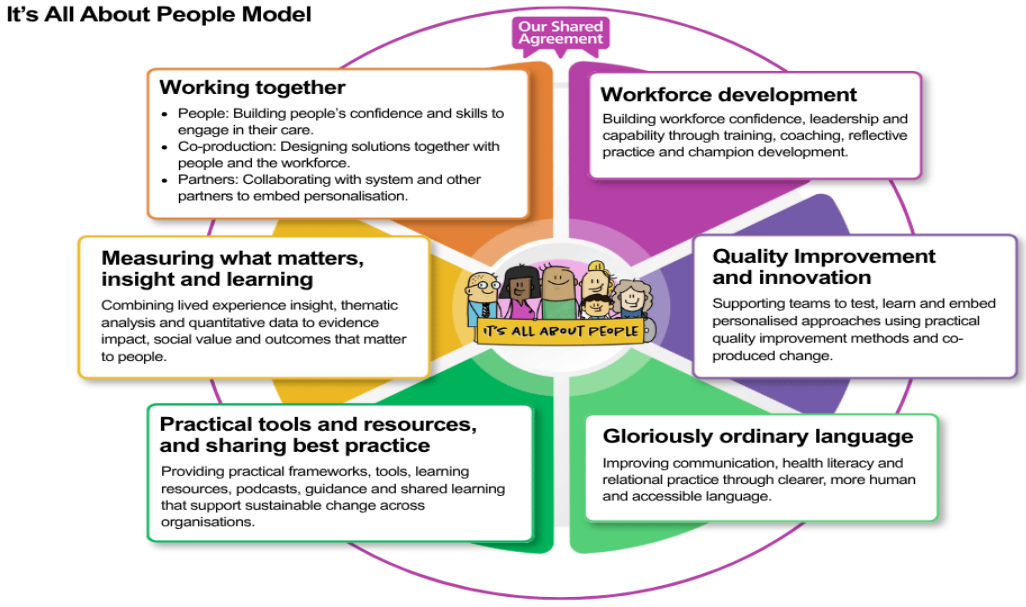


Figure 2: IAAP model and its contribution to reducing health inequalities

Clear communication and health literacy

A key area of work within the IAAP model has been the development and delivery of a language and health literacy programme in partnership with Gloriously Ordinary Language and the ICB Health Inequalities & Prevention team. Complex or institutional language can create confusion and barriers to understanding, particularly for people with lower health literacy, people whose first language is not English, or those experiencing disadvantage—contributing to poorer access, reduced confidence and widening inequalities.

This programme helps staff communicate in clearer, kinder and more accessible ways, supporting people to understand information more easily, feel more confident in conversations, and engage more fully in their health and wellbeing.

Examples of the impact of this work within our Trust include:

- An oncology team at the trust has stopped sending overwhelming information packs. Instead, they now send one simple letter, followed by a friendly, person-centred phone call.
- The Trust Patient Experience team is updating its Patient Information Policy to include Gloriously Ordinary Language, giving staff both support and permission to communicate in clearer, more human ways.

Other key IAAP initiatives being deployed within the Trust to support reducing health inequalities

- The Lincolnshire ICS Co – Production Framework is a tool that has been developed and is being used by ULTH and LCHG to embed co – production and co – design into our service transformation approach.
- Learning from Lived Experience: analysing People's Stories and Community Reporting to uncover insights that data alone cannot show.
- Using People's stories and experiences to understand the importance of the wider determinants of health and care and how that translates to a social value return on investment. Early data from the IAAP Team shows that for a group of 15 people who were supported in a personalised way, for every £1 spent there was £9.97 Return on Investment.
- It's All About People Health and Care Workforce Survey: exploring awareness and understanding of Personalisation across the workforce and the opportunities and barriers there are to embedding and delivery.
- Multi-agency collaboration: for example, the Grantham Joint Aches and Pains Hub, where ULTH and LCHS staff, along with other organisations work together to support local needs.

Growing a network of Champions

Our Health Inequalities Champions and Personalisation Champions network continues to grow. There are now over **40 staff members from ULTH and LCHS champions in each group**. Champions play a valuable role in promoting this agenda across our Trusts and represent a strong resource to support future work.

Group-wide delivery focus

The Health Inequalities and Personalisation Working Group supports both ULTH and LCHS and focuses on tackling health inequalities by embedding an organisation-wide, data-driven approach aligned to Core20PLUS5 priorities for adults and for children and young people. A robust communications plan supports this work, incorporating an awareness campaign, staff survey, training opportunities, and a dedicated resource hub. This includes embedding a health inequalities lens within our improvement & transformation framework to ensure services consider existing health inequalities as part of the redesign work. As part of this work an internal tool has been developed that can help to map travel distances for patients accessing our services in order to support the identification of opportunities to deliver care in locations that may be more accessible.

Improvement work and impact

Reducing smoking in pregnancy (Core20PLUS5 clinical priority)

Smoking is a significant component of the Core20PLUS5 clinical priorities. The NHS Long Term Plan and Saving Babies Lives (SBL) V2 recommend implementation of an in-house tobacco dependency service for all pregnant women who book into antenatal care as a smoker, have quit since conception, or have a raised carbon monoxide reading of 4ppm during pregnancy.

The Trust Smoking Team Action Advice and Refer (STAAR) has delivered a significant positive change in reducing smoking among pregnant women. Smoking is a high-prevalence risk factor in Lincolnshire; in 2021, the county had one of the highest rates of Smoking At Time Of Delivery (SATOD) at 17.1%, compared to a Midlands rate of 10.7% and a national rate of 9.1%. The national target was to reduce SATOD to 6% or lower.

Through a series of innovative and comprehensive processes, the team has successfully reduced SATOD to below 5%, taking Lincolnshire from one of the highest rates to below the national average. Some of these processes have been adopted regionally and nationally, which is a credit to the team. Work has also reduced Smoking At the Time Of Booking (SATOB) from over 21% (2021) to 8.33%, below the national average of 9%.

Since January 2026, the team has contacted 272 women to offer smoking cessation support, with 40 women quitting smoking before the antenatal SATOB appointment.

Improving access through transport (rurality and barriers to services)

Transport remains a key challenge for our population across rural Lincolnshire. To improve access to the Community Diagnostic Centre (CDC) in Lincoln, the Trust is undertaking a trial to provide public transport (with thanks to PC Coaches) from Lincoln Central Bus Station to the CDC, commencing on 1 June. Services will operate every 30 minutes from 08:45 to 15:15, Monday to Friday.

A temporary bus stop will be located close to the CDC so residents will have a short walk rather than 0.6 miles from the bus station. This venture has been supported by the Lincoln MP, Hamish Falconer.

Skegness CDC pilot – improving local access to outpatient care

A Skegness CDC pilot was established this year, supporting post-menopausal bleeding and subsequently widening to include Mirena coil insertions, unscheduled bleeding on HRT and difficult smears. This weekly service runs for one full day, can see 16 patients, and provides a valuable alternative to attending an acute hospital. Very positive feedback has been received, commenting on the service and the improved proximity compared with travelling further to Boston hospital.

Recording ethnicity: making every contact count

Accurate ethnicity data supports equitable, personalised and safe care. It helps us understand who is experiencing health inequalities and enables us to respond to the needs of all communities we serve.

This year, work has continued to improve ethnicity data capture and understand data capture issues across multiple systems. This has included staff awareness campaigns, guidance, targeted work with teams experiencing challenges, and further analysis requirements in community settings. Data accrued shows positive capture and also highlights areas where further support is needed to ensure this important information is recorded consistently.

Health Equity Assessment Tool (HEAT)

To support consistent consideration of health inequalities in decision-making, the Health Equity Assessment Tool (HEAT) has been introduced and embedded throughout the Trust. This has been communicated to staff, a resource area is in place, and robust governance has been established to ensure due consideration of health inequalities for any business case submission, project, or service change.

In addition to requiring staff to evidence due diligence on health inequalities, HEAT will provide clearer organisational visibility of health inequalities work and themes emerging across services.

Embedding Health Inequalities & Personalisation in Care Group Plans

A comprehensive set of Health Inequalities and Personalisation objectives has been agreed for Trust Care Groups (Alliance, Family Health, Medicine, Surgery Care Groups) within both the Annual Plan and 5-Year Plan. These objectives will strengthen due diligence, enable more consistent consideration of health inequalities, and support long-term alignment and delivery across the organisation.

Over the coming year, we will build on this progress by expanding the use of shared decision-making tools, strengthening co-production with people and communities, and ensuring health inequalities are consistently addressed within our improvement and transformation work. We will continue to improve the completeness and quality of ethnicity recording and will strengthen how we share data and insights with our staff and NHS partner organisations across Lincolnshire. By embedding population health management as “business as usual”, the Trust aims to further support patient experiences, fairer access and improved outcomes for the communities it serves.

Sustainability report

During the year the Trust’s Green Plan actions have been refreshed and published. 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 on 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:

- Growth of a Network of Green Champions
- Delivery of projects to reduce waste and the use of disposable items
- Development of our Clinical Services Strategy in line with net zero ambitions
- Funding for Solar panel installation at Grantham and Lincoln.
- Funding for decarbonising the Pilgrim Hospital site

Task force on Climate-related Financial Disclosures (TCFD)

United Lincolnshire Teaching Hospitals NHS Trust has not yet undertaken a Climate Change Risk assessment. This is planned for Summer 2026. Following the risk assessment a Climate Change Adaptation Plan will be developed which will describe the impacts of climate related risks and opportunities on the Trust's operations, strategy and financial planning.

