University Hospitals of Leicester
NHS Trust

Annual Report

2023/24

University Hospitals of Leicester NHS Trust

Annual Report 2023/24

Presented to Parliament pursuant to Schedule 7, Paragraph 25 (4) (a) of the National Health Service Act 2006

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Overview

Welcome from the Chair and Chief Executive

Against a backdrop of industrial action, urgent and emergency care (UEC) pressures, a large waiting list and financial challenges, this has been another year of sustained improvement at the University Hospitals of Leicester NHS Trust and I am grateful for the contributions of all colleagues.

Particular highlights include; increased use of Digital solutions, early adoption of the "Going further Faster" – GIRFT programme, increased clinical confidence in the use of Patient Initiated Follow Ups (PIFU), LLR Planned Care Partnership strengthening, phase one of the East Midlands Planned Care Centre opening in June 2023, new capital equipment including a second surgical robot at Leicester Royal Infirmary, a replacement Linear accelerator in October 2023, chemotherapy "bus" in place from November 2023, additional modular endoscopy unit at the Leicester General from July 2023 and successful international and local recruitment to imaging teams. All of this is integral to the delivery of safe, timely patient care and patient care today is safer than 12 months ago.

It has been recognised nationally that there are very few, if any, providers who have made as much progress as UHL with waits for cancer, planned care and diagnostics over the last year. The number of patients waiting for 62-day cancer care has reduced by 60%. There have been sustained improvement and achievement of the Faster Diagnosis Standard with 75% or more of patients referred as a suspected cancer pathway having cancer ruled out or confirmed within 28 days. Our planned care waiting list doubled during the first two years of Covid but it reduced by 20% in 2023-24. For diagnostics, since October 2022 there has been a 43% reduction in the overall waiting list and long waits have reduced by 71% for 6+ week waits and 80% for 13+ waits. We have achieved a huge amount for our patients and we know we have a lot more to do.

In 2023 we launched our new 2023- 2030 strategy, Leading in healthcare, trusted in communities, with the four goal areas of High quality care for all, A great place to work, Partnerships for impact and Research and educational excellence which are underpinned by our values; compassionate, proud, inclusive and one team. All our relationships have strengthened including with General Practice, Local Authority and local voluntary and charitable organisations and in October 2023 we formalised our partnership with the University Hospitals of Northamptonshire NHS Group. Our partnership with UHN gives us an important opportunity to work at scale.

Not everything has gone well though and I worry about three interlinked themes: our culture, UEC and money.

I am probably proudest about, and most worried about, our culture. Objectively, as measured by the NHS Staff Survey, we made significant progress in the last year. The key engagement question is, 'would you recommend your Trust as a place to work?' In the 2023 survey, 63.7% of UHL colleagues did, which ranks us 36th in the NHS out of 119 trusts. Last year we were 74th and our improvement from last year is the fourth best in the NHS. Fifty-nine per cent of colleagues completed the survey, up from 33% three years ago.

The experience of working at UHL is improving for most but not all. In the survey, a colleague anonymously stated; "I feel like a number instead of a person. The values are a joke and not adhered to." Sadly, their experience will not be unique and this needs to change. As a white, heterosexual, male Chief Executive, my experience of working at UHL will be different to most and I want my largely positive experience to be shared by many.

I worry about the UEC pathway including the impact it is having on our finances. There are many things we need to do to manage our finances more effectively and I am confident we are making progress with them, but unless we see a significant change in UEC, we will continue to need to spend more money. Despite a lot of effort put into UEC by many partners, including UHL, and better ambulance handover times for much of 2023-24, our emergency pathway is too busy. As stated last year, we must radically reform the way we care for patients.

John MacDonald retires in July 2024 after 35 years in the NHS and I would like to wish him all the best in his retirement. I am grateful for his leadership at UHL over the last three years.

To conclude, our vision at UHL is to be leading in healthcare and trusted in communities. Our compassion, pride, inclusivity, and teamwork will be clear throughout this report. I look forward to working with colleagues to build on our values to ensure a positive culture in everything we do.