The Trust has an Adverse Weather Policy which provides for Business Continuity actions in the wake of heatwaves or snow for example. The Trust also complies with planning legislation for building works which will consider the impact of flooding for example and measures needed to mitigate such risks.

Emergency Preparedness, Resilience and Response (EPRR)

For 2025/26 United Lincolnshire Teaching Hospitals NHS Trust (ULTH) has been assessed by the Lincolnshire Integrated Care Board (ICB) and NHS England (Midlands) as **Fully Compliant** with 58 out of 62 Core Standards.

Throughout 2025 ULTH achieved the following:

- 3 Strategic Commanders were trained.
- 6 Tactical Commanders were trained.
- The Trust Mandatory Major Incident training data on the Electronic Staff Record (ESR) averaged 88% this was slightly lower that the 92% average in 2024 but above the 85% target.

- The Trust took part in the following regional exercises:

    - Ex Tangra – pandemic tabletop exercise.
    - Ex Cinder Rose - Regional Summer Preparedness Exercise.

    - Ex Pegasus - National Tier 1 Pandemic Exercise
    - Ex Agnew 5 - Local Resilience Forum (LRF) Comms Exercise to validate the LRF Resilient Telecomms Plan and familiarise players with the use of / test Airwave Radios.
    - LRF Business Continuity and Cyber Exercise (attended by ICT Telecomms).
    - Ex Aegis – a health regional winter planning exercise.

- The EP team delivered three separate live Chemical, Biological, Radiological and Nuclear (CBRN) exercises at the Grantham, Lincoln and Pilgrim sites.

- The EP and Digital Services team delivered the following internal tabletop exercise:

    - Ex Sub Aqua - exercise focusing on procurement and contracting processes, theatre system outage and breach in a supply chain partner.

Business Continuity, Critical and Major Incidents

ULTH did not experience any Critical or Major Incidents in 2025, but the following Business Continuity Incidents were declared:

- March 2025 – Pilgrim Hospital's high voltage system tripped out during a planned electrical test.
- March 2025 - Lincoln County Hospital's (LCH) main water supply pipe burst.
- June 2025 - An expansion vessel in the Calorifier house burst a fitting and also a pipe joint in the void above reception split.
- July 2025 - Chillers at Pilgrim Hospital failed due to extreme heat.
- July 2025 - A planned update to our digital Careflow system resulted in our PAS going offline across the Trust.
- July 2025 - A network water pump failure, leading to a loss of mains cold water at the Grantham and District Hospital (GDH) and the surrounding area.
- September 2025 – Remote access to internal IT systems was unavailable due to certificate revocation process issues.
- October 2025 - The mains feed circuit breaker was tripping and causing intermittent power losses.
- December 2025 - Both CT scanners at LCH became unserviceable.
- December 2025 - Users at LCH and GDH sites reported wide scale IT outages with most systems and IT telephones affected.

Lessons and learning

ULTH undertook debriefs for each BCI and the lessons identified were used to update business continuity plans appropriately. Full reports for each BCI (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.

Business continuity

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

The ULTH Emergency Planning Team conducted independent testing of 18 BCPs using tabletop exercises.

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…….
Professor Karen Dunderdale
Chief Executive Officer 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 2025/26. 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).

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 2025/26, 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 6 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.

Mrs Elaine Baylis, reached the end of her term as Group Chair on 31 March 2026. Mrs Rebecca Brown was appointed Acting Group Chair with effect from 1 April 2026.

Professor Philip Baker resigned from his role as Non-Executive Director on the 31 March 2025. Mrs Vicki Wells was appointed into a Non-Executive Director role from 1 May 2025 having previously served as an Associate Non-Executive Director on the Board.

Professor Duncan French joined the Board in March 2025 as Teaching Hospital Non-Executive Director. Professor French resigned from the Board in July 2025. Professor Jamie Read was appointed as Teaching Hospital Non-Executive Director from 1 April 2026

Mr Paul Marsden and Mr John Underwood joined the Group Board as Associate Non-Executive Directors from 01 December 2025. Mrs Linda Jackson joined the Group Board as an Associate Non-Executive Director from 1 April 2026.

A full list of directors who have served during the year is shown within the remuneration report on page 60.

Audit and Risk Committee

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

For 2025/26, Audit and Risk Committee membership was as follows:

- Neil Herbert, Chair (November 2022 – ongoing)
- Daniela Cecchini (January 2022 – ongoing)
- Rebecca Brown (October 2022 – March 2026)
- Jim Connolly (October 2024 – ongoing)
- Vicki Wells (August 2022 – ongoing)

In Attendance

- Ian Orrell (February 2023 – 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 and took 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 through the annual governance statement in the annual report.	Compliant	Annual Report – Annual Governance Statement

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 2025/26

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

Statement of accounting/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

Professor Karen Dunderdale
Chief Executive Officer
Date:

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 the 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 Trust Board

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

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

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 2026 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 BAF 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 Opinion was based solely on the matters that came to the attention of the internal auditors during the course of the internal audit reviews carried out during the year and was not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or the Trust's ability to meet financial obligations which must be obtained by United Lincolnshire Teaching Hospitals NHS Trust from its various sources of assurance.

There are three key strategic objectives defined within the 2025/26 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 is considered both by the Trust Board and Quality Committee and the Audit and Risk Committee.

Risks to data security were specifically highlighted within the 2025/26 Board Assurance Framework. The treatment of these risks is through a cyber security plan and digital strategy which are reviewed through the Digital Oversight Group into the Integration Committee.

The key strategic risks to the organisation during 2025/26 that were the focus of consideration by the Trust Board and Executives were:

- Reliance on paper medical records
- Overdue patients on Ophthalmology PBWL
- Recovery of planned care cancer pathways
- Patient flow through Emergency Departments
- Delivery of paediatric epilepsy pathways-across acute and community
- 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
- Consultant workforce capacity (Haematology)
- Service configuration (Haematology)
- Exceeding the agency cap due to the cost of reliance upon temporary clinical staff
- Reliance on agency / locum medical staff in urgent and emergency care
- Compliance with subject access requests
- Risk of failure to deliver the CIP target in full for 2025/2026
- Cancellation of elective lists due to lack of theatre staff
- Neurology – Service sustainability
- Risk to our transformation programme due to changes within the ICB

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;
- 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 BAF 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 Trust 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 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 Trust 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 care group 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 2026 the Trust's External Audit provider highlighted the following significant risks to the financial statements.

- Risk of fraud in revenue recognition (income from Patient Care Activities)
- Management override of controls (a mandatory significant risk for all entities)
- Valuation of land and buildings

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

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 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.

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 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 2 Information governance data breaches which were reportable in line with the Information Commissioners Office (ICO) guidance in 2025/26. One case has been concluded with no formal action against the Trust by the ICO, and one is yet to receive a response. All reported data breaches were 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 ensured 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 Committee throughout the year.

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 Trust 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 Trust Board.

The Trust Board have received assurance reports from the Audit and Risk Committee, Quality Committee, Finance and Performance Committee, People Committee and Integration Committee as well as considering the Trust Integrated Performance Report and BAF. The Trust 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 Trust 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 (BAF), and the risk improvement plans and have monitored the delivery of internal and external audit plans.

Clinical Audit

During 2025/26, the Trust achieved 100% participation in all eligible national clinical audits and national confidential enquiries. This full engagement has provided assurance that services are safe and effective, with outcomes demonstrating alignment to evidence-based practice and established standards of care.

Internal Audit

The Head of Internal Audit provides an opinion for 2025/26 that United Lincolnshire Teaching Hospitals NHS Trust has reasonable and effective risk management, control and governance processes in place.

The Opinion was based solely on the matters that came to the attention of the internal auditors during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by United Lincolnshire Teaching Hospitals NHS Trust from its various sources of assurance

Internal Audit reported two urgent recommendations and issued one limited assurance report with weaknesses in a number of areas that put some system objectives at risk.

The most significant weakness was identified in the Theatre Productivity Review.

Conclusion

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

- The Trust CQC Well Led rating is Good however the Trust still remains assessed overall as Requires Improvement
- The Trust has faced significant financial pressures and a significant cost improvement programme which has been overseen through the Finance and Performance Committee. The Trust has delivered improved recurrent cost

improvements and secured non-recurrent support to deliver the financial plan and achieve a surplus position.

- The Trust has faced operational pressures with increasing demand for services. As a result, constitutional standards have not all been met. The Trust ended the year delivering UEC and RTT standards and continues to work to meet the standards for Cancer.

- The Trust continues to work to address its reliance on temporary medical staffing to deliver services. Robust improvement actions to deliver a reduction in temporary staffing costs and to support operational performance are in place

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……...

Professor 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 approved performance-related bonuses to be paid to Executive Board members on the recommendations of the Nominations and Remuneration Committee.

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 (VSM) 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.

Salaries are reviewed when new appointments are made and where the proposed salary is above £170,000, approval is sought from NHSE and HM Treasury, in line with the policy for VSM appointments.

The remuneration package comprises:

- Base salary
- Benefits
- Pension

Compliance with the NHS Very Senior Managers Pay Framework

The remuneration of Very Senior Managers (VSMs) is set in accordance with the NHS Very Senior Managers Pay Framework issued by NHS England and the Department of Health and Social Care.

The Trust confirms that all VSM remuneration arrangements in 2025/26 were compliant to the requirements of the framework, including the application of appropriate approval processes for senior pay levels, the use of relevant benchmarking information, and adherence to national guidance. No departures from, or exceptions to, the NHS VSM Pay Framework were made during the year.

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 key decision makers within the Trust for the purposes of the Remuneration and Staff Report are Board Executive and Non-Executive Members. They are paid benefits in line with agreed terms and conditions of their engagement.

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 2026. These are attached to comparative figures for 2024/25.

There were no extra payments made to former Directors in 2025/26. There were performance payments paid to Executive members of the board in line with strides made by the Trust for meeting plan and objectives. Benefits in kind were in respect of use of leased vehicles and home electronics by senior staff.

Single total figure remuneration table

					2025/26						
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	Group Chair		Aug-21	Mar-26	50 - 55	6	-	-	-	-	50 - 55
Rebecca Brown	Non-Executive Director		Aug-22	Ongoing	10 - 15	7	-	-	-	-	10 - 15
Dani Cecchini	Non-Executive Director		Jan-22	Ongoing	5 - 10	4	-	-	-	-	5 - 10
Neil Herbert	Non-Executive Director		Aug-22	Ongoing	5 - 10	-	-	-	-	-	5 - 10
Vicki Wells	Non-Executive Director		Aug-22	Ongoing	10 - 15	-	-	-	-	-	10 - 15
David (Jim) Connolly	Non-Executive Directors		Oct-24	Ongoing	10 - 15	-	-	-	-	-	10 - 15
Gail Shadlock	Non-Executive Director		Feb-22	Jul-25	0 - 5	-	-	-	-	-	0 - 5
Sarah Buik	Associate Non-Executive Director		Aug-22	Ongoing	5 - 10	2	-	-	-	-	5 - 10
Ian Orrell	Associate Non-Executive Director		Apr-24	Ongoing	5 - 10	-	-	-	-	-	5 - 10
Karen Dunderdale	Group Chief Executive Officer	1, 4	Feb-20	Ongoing	140 - 145	14	0 - 5	-	-	34	150 - 155
Daren Fradgley	Group Chief Integration Officer		Aug-24	Ongoing	125 - 130	2	0 - 5	-	167.5 - 170	10	300 - 305
Colin Farquharson	Group Chief Medical Officer		Aug-21	Mar-26	165 - 170	-	0 - 5	-	65 - 67.5	-	235 - 240
Paul Antunes Goncalves	Group Chief Finance Officer	5	Oct-24	Ongoing	95 - 100	2	0 - 5	-	70 - 72.5	20	175 - 180
Claire Low	Group Chief People Officer	1, 4	Oct-22	Ongoing	125 - 130	7	0 - 5	-	-	38	130 - 135
Kathryn Helley	Group Chief Clinical Governance Officer		Nov-23	Ongoing	90 - 95	4	0 - 5	-	105 - 107.5	13	200 - 205
Caroline Landon	Group Chief Operating Officer		Aug-24	Ongoing	95 - 100	2	0 - 5	-	-	-	100 - 105
Michael Parkhill	Group Chief Estates and Facilities Officer		Aug-24	Ongoing	95 - 100	-	0 - 5	-	282.5 - 285	26	385 - 390
Jayne Warner	Group Director of Corporate Affairs		Aug-24	Ongoing	55 - 60	-	0 - 5	-	52.5 - 55	9	110 - 115
Nerea Odongo	Group Chief Nurse	2	Jul-24	Ongoing	85 - 90	-	0 - 5	-	52.5 - 55	-	140 - 145

Single total figure remuneration table

					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
Philip Baker	Non-Executive Director		Aug-21	Mar-25	10 - 15	2	-	-	-	-	10 - 15
Rebecca Brown	Non-Executive Director		Aug-22	Ongoing	10 - 15	10	-	-	-	-	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
Andrew Morgan	Chief Executive Officer		Oct-23	Sep-24	35 - 40	-	-	-	-	-	35 - 40
Jonathan Young	Director of Finance		Oct-23	Sep-24	70 - 75	-	-	-	5 - 7.5	13	75 - 80
Karen Dunderdale	Group Chief Executive Officer		Feb-20	Ongoing	135 - 140	10	-	-	-	11	135 - 140
Angie Davies	Deputy Director of Nursing		Nov-23	Jul-24	40 - 45	2	-	-	-	-	40 - 45
Colin Farquharson	Group Chief Medical Officer		Aug-21	Ongoing	200 - 205	-	-	-	152.5 - 155	-	355 - 360
Paul Antunes Goncalves	Group Chief Finance Officer		Oct-24	Ongoing	45 - 50	1	-	-	12.5 - 15	-	60 - 65
Claire Low	Group Chief People Officer		Oct-22	Ongoing	110 - 115	2	-	-	-	59	120 - 125
Sameedha Rich-Mahadkar	Director of Improvements & Integration		Jan-22	Aug-24	55 - 60	-	-	-	0 - 2.5	1	60 - 65
Kathryn Helley	Group Chief Clinical Governance Officer		Nov-23	Ongoing	105 - 110	1	-	-	102.5 - 105	9	210 - 215
Daren Fradgley	Group Chief Integration Officer		Aug-24	Ongoing	70 - 75	4	-	-	50 - 52.5	7	125 - 130
Caroline Landon	Group Chief Operating Officer		Aug-24	Ongoing	60 - 65	-	-	-	7.5 - 10	-	70 - 75
Michael Parkhill	Group Chief Estates and Facilities Officer		Aug-24	Ongoing	45 - 50	-	-	-	-	-	45 - 50
Jayne Warner	Group Director of Corporate Affairs		Aug-24	Ongoing	35 - 40	-	-	-	40 - 42.5	9	75 - 80
Nerea Odongo	Group Chief Nurse		Jul-24	Ongoing	60 - 65	-	-	-	30 - 32.5	-	90 - 95

Remuneration Ratios and Director Total Earnings

Name	Position	Group/Trust	ULTH Ratios	LCHS Ratios	Salary (bands of £5,000) £000s	Expense payments - taxable (total to nearest £100) £00's	Performance pay and bonuses (bands of £5,000) £000s	All Pension Benefits (bands of £2,500) £000s	Benefit in Kind total to nearest £100 £00s	Total Costs (Bands of £5000) £000s
Elaine Baylis	Group Chair	Group	64%	36%	75 - 80	9	-	-	-	80 - 85
Rebecca Brown	Non Executive Director	Group	47%	53%	25 - 30	15	-	-	-	25 - 30
Dani Cecchini	Non Executive Director	Group	47%	53%	15 - 20	9	-	-	-	15 - 20
Neil Herbert	Non Executive Director	Group	45%	55%	15 - 20	-	-	-	-	15 - 20
Vicki Wells	Non Executive Director	Group	60%	40%	15 - 20	-	-	-	-	15 - 20
David (Jim) Connolly	Non-Executive Directors	Group	72%	28%	15 - 15	-	-	-	-	15 - 15
Gail Shadlock	Non Executive Director	Group	46%	54%	0 - 5	-	-	-	-	0 - 5
Sarah Buik	Associate Non-Executive Director	Group	47%	53%	10 - 15	5	-	-	-	10 - 15
Ian Orrell	Associate Non-Executive Director	Group	45%	55%	15 - 15	-	-	-	-	15 - 20
Karen Dunderdale	Group Chief Executive Officer	Group	53%	47%	265 - 270	27	5 - 10	-	64	280 - 285
Colin Farquharson	Group Chief Medical Officer	Group	63%	37%	265 - 270	-	0 - 5	105 - 107.5	-	375 - 380
Paul Antunes Goncalves	Group Chief Finance Officer	Group	53%	47%	185 - 190	4	5 - 10	135 - 137.5	38	330 - 335
Claire Low	Group Chief People Officer	Group	62%	38%	200 - 205	11	5 - 10	-	61	215 - 220
Kathryn Helley	Group Chief Clinical Governance Officer	Group	57%	43%	155 - 160	6	5 - 10	185 - 187.5	23	350 - 355
Daren Fradgley	Group Chief Integration Officer	Group	64%	36%	200 - 205	3	5 - 10	262.5 - 265	16	470 - 475
Caroline Landon	Group Chief Operating Officer	Group	54%	46%	180 - 185	4	5 - 10	-	-	185 - 190
Michael Parkhill	Group Chief Estates and Facilities Officer	Group	61%	39%	160 - 165	-	5 - 10	462.5 - 465	42	635 - 640
Jayne Warner	Group Director of Corporate Affairs	Group	45%	55%	120 - 125	-	0 - 5	117.5 - 120	21	245 - 250
Nerea Odongo	Group Chief Nurse	Group	54%	46%	155 - 160	-	5 - 10	100 - 102.5	-	265 - 270

Notes for 2025/26

1. Salary payments for Professor Karen Dunderdale, Claire Low and Paul Antunes Goncalves (from January 2026) include pension restructuring payments for pension fund performance over the year.
2. Nerea Odongo appointed Group Chief Nurse July 2024 - remained seconded from Northampton to December 2025.
3. With the formation of the Lincolnshire Community and Hospitals NHS Group most directors had roles overlapping the two trusts. A schedule of their spilt is shown.
4. Professor Karen Dunderdale and Claire Low opted out of the NHS Pension scheme - their pension benefits are listed as Nil.
5. Paul Antunes Goncalves opted out of NHS Pension Scheme from 1st January 2026.
6. All Executive were paid a performance bonus in line with the performance of the Group for the year. The payments were approved through the Nominations and Remuneration Committee.
7. Elaine Baylis remuneration in 2025/26 includes backpay for Group responsibilities relating to 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 benefits in kind associated with lease cars and home electronics obtained through the Trust Salary Sacrifice Schemes.