Richard Mitchell

Chief Executive,

UHL NHS Trust

27 June 2024

John MacDonald

Trust Chair

(date)

Overview: About us

Welcome to our 2023/24 Annual Report which describes our achievements during the year, how we are governed, our finances, and performance in key areas. Our Quality Account, which is published on our website: www.leicestershospitals.co.uk provides a more in-depth report on how we are continuously improving quality, safety, and patient experience in our hospitals.

Purpose of the overview section
This overview section gives a short summary of our organisation, our purpose, our objectives and what we have achieved against them, our performance against national standards and the key risks to our delivery. You will also find details of our sustainability plans and performance.

Our history and structure

University Hospitals of Leicester NHS Trust (UHL/the Trust) was established on 1st April 2000, from a merger of three previously separate hospitals - Leicester Royal Infirmary; Glenfield Hospital, and Leicester General Hospital. Our organisation is formed of seven Clinical Management Groups ('CMGs') that are supported by several corporate directorates. The Clinical Management Groups are:

- Cancer, Haematology, GI Medicine and Surgery
- Emergency and Specialist Medicine
- Musculoskeletal and Specialist Surgery
- Clinical Support and Imaging
- Renal, Respiratory and Cardiovascular
- Intensive/Critical Care, Theatres, Anaesthesia, Pain and Sleep
- Women's and Children's

The corporate directorates are:

- Corporate Medical
- Corporate Nursing
- Corporate Operations
- Finance
- People and Organisational Development
- Estates and Facilities
- Communications and Engagement
- Information Management and Technology
- Corporate and Legal Affairs
- Reconfiguration, strategy, transformation

The CMGs and corporate directorates are overseen by our Trust Leadership Team and Trust Board.

Our Strategy

In 2023/24, UHL launched our new strategy for 2023-2030: Leading in healthcare, trusted in communities, with the four goal areas of:

- High quality care for all
- A great place to work
- Partnerships for impact, and
- Research and educational excellence

These are underpinned by our values: **compassionate, proud, inclusive and one team.**

You can read our full strategy on our website: Our strategy 2023-2030 (leicestershospitals.nhs.uk)

Our Future Hospitals and Transformation

Our Future Hospitals

This ambitious programme will reconfigure acute and maternity services for the people of Leicestershire, Leicester and Rutland health system (known hereafter as LLR) by 2030. At the Leicester Royal Infirmary (LRI) site, we plan to build a dedicated Women's hospital, a new build Intensive Care Unit (ICU) along with a stand-alone Children's Hospital. State-of-the-art Education and Training centres will be created in the historic Victoria building, providing our medical students and staff with modern learning environments. The Glenfield Hospital (GH) site will see a new build for additional intensive care beds, theatres, and wards.

The programme will address the increasing imbalance between emergency and elective care and will make more efficient use of our resources across the three sites. By using creative building designs following the National Hospital Programme's standard hospital design, we will ensure flexibility to meet our future growth and capacity requirements.

UHL's Transformation agenda will be supported and enabled through digitally enabled facilities. All our new buildings will be standardised using modern methods of construction (MMC) and will meet central Net Zero Carbon targets, thereby reducing our backlog maintenance and improving the critical infrastructure.

Enabling Works
Currently, we are carrying out the early enabling works to facilitate the planned new builds. At the LRI, several old and costly to maintain buildings are due for clearance and demolition. This will involve a complex sequencing of moves, some temporary, to ensure that the emptying of the site is on target to enable the start of construction for the new Women's and ICU Hospital. The current occupants, clinical and support services, will be relocated into new or refurbished accommodation. The new accommodation includes an extension to the Windsor Building on the LRI, providing modern facilities to a number of clinical services. Construction is expected to commence mid-2025, with completion planned in 2026.

East Midlands Planned Care Centre
During 2022/23 we started to develop plans for our new East Midlands Planned Care Centre at the Leicester General Hospital; a £46m investment to improve care and reduce waiting lists for the people of Leicester and beyond. Phase 1 opened in May 2023 and provided 2 operating theatres. Phase 2 is due to open in December 2024 and will consist of 14 outpatient rooms, 4 procedure rooms, 2 theatres and a surgical recovery 17 bed day case facility, together with two 18-bedded wards, one dedicated to medical day case and one 23-hour for surgical activity (only using 12 of 18 beds). By the time it is fully open over 100,000 people per year will be treated there.

Endoscopy
Designs for a new £17m Endoscopy Unit at the Leicester General Hospital site, adjacent to the East Midlands Planned Care Centre, were developed in 2023. The new Endoscopy Unit will increase capacity and reduce our waiting list. Four rooms will open initially, and 2 rooms will be built and ready for future development. The Unit is currently under construction and is planned to be open and operational in Spring 2025.

Year in review – news highlights

April to June 2023

British Association of Physicians of Indian Origin (BAPIO)
UHL hosted our first conference with BAPIO and the British Indian Nurses Association (BINA) in April. Over 150 delegates took part in discussions about leadership, education, research, and training. We are proud of the diverse workforce at UHL, and keen to work closely with BAPIO and BINA to improve the experience of our international colleagues. The partnership – formalised through a memorandum of understanding - strengthens UHL's pre-arrival offer for doctors and nurses joining the Trust from India. This includes enhanced support for individuals and families to settle in the city, understand the NHS, and in the words of conference delegate and Consultant Pathologist Prashanth Patel, 'build a life.' BAPIO also supports UHL teams to embed their co-developed 'Dignity in Work Standards' and provide an early conflict resolution service.

GMC sponsorship
In April, UHL was authorised as a General Medical Council sponsor organisation - the first acute NHS Trust in the East Midlands to be an approved GMC sponsor organisation and the only NHS organisation in the East Midlands to have GMC sponsorship covering all specialities. As a result, UHL can recruit international doctors to any speciality, at any grade, from any country, at any time of the year without the need for Health Education England or Royal College approval. This means we can create career pathways from clinical attachment through to sub-consultant and recruit and sponsor doctors to neighbouring organisations.

East Midlands Planned Care Centre opening
The first phase of the new East Midlands Planned Care Centre at the Leicester General Hospital, opened to patients on 1 June, enabling us to improve patient experience and waiting times. The centre will be able to see around 100,000 people each year for low complexity procedure when it opens fully in December 2024. The £40m investment forms part of our enhanced plans to improve planned care access Other initiatives include targeted health inequalities projects to ensure that seldom heard communities receive more proactive care.

New 'secret' garden opens at Glenfield to honour nurses at Leicester's Hospitals
In June 2023, UHL welcomed Chief Nursing for England, Dame Ruth May, to officially open *The Daisy Garden, in Glenfield Hospital's Victorian-walled Secret Garden.*
The Daisy Garden is the latest stage in an ambitious project that began in 2016, to create the 'Secret Garden', a green escape in one of the country's top respiratory hospitals.

The Daisy Garden, was made possible thanks to funding from the National Garden Scheme, a national nursing charity and the support of a local contractor who provided groundworks. The garden is adorned with ceramic daisies, created by local artists Fiona Meagher and Paul Reiley. The daisies commemorate the UHL nurses who have been honoured with a 'DAISY Award', an international award that recognises nurses who provide above-and-beyond, compassionate care to patients and families. It is anticipated that all 50 DAISY Award winners will have their own specially-commissioned ceramic daisy in the garden.

NIHR capital award to provide more cutting-edge research equipment in Leicester

UHL was awarded £4.7 million from the National Institute for Health and Care Research (NIHR) for capital projects to support high-quality research across its NIHR infrastructure, which includes the Leicester Biomedical Research Centre (BRC).

The investment in cutting-edge research equipment further supports ground-breaking research already taking place in Leicester, for the benefit of patients and the wider community and covers state-of-the-art equipment such as CT and hyperpolarized Xenon MRI scanners, and a mass spectrometer to analyse chemicals in samples taken from patients and volunteers.

July to September 2023

Celebrating 75 years of the NHS
UHL celebrated 75 years of the NHS with a garden party held for key community representatives in the Secret Garden at Glenfield Hospital.