There were performance related pay and bonus payments made in 2025/26 and none in 2024/25.

Pensions entitlement table 2025/26

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 Mar 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 Mar 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 31 Mar 2025	Cash Equivalent Transfer Value at 31 Mar 2026	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	-	-	-	-	-	-	-	
Daren Fradgley	Group Chief Integration Officer		12.5 - 15	27.5 - 30	75 - 80	185 - 190	1,313	1,626	266	
Paul Antunes Goncalves	Group Chief Finance Officer	5	5 - 7.5	12.5 - 15	40 - 45	95 - 100	623	762	113	
Caroline Landon	Group Chief Operating Officer	4	-	-	5 - 10	-	318	171	-	
Colin Farquharson	Group Chief Medical Officer		5 - 7.5	2.5 - 5	85 - 90	200 - 205	1,753	1,929	112	
Nerea Odongo	Group Chief Nurse		5 - 7.5	-	40 - 45	-	485	583	71	
Claire Low	Group Chief People Officer	1	-	-	-	-	-	-	-	
Kathryn Helley	Group Chief Clinical Governance Officer	2	7.5 - 10	17.5 - 20	60 - 65	160 - 165	1,202	1,439	197	
Jayne Warner	Group Director of Corporate Affairs		5 - 7.5	10 - 12.5	40 - 45	100 - 105	758	909	125	
Michael Parkhill	Group Chief Estates and Facilities Officer	3	22.5 - 25	-	20 - 25	-	-	378	360	

Pensions entitlement table 2024/25

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

The Trust operates the standard NHS Pension Scheme

Notes (2025/26):

1. Professor Karen Dunderdale and Claire Low opted out of the NHS Pension Scheme and were not covered in the current financial year.
2. Kathryn Helley was affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.
3. Michael Parkhill rejoined the NHS Pension Scheme after opting out in 2022. Comparative numbers for 2024/25 were not available.
4. Caroline Landon - benefits in the 2008 and 2015 schemes were revised because of the break in membership between 31/03/2019 and 05/08/2024
5. Paul Antunes Goncalves opted out of NHS Pension Scheme from 1st January 2026.

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 1.7% supplied by the Business Services Authority (Disclosure of Senior Managers Remuneration (Greenbury) 2026-20260106-(V1)). A rate of 6.7% 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 2025/26 and 2024/25.

Payments to past directors

There were no payments made to former Directors in 2025/26. There were performance bonuses to executives during 2025/26 determined on the performance of the Trust. Benefits in kind were in respect of use of leased vehicles by senior staff.

Comparison of remuneration of highest paid director

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 paid Executive Directors Performance pay in line with agreement with the Remuneration Committee.

Remuneration is calculated on the annualised full time equivalent staff in post at the Trust at the reporting date of 31st March 2026

All Directors have been operating across United Lincolnshire Teaching Hospitals NHS Trust (ULTH) and Lincolnshire Community Health Services NHS Trust (LCHS) during 2025/26. 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.

Colin Farquharson, Group Medical Director, was the highest paid directors for United Lincolnshire Teaching Hospitals NHS Trust in the financial year 2025/26. Earnings attributed to the Trust were £170k compared to £204k in 2024/25 which was a reduction of 17% (2024/25 reduction of 12%) Both years were impacted by the changes in ratios between ULTH and LCHS.

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

	Remuneration all Trust staff		
Year	25th percentile total £	Median total £	75th percentile total £
2025/26	30,162	43,441	58,487
2024/25	27,691	36,329	48,526

	Pay Remuneration Ratio		
Year	25th percentile	Median total	75th percentile total
2025/26	6:1	4:1	3:1
2024/25	7:1	6:1	4:1

In 2025/26, 139 (2024/25, 210) employees received remuneration more than the highest-paid director. Remuneration ranged from £436,434 to £17,126 (2024/26 £513,047 to £13,387).

The average employee earnings for 2025/26 was £51,161 (2024/25 was £47,482) which was 7.7% above average for 2024/25 (1.4% between 2024/25 and 2023/24).

Note that Non-Executive Directors were excluded from Fair Pay calculations in line with the GAM section 3.109.

Staff report

Staff numbers and costs

The table below shows the total cost of employees employed by the trust – over the two years 2025/26 and 2024/25.

			2025/26	2024/25
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	472,215	6,762	478,977	**467,708**
Social security costs	62,454	-	62,454	**46,988**
Apprenticeship levy	2,356	-	2,356	**2,306**
Employer's contributions to NHS pension scheme	86,542	-	86,542	**81,593**
Pension cost - other		211	211	**137**
Temporary staff		17,940	17,940	**23,851**
Total gross staff costs	**623,567**	**18,151**	**648,480**	**622,583**
Total staff costs	**623,567**	**18,151**	**648,480**	**622,583**
Of which				
Costs capitalised as part of assets	**3,658**	**3,222**	**6,880**	**4,730**

Staff composition*

The table below shows the total number of employees employed by the Trust – average over the two years 2025/26 and 2024/25.

			2025/26	2024/25
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,153	215	**1,368**	**1,362**
Ambulance staff	0	0	**0**	**10**
Administration and estates	2,153	48	**2,201**	**2,206**
Healthcare assistants and other support staff	2,053	265	**2,318**	**1,960**
Nursing, midwifery and health visiting staff	2,792	115	**2,907**	**2,884**
Scientific, therapeutic and technical staff	800	22	**822**	**771**
Healthcare science staff	113	0	**113**	**120**
Total average numbers	**9,064**	**665**	**9,729**	**9,313**
Of which:				
Number of employees (WTE) engaged on capital projects	57	25	82	64

*Please note this table includes all staff members inclusive of fixed term contracts, trainees, locums and other non-permanent staff.

Based on Staff in Post on 31 March 2026

Permanent Staff (nearest WTE) composition by pay band and gender 2025/26 (ULTH)*

Pay Band/Grade	Female	Male
Apprentice	-	-
Band 1	14	4
Band 2	793	246
Band 3	1121	255
Band 4	355	121
Band 5	1579	296
Band 6	770	259
Band 7	496	117
Band 8a	235	86
Band 8b	63	25
Band 8c	21	16
Band 8d	11	11
Band 9	9	6
Specialty Doctor	55	132
Associate Specialist	3	18
Consultant	76	196
Locally Agreed (Medical)	15	26
Director	9	12
Total	**5625**	**1826**

*Please note that this table included only permanent staff by role type as at 31 March 2026, This excludes roles such as fixed term contracts, locums, trainees and other non-permanent staff.

Sickness absence*

Average sick days per FTE = FTE Days Lost / Average FTE			Statistics Produced by NHS Digital	
Average FTE 2025/26	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
8,295	16,776	2.02	280,267	16,776

*Please note that the data is from NHS Digital as at January 2026

Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse

Period covered: February 2025 to January 2026.

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, United Lincolnshire Teaching Hospitals NHS Trust 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 staff side 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.

ULTH 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 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. To date all contractual policies have been harmonised and developed into Group policies. 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.

Other employee matters

Group

- Turnover rate across both LCHS an ULTH has seen an improved position over recent months with a stabilisation across both providers
- Sickness rate across ULTH has seen a stabilised position, although an increase in LCHS.
- Core learning compliant at LCHS and ULTH and is being sustained.
- Temporary staffing has reduced overall when compared to 2024/25.
- Appraisal rates within LCHS saw compliance achieved by the end of Q1 in line with the appraisal window. Within ULTH the appraisal rate did not meet target, although was improved in year. ULTH will formally move to the appraisal cycle to be in line with LCHS as of 2026/27.

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.

ULTH shows a consistent pattern of decline across key staff experience indicators. Staff engagement fell alongside raising concerns indicating weaker confidence in speaking up and overall involvement. All engagement sub-themes declined, with advocacy experiencing the most significant decrease, reflected in lower recommendation rates and reduced confidence in organisational priorities and care quality.

There are also deteriorations in perceptions of wellbeing support, staffing levels, and work–life balance, alongside reduced trust in organisational action and reputation. This is reinforced by a decrease in league table position from 44th to 47th out of 50.

Despite these challenges, there are some areas of improvement. Response rates increased markedly to 49%, slightly above the national average, indicating stronger staff participation. Improvements are also seen in aspects of team culture and day-to-day experience, including reduced pressure to work when unwell, greater openness to suggestions, improved trust within teams, and clearer role understanding. In addition, the “compassionate and inclusive” People Promise score has been maintained.

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.

This is supported by a structured cascade through leadership tiers. Executive Leadership Team and Group Leadership Team have firstly reviewed and aligned on the findings and priorities, creating a shared understanding of the key issues and expectations.

From this point, facilitated cascade workshops have been delivered with operational and clinical leaders. These sessions are critical as they not only communicate the data, but also provide context, enable reflection, and drive local ownership of the issues and solutions.