UHL Senior Nuclear Medicine Technologist, Hazel Williams, also marked a special service milestone of her own - 55 years of NHS service - which coincided with the birthday. When Hazel started work at Leicester Royal Infirmary in April 1968, The Beatles were number one in the charts, Sean Connery was starring as James Bond and England were football world champions. As our longest-serving colleague, Hazel was one of three UHL representatives who attended a service at Westminster Abbey to mark the 75th birthday celebrations.

Samworth Foundation provides £1.5m boost for robotic-assisted surgery at Leicester's hospitals

The number of cancer patients who can benefit from pioneering robot-assisted surgery is set to quadruple thanks to a £1.5million grant from the Samworth Foundation, the Samworth family charity. The legacy gift was made to the Leicester Hospitals Charity in 2023 in honour of local businessman and philanthropist, Sir David Samworth, who died last year aged 87, and has funded a new surgical robot at the Leicester Royal Infirmary.

More than 900 patients a year will be treated at the planned Sir David Samworth Robotic Theatre. Around 300 patients a year currently receive the cutting-edge treatment at the Leicester General Hospital, primarily for kidney and prostate cancer.

The second robot means a greater range of people – including gynaecological patients and those with rectal, pelvic and head and neck cancers – will now be able to access the ground-breaking technology and its benefits.

Robotic surgery is minimally invasive and allows greater accuracy than traditional surgery, leading to improved patient experience, fewer complications and shorter stays in hospital. The new robot also creates opportunities for the Trust to train surgeons in robotic surgical techniques.

UHL's Annual Public Meeting – thank you for joining us

In September 2023, UHL held our first in-person Annual Public Meeting since 2019 at the Peepul Centre in Belgrave. Thank you to the over 100 people who attended and the more than 300 people who visited the health and care fair earlier in the day. The work we do with partners is felt far beyond our hospital walls, and we know that to be a leading and trusted provider of healthcare, listening is vital. We heard a range of views and experiences, and value the insight this offered.

October to December 2023

Leading in healthcare, trusted in communities

In October, UHL published our new strategy, 'Leading in healthcare, trusted in communities' to support and guide our improvement over the next seven years.

The strategy, including a new vision and values, was co-produced based on feedback received in April and May 2023 from UHL colleagues, our communities and partner organisations. It confirms where we will focus our efforts to shape our future.

Leicester's Hospitals retains Gold in support for Armed Forces

In October 2023, UHL was recognised for outstanding support and advocacy of the Armed Forces by being re-awarded Gold in the Employer Recognitions Scheme (ERS).

The ERS recognises employer organisations that advocate support for the armed forces community, and UHL is one of only a few NHS Trusts to have achieved and retained a Gold award. In June 2023, we re-signed the Armed Forces covenant which contained new commitments, including, increasing paid leave arrangements to reflect 12 paid days for reserves, six paid days for cadets and two paid days for regular spouses to accommodate unforeseen military delays. We have also established an Armed Forces Network and implemented a guaranteed interview scheme for the armed forces community.

UHL to host new NIHR Regional Research Delivery Network

November 2023 saw the announcement by the Department of Health and Social Care (DHSC) that a new National Institute for Health and Care Research (NIHR) Research Delivery Network (RDN) will commence in 2024 to support the successful delivery of health and social care research in England. As part of this, 12 new Regional Research Delivery Networks (RRDNs) will be hosted by NHS organisations the length and breadth of the country, covering all English regions. After an open competition, UHL was successful in its bid to become the RRDN for the East Midlands. The RRDNs are being launched on 1 October 2024.

We are looking forward to the opportunity to further strengthen clinical research in the region, as well as working as part of a national leadership function to drive best practice across England, all with the aim of improving the health of our communities.

UHL hosts 2023 British Indian Nursing Association annual conference

We were delighted to host the British Indian Nursing Association (BINA) annual conference at Leicester racecourse in December 2023. Over 400 nursing colleagues joined us, including 150 from UHL and UHN, to discuss how we can provide a more supportive environment for overseas colleagues. We are proud of the diversity of our workforce, and grateful for our partnerships with BINA and others, including the British Association of Physician of Indian Origin (BAPIO), with whom we hosted another successful event earlier in the year.