Following the workshops, responsibility shifts to Care Groups, divisions, and local teams to develop tailored local culture action plans. These plans are expected to align with the overarching organisational themes but respond specifically to local challenges and team-level insights. In addition, an overarching organisational culture plan has been developed to address high-level themes across the Group.

Recruitment and Retention

The attrition rate for ULTH has reduced from 9.19% in April 2025 to 8.34% in March 2026.

The vacancy rate for ULTH has increased from 5.98% in April 2025 to 6.74% in March 2026. This is an expected increase as we continued with risk-based vacancy control processes, and harmonisation of services across our Group.

The recruitment market for medical staff remains a challenge. The Trust has seen an increase in vacancy rate of c. 3% for this staff group during 2025/26, however this is as a result of increases within budgeted establishment as a result of additional Trainee Doctors in Q2.

Allied health professionals remain a challenge however, the Group 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 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 (FTSU)

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy culture of speaking up is an indicator of a well-led trust and ULTH is committed to ensuring that speaking up is part of the culture of the

organisation. Speaking up cases raised with the Trust's Freedom to Speak Up Guardian in 2025/26:

	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	124	10	22	12	27	0
Q2	120	2	10	2	35	0
Q3	93	1	15	4	28	1
Q4	86	0	6	14	33	0

The Trust has a Freedom to Speak Up Group 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.

The staff survey results have shown a slight decrease of 1% for staff feeling secure to raise concerns about unsafe clinical practice and a 1.3% decrease in staff feeling confident to address concerns about unsafe clinical practice. A slightly higher decrease of 3.6% for staff feeling safe to speak up about anything that concerns them in the organisation was shown, which align to the national results and a 4.4% decrease in staff feeling the organisation would address any concerns raised.

The freedom to speak up guardian continuously works with staff on raising awareness of speaking up through various avenues 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 2025/26 the Trust spent £5,402k on the following consultations:

a)	Estates	£567k
b)	External Consultancy	£4,835k

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 2026, earning £245 or more per day:

No. of existing engagements as of 31 March 2026 *	11
Of which the number that have existed:	
for less than one year at time of reporting	1

for between one and two years at time of reporting	3
for between two and three years at time of reporting	7
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 2025 and 31 March 2026.

**No. of off-payroll workers engaged between 1 April 2025 and 31 March 2026	24
Of which	
Not Subject to off-payroll legislation	
Subject to off payroll legislation and determined as in the scope of IR35	14
Subject to off payroll legislation and determined as out of scope of IR35	10
No of engagements reassessed for compliance or assurance purposes during the year	0
Of which: Number of engagements that saw a change to IR35 status following review	0

** 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 2025 and 31 March 2026.

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 2025/26

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
<£10,000		16	16
£10,000 - £25,000	-	25	**25**
£25,001 - 50,000	-	6	**6**
£50,001 - £100,000	-	7	**7**
Total number of exit packages by type		54	**54**
Total resource cost (£)	**£0**	**£1,142,000**	**£1,142,000**

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			
£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**

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 expenses 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.

	2025/26		2024/25	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000		
Mutually agreed resignations (MARS) contractual costs	53	1,119	-	-
Non-contractual payments requiring HMT approval	1	23	2	61
Total	**54**	**1,142**	**2**	**61**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	1	23	-	-

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

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	3	907,908	846,199
Other operating income	4	57,718	53,359
Operating expenses	7,9	(975,218)	(920,042)
Operating surplus/(deficit) from continuing operations		**(9,592)**	**(20,484)**
Finance income	11	1,401	1,816
Finance expenses	12	(394)	(310)
PDC dividends payable		(11,519)	(9,928)
Net finance costs		**(10,512)**	**(8,422)**
Other gains / (losses)	13	66	346
Surplus / (deficit) for the year from continuing operations		**(20,038)**	**(28,560)**
Surplus / (deficit) for the year		**(20,038)**	**(28,560)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(7,020)	(521)
Revaluations	16	1,444	5,290
Total other comprehensive income for the period		**(5,576)**	**4,769**
Total comprehensive income / (expense) for the period		**(25,614)**	**(23,791)**

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	14	32,250	11,958
Property, plant and equipment	15	426,533	384,195
Right of use assets	17	14,150	13,686
Receivables	19	2,215	2,084
Total non-current assets		**475,148**	**411,923**
Current assets			
Inventories	18	8,559	6,362
Receivables	19	31,882	24,167
Non-current assets for sale and assets in disposal groups	21	525	-
Cash and cash equivalents	22	49,758	19,146
Total current assets		**90,724**	**49,675**
Current liabilities			
Trade and other payables	23	(126,448)	(81,341)
Borrowings	25	(3,867)	(3,080)
Provisions	26	(4,070)	(12,594)
Other liabilities	24	(2,490)	(1,259)
Total current liabilities		**(136,875)**	**(98,274)**
Total assets less current liabilities		**428,997**	**363,324**
Non-current liabilities			
Borrowings	25	(11,818)	(12,922)
Provisions	26	(5,205)	(5,371)
Other liabilities	24	(9,560)	(10,063)
Total non-current liabilities		**(26,583)**	**(28,356)**
Total assets employed		**402,414**	**334,968**
Financed by			
Public dividend capital		912,761	819,701
Revaluation reserve		45,132	52,015
Other reserves		190	190
Income and expenditure reserve		(555,669)	(536,938)
Total taxpayers' equity		**402,414**	**334,968**

The notes on pages 89 to 150 form part of these accounts.

Name PROFESSOR KAREN DUNDERDALE

Position GROUP CHIEF EXECUTIVE OFFICER

Date

Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(9,592)	(20,484)
Non-cash income and expense:			
Depreciation and amortisation	7	32,728	33,029
Net impairments	8	25,511	8,079
Income recognised in respect of capital donations	4	(2,626)	(147)
Amortisation of PFI deferred credit		(503)	(503)
(Increase) / decrease in receivables and other assets		5,413	(4,372)
(Increase) / decrease in inventories		(2,197)	219
Increase / (decrease) in payables and other liabilities		7,771	(3,476)
Increase / (decrease) in provisions		(8,741)	490
Net cash flows from / (used in) operating activities		**47,764**	**12,835**
Cash flows from investing activities			
Interest received		1,258	1,828
Purchase of intangible assets		(25,483)	(7,107)
Purchase of PPE and investment property		(73,922)	(89,050)
Sales of PPE and investment property		86	353
Receipt of cash donations to purchase assets		2,331	-
Net cash flows from / (used in) investing activities		**(95,730)**	**(93,976)**
Cash flows from financing activities			
Public dividend capital received		93,060	62,941
Movement on other loans		(805)	(805)
Capital element of lease rental payments		(1,917)	(2,431)
Other interest		(25)	(10)
Interest paid on lease liability repayments		(318)	(241)
PDC dividend (paid) / refunded		(11,417)	(10,016)
Cash flows from (used in) other financing activities		-	(9)
Net cash flows from / (used in) financing activities		**78,578**	**49,429**
Increase / (decrease) in cash and cash equivalents		**30,612**	**(31,712)**
Cash and cash equivalents at 1 April - brought forward		**19,146**	**50,858**
Cash and cash equivalents at 1 April - restated		**19,146**	**50,858**
Cash and cash equivalents at 31 March	22	**49,758**	**19,146**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	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' equity at 1 April 2025 - brought forward	**819,701**	**52,015**	**-**	**190**	**-**	**(536,938)**	**334,968**
Surplus/(deficit) for the year	-	-	-	-	-	(20,038)	**(20,038)**
Impairments	-	(7,020)	-	-	-	-	**(7,020)**
Revaluations	-	1,444	-	-	-	-	**1,444**
Transfer to retained earnings on disposal of assets	-	(1,307)	-	-	-	1,307	**-**
Public dividend capital received	93,060	-	-	-	-	-	**93,060**
Taxpayers' equity at 31 March 2026	**912,761**	**45,132**	**-**	**190**	**-**	**(555,669)**	**402,414**

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' 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' equity at 31 March 2025	**819,701**	**52,015**	**-**	**190**	**-**	**(536,938)**	**334,968**

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 2025/26 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 Teaching 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.

The Trust recognises revenue from contracts with customers in accordance with IFRS 15 – Revenue from Contracts with Customers. Revenue primarily arises from the delivery of healthcare services commissioned by NHS England, Integrated Care Boards (ICBs), local authorities, and other third-party organisations. Additional income is generated from education, training, research, and other non-clinical activities.

Revenue is measured at the transaction price allocated to each performance obligation and is recognised when control of the promised service transfers to the customer.

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 2025/26, 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.

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.

Revenue from Education and Training

Performance obligations typically relate to the delivery of defined teaching programmes or training activities. Revenue is recognised either over time based on the period of delivery or at the point specific outputs are provided.

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 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, and 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 it’s 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. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. 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 liabilities in 2023/24

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

Note1.9 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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as ‘deemed cost’.

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 1.10 Inventories

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

Note 1.11 Cash and cash equivalents.

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by 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 24.62% 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 1.13 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 in line with the GAM.

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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026. Revaluations and additions to leased assets may be subject to the new rates.

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 1.14 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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 26.1 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 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the 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 1.16 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. Such adjustments would be paid out or charged in subsequent years.

Note 1.17 Value added tax (VAT)

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 PPE/Intangibles. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 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.

The Trust had no material third assets to report in 2025/26

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on 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 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.21 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 2025/26:

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.

Note 1.22 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.

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 1.23 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 2026: £490.3 million (2024/25 £442.6 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 £276.4 million and is detailed on Note 16

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 2026 £40.2 million (2024/25 was £48.3 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 2025. 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 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.

	2025/26		2024/25	
	£000s	**%**	**£000s**	**%**
Revenue from HM Government sources	907,908	**94.0**	846,199	**94.1**
Revenue from non-HM Government sources	57,718	**6.0**	53,359	**5.9**
Total	**965,626**	**100.0**	**899,558**	**100.0**

Revaluation and Impairment	**2025/26 £000s**	2024/25 **£000s**
Revaluation Reserve Adjustments	1,444	5,290
Impairments	(7,020)	(521)
	(5,576)	4,769

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)

	2025/26 £000	2024/25 £000
Income from commissioners under API contracts - variable element*	148,236	137,234
Income from commissioners under API contracts - fixed element*	653,948	602,716
High cost drugs income from commissioners	64,453	67,296
Other NHS clinical income	4,076	5,216
All services		
Private patient income	132	123
National pay award central funding***	-	1,380
Additional pension contribution central funding**	34,270	32,234
Other clinical income	2,793	-
Total income from activities	**907,908**	**846,199**

*Aligned payment and incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 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 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 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)

	2025/26	2024/25
Income from patient care activities received from:	**£000**	**£000**
NHS England	95,924	91,823
Integrated care boards	809,059	751,493
Department of Health and Social Care	29	23
Other NHS providers	155	316
NHS other	-	-
Local authorities	115	115
Non-NHS: private patients	132	123
Non-NHS: overseas patients (chargeable to patient)	860	506
Injury cost recovery scheme	1,148	1,239
Non NHS: other	486	561
Total income from activities	**907,908**	**846,199**
Of which:		
Related to continuing operations	907,908	846,199
Related to discontinued operations	-	-

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

	2025/26	2024/25
	£000	**£000**
Income recognised this year	860	506
Cash payments received in-year	314	530
Amounts added to provision for impairment of receivables	203	631
Amounts written off in-year	574	343

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	2,040	-	**2,040**	1,940	-	**1,940**
Education and training	27,958	3,324	**31,282**	28,035	2,576	**30,611**
Non-patient care services to other bodies	8,628	-	**8,628**	6,081	-	**6,081**
Income in respect of employee benefits accounted on a gross basis	5,246	-	**5,246**	5,127	-	**5,127**
Receipt of capital grants and donations and peppercorn leases	-	2,626	**2,626**	-	147	**147**
Charitable and other contributions to expenditure	-	-	**-**	-	56	**56**
Revenue from operating leases	-	1,297	**1,297**	-	1,257	**1,257**
Amortisation of PFI deferred income / credits	-	503	**503**	-	503	**503**
Other income[2]	6,096	-	**6,096**	7,637	-	**7,637**
Total other operating income	**49,968**	**7,750**	**57,718**	**48,820**	**4,539**	**53,359**
Of which:						
Related to continuing operations			57,718			53,359

[2] Other Income includes: car parking £1.8m (2024/25: £1.1m), catering £3.4m (2024/25: £3.1m), retail and other sales £0.5 m (2024/25: £1.3m) analysed on Note 5.1

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 also disclosed.

	2025/26 £000	2024/25 £000
Income	5,752	5,481
Full cost	(3,869)	(5,007)
Surplus / (deficit)	**1,883**	**474**

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 2025/26 retail sales from the public and staff.

Catering	**2025/26** **£000s**	**2024/25** £000s
Income	**3,394**	**3,091**
Full cost	**(3,286)**	**(3,418)**
Surplus / (deficit)	**108**	**(327)**

Car Parking	**2025/26** **£000s**	**2024/25** £000s
Income	**1,836**	**1,073**
Full cost	**(271)**	**(226)**
Surplus / (deficit)	**1,565**	**847**

Retail and other Sales	**2025/26** **£000s**	**2024/25** £000s
Income	**522**	**1,317**
Full cost	**(312)**	**(1,363)**
Surplus / (deficit)	**210**	(46)

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

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,297	1,112
Variable lease receipts / contingent rents	-	145
Total in-year operating lease income	**1,297**	**1,257**

Note 6.2 Future lease receipts

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	229	241
- later than one year and not later than two years	195	230
- later than two years and not later than three years	19	195
- later than three years and not later than four years	19	19
- later than four years and not later than five years	1	19
- later than five years	-	6
Total	**463**	**710**

Note 7 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	49	37
Purchase of healthcare from non-NHS and non-DHSC bodies	10,131	8,573
Purchase of social care	-	5
Staff and executive directors costs	631,310	609,208
Remuneration of non-executive directors	228	160
Supplies and services - clinical (excluding drugs costs)	86,009	83,272
Supplies and services - general	14,598	12,800
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	77,907	74,632
Inventories written down	262	261
Consultancy costs	5,402	12
Establishment	6,564	8,862
Premises	36,840	34,334
Transport (including patient travel)	1,957	2,095
Depreciation on property, plant and equipment	27,488	27,359
Amortisation on intangible assets	5,240	5,670
Net impairments	25,511	8,079
Movement in credit loss allowance: contract receivables / contract assets	(645)	385
Change in provisions discount rate(s)	(86)	9
audit services- statutory audit	151	182
Internal audit costs	249	238
Clinical negligence	24,866	24,185
Legal fees	828	382
Insurance (as a policy holder)	21	36
Research and development	2,283	2,277
Education and training	12,494	11,979
Expenditure on short term leases	289	228
Early retirements	1,142	-
Car parking & security	169	68
Hospitality	-	1
Losses, ex gratia & special payments	218	(1,053)
Grossing up consortium arrangements	-	-
Other services, eg external payroll	513	3,907
Other	3,230	1,859
Total	**975,218**	**920,042**
Of which:		
Related to continuing operations	975,218	920,042
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 2025/26 nor 2024/25.

Note 8 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	25,511	8,079
Total net impairments charged to operating surplus / deficit	**25,511**	**8,079**
Impairments charged to the revaluation reserve	7,020	521
Total net impairments	**32,531**	**8,600**

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:

	2025/26	2024/25
	£000	£000
Reversals of impairments charged to SOCI in previous years:		
PARU Modular Building		(1,766)
New Resus Building-Lincoln		(2,594)
external Areas, Pilgrim	(820)	-
Tower Block Pilgrim	(377)	-
Boiler House Lincoln	(435)	-
Other - buildings*	(1,988)	(1,437)
Impairments charged to SOCI in current year:		
Tower Block Pilgrim Hospital	-	218
Generator House Lincoln County Hospital	-	47
Maternity Unit Pilgrim	78	107
New HV Substation	4,147	-
New LV Substation	2,356	-
Data Centre 3 new Build	-	399
Phase II	627	2,472
A & E Building Pilgrim	102	737
external Areas, Pilgrim	-	820
Skegness Community Diagnostic Centre	-	3,223
Lincoln Community Diagnostic Centre	2,163	3,364
Old Trust HQ and purchasing offices Grantham	697	
Pathology Lincoln	619	
Boiler House Pilgrim	826	
Pilgrim ED	12,710	
Modular data centre PHB	1,752	
CDC Boston Land	724	
Other - buildings [a]	2,330	2,489
	25,511	**8,079**

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

Note 8.2 Other Material Impairment losses / (reversals) charged to SOCI are summarised below:

The Trust entered into a peppercorn lease contract with a third party in 2006, Progress Living, in which accommodation is provided to Trust employees at Lincoln, Boston and Grantham sites. Under the terms of the contract, the Trust guarantees an occupancy level of 85.3%. The Trust pays Progress Housing for variance from the agreed occupancy level.

The occupancy levels and income streams associated with the contract are reviewed annually. The properties are revalued annually and the valuation takes into account projected occupancy levels.

Note 8.3 Property, Plant and Equipment impairments and reversals charged to the revaluation reserve

	2025/26	2024/25
	£000	£000
Other	7,203	-
Changes in market price	(183)	521
Total impairments for PPE charged to reserves	**7,020**	**521**

Note 9 Employee benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	478,977	467,708
Social security costs	62,454	46,988
Apprenticeship levy	2,356	2,306
Employer's contributions to NHS pensions	86,542	81,593
Pension cost - other	211	137
Temporary staff (including agency)	17,940	23,851
Total gross staff costs	**648,480**	**622,583**
Recoveries in respect of seconded staff	-	-
Total staff costs	**648,480**	**622,583**
Of which		
Costs capitalised as part of assets	6,880	4,730

Note 9.1 Retirements due to ill-health

During 2025/26 there were 6 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £288k (£63k in 2024/25).

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 as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the 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 taken into account 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 £34,271k

Note 11 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,401	1,816
Total finance income	**1,401**	**1,816**

Note 12 Finance expenditure

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

	2025/26 £000	2024/25 £000
Interest expense:		
Interest on lease obligations	318	241
Interest on late payment of commercial debt	17	10
Total interest expense	**335**	**251**
Unwinding of discount on provisions	51	51
Other finance costs	8	8
Total finance costs	**394**	**310**

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

	2025/26 £000	2024/25 £000
Total liability accruing in year under this legislation as a result of late payments	321	1,483
Amounts included within interest payable arising from claims made under this legislation	17	10

Note 13 Other gains / (losses)

	2025/26 £000	2024/25 £000
Gains on disposal of assets	87	350
Losses on disposal of assets	(21)	(4)
Total other gains / (losses)	**66**	**346**

Note 14 Intangible assets - 2025/26

	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
Cost at 1 April 2025 - brought forward *	**28,127**	**-**	**-**	**20**	**-**	**-**	**15**	**1,959**	**-**	**30,121**
Additions	8,555	-	-	-	-	-	28	16,945	-	**25,528**
Reclassifications	4	-	-	-	-	-	-	-	-	**4**
Disposals / derecognition	(8,272)	-	-	-	-	-	-	-	-	**(8,272)**
Cost at 31 March 2026	**28,414**	**-**	**-**	**20**	**-**	**-**	**43**	**18,904**	**-**	**47,381**
Amortisation at 1 April 2025 - brought forward	**18,128**	**-**	**-**	**20**	**-**	**-**	**15**	**-**	**-**	**18,163**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Provided during the year	5,240	-	-	-	-	-	-	-	-	**5,240**
Disposals / derecognition	(8,272)	-	-	-	-	-	-	-	-	**(8,272)**
Amortisation at 31 March 2026	**15,096**	**-**	**-**	**20**	**-**	**-**	**15**	**-**	**-**	**15,131**
Net book value at 31 March 2026	**13,318**	**-**	**-**	**-**	**-**	**-**	**28**	**18,904**	**-**	**32,250**
Net book value at 1 April 2025	**9,999**	**-**	**-**	**-**	**-**	**-**	**-**	**1,959**	**-**	**11,958**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.1 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 15 Property, plant & equipment - 2025/26

	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 2025 - brought forward	**11,800**	**203,856**	**48,259**	**56,742**	**97,576**	**604**	**22,367**	**1,418**	**442,622**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	1,409	12,166	-	68,451	11,141	-	6,173	27	**99,367**
Impairments	(724)	(33,954)	(8,010)	-	-	-	-	-	**(42,688)**
Reversals of impairments	330	1,494	-	-	-	-	-	-	**1,824**
Revaluations	370	111	-	-	-	-	-	-	**481**
Reclassifications	-	40,098	-	(42,922)	2,813	-	7	-	**(4)**
Transfers to / from assets held for sale	(525)	-	-	-	(3,727)	-	-	(23)	**(4,275)**
Disposals / derecognition	-	(255)	-	-	(3,451)	-	(3,270)	(8)	**(6,984)**
Valuation/gross cost at 31 March 2026	**12,660**	**223,516**	**40,249**	**82,271**	**104,352**	**604**	**25,277**	**1,414**	**490,343**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**-**	**48,894**	**517**	**8,272**	**744**	**58,427**
Provided during the year	-	8,745	806	-	10,234	19	5,432	176	**25,412**
Impairments	-	(3,777)	(806)	-	-	-	-	-	**(4,583)**
Reversals of impairments	-	(3,750)	-	-	-	-	-	-	**(3,750)**
Revaluations	-	(963)	-	-	-	-	-	-	**(963)**
Transfers to / from assets held for sale	-	-	-	-	(3,726)	-	-	(23)	**(3,749)**
Disposals / derecognition	-	(255)	-	-	(3,451)	-	(3,270)	(8)	**(6,984)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**51,951**	**536**	**10,434**	**889**	**63,810**
Net book value at 31 March 2026	**12,660**	**223,516**	**40,249**	**82,271**	**52,401**	**68**	**14,843**	**525**	**426,533**
Net book value at 1 April 2025	**11,800**	**203,856**	**48,259**	**56,742**	**48,682**	**87**	**14,095**	**674**	**384,195**

Note 15.1 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 15.2 Property, plant and equipment financing - 31 March 2026

	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	12,660	222,968	-	79,940	51,164	68	14,830	525	**382,155**
On-SoFP PFI contracts and other service concession arrangements	-	-	40,249	-	-	-	-	-	**40,249**
Owned - donated/granted	-	548	-	2,331	1,237	-	13	-	**4,129**
Total net book value at 31 March 2026	**12,660**	**223,516**	**40,249**	**82,271**	**52,401**	**68**	**14,843**	**525**	**426,533**

Note 15.3 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 16 Revaluations of property, plant and equipment

The Trust commissioned a desktop revaluation of land, buildings and dwellings with a valuation date of 31 March 2026. 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 2025: £1.0m). £525k of this was transferred to Held for Sale
3. Dwellings are valued on an Existing Use Value (EUV) at 31 March 2026

Revaluations of property, plant and equipment

	2025/26 £000s	2024/25 £000s
Land	12,660	11,800
Dwellings*	40,249	48,259
Buildings	223,516	203,856
	276,425	263,915

	2025/26 £000s	2024/25 £000s
Revaluation Reserves Movement		
Revaluation reserve at 1 April - brought forward	**52,015**	48,454
Net impairments	**(7,020)**	(521)
Revaluations	**1,444**	5,290
Transfers to other reserves	**(1,307)**	(1,208)
Revaluation reserve at 31 March	**45,132**	52,015

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

Accounting policies note 1.9 provides further information regarding the method of valuation.

The useful economic asset lives for intangibles and property, 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 £2.35m (31 March 2025: £6.2m).

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

	2025/26	2024/25
	£000s	£000s
Net book value 1 April	**10,983**	10,842
New leases	**-**	-
Additions	**2,027**	115
Depreciation	**(401)**	(326)
Increase in valuation 31 March	**40**	686
Impairments/Reversals	**(1,624)**	262
Terminated Leases		(596)
Net book value 31 March	**11,025**	10,983

Note 17 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 several 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 (2024/25: £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 (2024/25: £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 17.1 Right of use assets - 2025/26

	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 2025 - brought forward	**14,007**	**6,126**	**361**	**-**	**-**	**-**	**20,494**	**9,317**
Additions	1,316	239	657	-	-	-	**2,212**	97
Remeasurements of the lease liability	156	620	-	-	-	-	**776**	123
Disposals / derecognition	-	(1,857)	(103)	-	-	-	**(1,960)**	-
Valuation/gross cost at 31 March 2026	**15,479**	**5,128**	**915**	**-**	**-**	**-**	**21,522**	**9,537**
Accumulated depreciation at 1 April 2025 - brought forward	**2,774**	**3,871**	**163**	**-**	**-**	**-**	**6,808**	**2,446**
Provided during the year	1,107	863	106	-	-	-	**2,076**	768
Disposals / derecognition	-	(1,409)	(103)	-	-	-	**(1,512)**	-
Accumulated depreciation at 31 March 2026	**3,881**	**3,325**	**166**	**-**	**-**	**-**	**7,372**	**3,214**
Net book value at 31 March 2026	**11,598**	**1,803**	**749**	**-**	**-**	**-**	**14,150**	**6,323**
Net book value at 1 April 2025	**11,233**	**2,255**	**198**	**-**	**-**	**-**	**13,686**	**6,871**

Net book value of right of use assets leased from other NHS providers	130
Net book value of right of use assets leased from other DHSC group bodies	6,193

Note 17.2 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 17.3 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.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**13,989**	**13,906**
Lease additions	2,058	2,356
Lease liability remeasurements	776	158
Interest charge arising in year	318	241
Early terminations	(429)	-
Lease payments (cash outflows)	(2,235)	(2,672)
Carrying value at 31 March	**14,477**	**13,989**

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

Note 17.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	3,062	763	2,555	809
- later than one year and not later than five years;	7,816	4,047	5,787	3,233
- later than five years.	6,029	2,024	7,808	3,516
Total gross future lease payments	**16,907**	**6,834**	**16,150**	**7,558**
Finance charges allocated to future periods	(2,430)	(307)	(2,161)	(364)
Net lease liabilities at 31 March 2026	**14,477**	**6,527**	**13,989**	**7,194**
Of which:				
Leased from other NHS providers		133		161
Leased from other DHSC group bodies		6,394		7,033

Note 18 Inventories

	31 March 2026	31 March 2025
	£000	£000
Drugs	3,658	3,185
Consumables	4,901	3,177
Total inventories	**8,559**	**6,362**

Inventories recognised in expenses for the year were £79,203k (2024/25: £77,582k). Write-down of inventories recognised as expenses for the year were £11k (2024/25: £261k).

Note 19 Receivables

	31 March 2026	31 March 2025
	£000	£000
Current		
Contract receivables	17,127	14,181
Allowance for impaired contract receivables / assets	(637)	(1,338)
Prepayments (non-PFI)	13,218	8,472
Interest receivable	274	131
PDC dividend receivable	309	411
VAT receivable	1,258	263
Other receivables	333	2,047
Total current receivables	**31,882**	**24,167**
Non-current		
Contract receivables	2,303	2,073
Allowance for impaired contract receivables / assets	(563)	(507)
Other receivables	475	518
Total non-current receivables	**2,215**	**2,084**
Of which receivable from NHS and DHSC group bodies:		
Current	13,686	9,903
Non-current	475	518

Note 19.1 Allowances for credit losses

	2025/26		2024/25	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,845**	**-**	**1,836**	**-**
New allowances arising	-	-	1,727	-
Reversals of allowances	(645)	-	(1,342)	-
Utilisation of allowances (write offs)	-	-	(376)	-
Allowances as at 31 Mar 2026	**1,200**	**-**	**1,845**	**-**

Note 19.2 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 2026	31 March 2025
	£000	£000
0 - 30 days	-	-
30-60 Days	4	-
60-90 days	55	-
90- 120 days	27	52
Over 120 days	277	746
Total	**363**	**798**

Ageing of non-impaired financial assets past their due date

	31 March 2026	31 March 2025
	£000	£000
0 - 30 days	2,268	3,857
30-60 Days	961	255
60-90 days	54	82
90- 120 days	249	43
Over 120 days		85
Total	**3,532**	**4,322**

In addition to providing against specific invoiced debt £0.8m (2024/25: £0.9m), the Trust also makes general provision for impairment based upon expected recovery rates.

This covers both invoiced debt £0.2m (2024/25: £0.2m) and income from the Compensation recovery unit £0.8m (2024/25: £0.8m).

Note 20 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 21 Non-current assets held for sale and assets in disposal groups

	2025/26 £000	2024/25 £000
Assets classified as available for sale in the year	526	3
Assets sold in year	(1)	(3)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**525**	**-**

The Trust made decision to sell land that was not being used to developers. A tender process was carried out, and the winning buyer is in the process of finalising the sale agreement. Payment for the land is expected in 2026/27 financial year

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.

	2025/26	2024/25
	£000	£000
At 1 April	**19,146**	**50,858**
Prior period adjustments		-
At 1 April (restated)	**19,146**	**50,858**
Net change in year	30,612	(31,712)
At 31 March	**49,758**	**19,146**
Broken down into:		
Cash at commercial banks and in hand	14	13
Cash with the Government Banking Service	49,744	19,133
Total cash and cash equivalents as in SoFP	**49,758**	**19,146**
Total cash and cash equivalents as in SoCF	**49,758**	**19,146**

Note 23 Trade and other payables

	31 March 2026	31 March 2025
	£000	£000
Current		
Trade payables	10,506	11,531
Capital payables	55,118	16,551
Accruals	38,206	33,245
Social security costs	7,499	6,119
Other taxes payable	7,445	6,814
Pension contributions payable	7,127	6,823
Other payables	547	258
Total current trade and other payables	**126,448**	**81,341**
Of which payables from NHS and DHSC group bodies:		
Current	3,662	4,426
Non-current	-	-

Note 24 Other liabilities

	31 March 2026	31 March 2025
	£000	£000
Current		
Deferred income: contract liabilities	1,987	756
Deferred PFI credits / income [1]	503	479
Other deferred income	-	24
Total other current liabilities	**2,490**	**1,259**
Non-current		

Deferred PFI credits / income	9,560	9,578
Other deferred income	-	485
Total other non-current liabilities	**9,560**	**10,063**

[1] The Trust entered into an agreement with Progress Care Housing Association Ltd in 2006, whereby the Trust transferred ownership of several 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 2026	31 March 2025
	£000	£000
Current		
Other loans	805	805
Lease liabilities	3,062	2,275
Total current borrowings	**3,867**	**3,080**
Non-current		
Other loans	403	1,208
Lease liabilities	11,415	11,714
Total non-current borrowings	**11,818**	**12,922**

Note 25.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Lease Liabilities	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**-**	**2,013**	**13,989**	**-**	**16,002**
Cash movements:					
Financing cash flows - payments and receipts of principal	-	(805)	(1,917)	-	**(2,722)**
Financing cash flows - payments of interest	-	-	(318)	-	**(318)**
Non-cash movements:					
Additions	-	-	2,058	-	**2,058**
Lease liability remeasurements	-	-	776	-	**776**
Application of effective interest rate	-	-	318	-	**318**
Early terminations	-	-	(429)	-	**(429)**
Carrying value at 31 March 2026	**-**	**1,208**	**14,477**	**-**	**15,685**

	Loans from DHSC	Other loans	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£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	**-**	**2,013**	**13,989**	**-**	**16,002**

Note 26 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**590**	**1,492**	**1,011**	**14,872**	**17,965**
Change in the discount rate	(10)	(74)	(1)	(38)	**(123)**
Arising during the year	56	45	458	1,730	**2,289**
Utilised during the year	(91)	(107)	(687)	(1,976)	**(2,861)**
Reversed unused	(81)	-	(164)	(7,832)	**(8,077)**
Unwinding of discount	14	36	-	32	**82**
At 31 March 2026	**478**	**1,392**	**617**	**6,788**	**9,275**
Expected timing of cash flows:					
- not later than one year;	83	104	617	3,266	**4,070**
- later than one year and not later than five years;	309	414	-	3,030	**3,753**
- later than five years.	86	874	-	492	**1,452**
Total	**478**	**1,392**	**617**	**6,788**	**9,275**

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 £590k to £477k due to low arisings and 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 excess claims as notified by NHS Resolution were £366k (2024/25: £323 k)
   b) Projected liabilities in relation to claims made against the Trust for employment, commercial and other litigation issues £618k (2024/25: £708k)
3. General Provisions:
   a) Flowers On Call balance £392k
   b) Restore contract balance £3,017k
   c) Job Planning balance £1,114K

d) Anaesthetists Annual Leave provision balance £967k

Note 26.1 Clinical negligence liabilities

At 31 March 2026 £323m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of United Lincolnshire Teaching Hospitals NHS Trust (31 March 2025: £325m

Note 26.2 Clinical negligence liabilities

	31 March 2026	31 March 2025
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(61.5)	(69.2)
Net value of contingent liabilities	**(61.5)**	**(69.2)**
Net value of contingent assets	**-**	**-**

Note 27 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	36,756	8,125
Intangible assets	9,271	428
Total	**46,027**	**8,553**

Note 28 On-SoFP PFI 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 28.1 Impact of change in accounting policy for on-SoFP PFI 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 29 Financial instruments

Note 29.1 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 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non-financial assets	19,312	-	-	**19,312**
Cash and cash equivalents	49,758	-	-	**49,758**
Total at 31 March 2026	**69,070**	**-**	**-**	**69,070**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£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**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Obligations under leases	14,477	-	**14,477**
Other borrowings	1,208	-	**1,208**
Trade and other payables excluding non financial liabilities	101,832	-	**101,832**
Provisions under contract	6,746	-	**6,746**
Total at 31 March 2026	**124,263**	**-**	**124,263**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£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**

Note 29.4 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 2026	31 March 2025
	£000	£000
In one year or less	115,508	72,798
In more than one year but not more than five years	7,816	7,075
In more than five years	6,029	11,185
Total	**129,353**	**91,058**

Note 29.5 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 30 Losses and special payments

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	7	4	26	31
Fruitless payments and constructive losses	41	991	2	703
Bad debts and claims abandoned	244	596	242	367
Stores losses and damage to property	42	185	3	261
Total losses	**334**	**1,776**	**273**	**1,362**
Special payments				
Compensation under court order or legally binding arbitration award	50	204	15	314
Ex-gratia payments	61	27	73	38
Special severance payments	1	23	2	61
Total special payments	**112**	**254**	**90**	**413**
Total losses and special payments	**446**	**2,030**	**363**	**1,775**

Note 31 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 2025/26 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) Colin Farquharson - University of Lincoln (Honorary Clinical Professor of Cardiology) – value of trade with Trust - no income and £1,750k expenditure (2025/26 - £267k income, £323k 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 2025/26 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
NHS Midlands Regional Office

The Trust is the Corporate Trustee for the United Lincolnshire Teaching 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 £58k (2024/25 - £133) total transactions of £380k (2024/25 - £387k)

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 2025/26 to the value of £141k including the purchase / donation of various capital assets to the Trust as detailed at note 16.

Note 32 Better Payment Practice code

	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	100,606	309,071	108,610	311,061
Total non-NHS trade invoices paid within target	92,458	276,109	98,793	279,892
Percentage of non-NHS trade invoices paid within target	91.9%	89.3%	91.0%	90.0%
NHS Payables				
Total NHS trade invoices paid in the year	4,600	61,516	2,716	56,709
Total NHS trade invoices paid within target	4,004	51,234	2,260	50,974
Percentage of NHS trade invoices paid within target	87.0%	83.3%	83.2%	89.9%

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 33 Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	127,883	88,274
Less: Disposals	(449)	(6)
Less: Donated and granted capital additions	(2,626)	(147)
Charge against Capital Resource Limit	**124,808**	**88,121**
Capital Resource Limit	124,808	88,121
Under / (over) spend against CRL	**-**	**-**

Note 34 Adjusted Financial Performance

	2025/26	2024/25
	£000	£000
Surplus / (deficit) for the period per SOCI	(20,038)	(28,560)
Remove net impairments not scoring to the departmental expenditure limit	25,511	8,079
Remove I&E impact of capital grants and donations	(2,029)	718
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	1,491	1,481
Remove net impact of DHSC centrally procured inventories	-	28
Adjusted financial performance surplus / (deficit)	**4,935**	**(18,254)**

Note 35 Breakeven duty rolling assessment

	2025/26
	£000
Adjusted financial performance surplus / (deficit)	4,935
Breakeven duty financial performance surplus / (deficit)	**4,935**

Note 35.1 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	2025/26
	£000	£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)	4,935
Breakeven duty cumulative position	(242,529)	(330,474)	(372,350)	(369,201)	(366,536)	(379,573)	(399,217)	(417,471)	(412,536)
Operating income	433,161	447,492	539,248	643,878	680,194	757,678	788,589	899,558	965,626
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%)	(42.7%)

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.