January to March 2024

UHL and partners publish first ever annual report on prevention

In January 2024, we published our first ever annual report on prevention, which highlights the range of work being undertaken across UHL and our partners to make prevention mainstream and support local people to stay well and independent for longer.

At UHL, our vision is to be leading in healthcare and trusted in communities. A growing focus on prevention is fundamental to this and we know that in order to effect radical change in the NHS, we need to think differently about our role and the care we provide. This commitment to health equality is at the heart of UHL's new strategy.
The report shows we are already making a difference through targeted intervention on alcohol and tobacco use, tuberculosis, and colleague wellbeing, overseen by UHL's Prevention Taskforce. We know there is much more we can do.

Chest X-ray AI goes live with aim to expedite the detection of lung cancer

February 2024 saw UHL go live with Artificial Intelligence (AI) for the prioritisation of abnormal chest X-rays. The AI implementation is part of a multi-NHS site

‘LungIMPACT’ research study to gather real-world evidence of the impact of immediate AI enabled patient triage to chest CT on the lung cancer pathway.

As part of the research trial, the AI will review approximately 100-150 GP-referred X-rays each day to identify and triage the presence of potential lung abnormalities, providing immediate reporting to clinicians to make next stage decisions on CT referrals or treatment planning.

We will be evaluating the study results after completion of the trial, to assess the real-world impact of an AI prioritisation tool in early detection of lung cancer.

UHL launches a Health Equality Partnership
UHL’s new Health Equality Partnership (UHEP), a new forum designed to tackle health inequalities in the area, launched at the end of February 2023 and continues to welcome community leaders as new members.

Health inequalities are avoidable differences in health between different groups in society. There is currently a 12-year life expectancy gap between the most and least deprived wards in Leicester, Leicestershire and Rutland, with factors like ethnicity, gender and disability also playing a significant role.

UHEP advises the Trust on its growing programme of work to reduce health inequalities, including a project to improve attendance at outpatient appointments. Prior to the pilot project, the rate of non-attendance among people from the most deprived areas was twice as high as the Trust average – putting people at increased risk of future health problems. That gap has now closed following targeted action, including telephone calls to people awaiting a planned appointment, and the offer of additional support to attend where needed.

Staff survey results
In March 2023, the publication of National Staff Survey results show that colleagues believe UHL is now a better place to work than it was last year in 96 out of 103 questions. We were one of the top five improved Trusts in the country.

Over 10,000 UHL colleagues completed the 2023 survey. This is 58% of the people who work at UHL, up from 48% last year and 33% three years ago.

The results show that nine per cent more people would recommend UHL as a place to work and five per cent more people are happy to recommend UHL as a place to receive care.

These are big changes against a challenging national picture and UHL marked the results with a thank you to all colleagues who have helped make these improvements happen.

There is strong evidence that in organisations where colleagues feel consistently well supported, patient care improves meaning UHL’s goals to provide high-quality care for all and become a great place to work go hand in hand.

New maternity app to reduce health inequalities
In February 2024, a new app, developed by Professor Angie Doshani, Consultant

Obstetrician and Gynaecologist at UHL, launched with the aim of improving perinatal health, reducing health inequalities and improving maternity outcomes for new mums from the South Asian population.
The JanamApp has been designed to address educational, cultural and social barriers in pregnancy and the post-natal period by providing culturally sensitive and linguistically appropriate information in multiple South Asian languages. By providing women with validated evidence-based information in a language that they can understand and with appropriate visual images and animations the app will improve accessibility for women from different ethnic groups empowering them to make informed decisions about their care.

It's hoped the app will reduce missed and cancelled appointments by explaining the importance of engagement with healthcare and that targeted information in the app will help support women to know what to look out for and how to self-manage common issues as well as understanding when and how to raise concerns with healthcare professionals.

UHL launches kindness campaign
A new campaign to encourage kindness towards UHL staff launched in March 2024. While most of our patients and visitors show respect and gratitude, the unacceptable actions of a small minority can be devastating to the health and well-being of our teams and can have a negative impact on the care we are able to deliver.

The new kindness campaign features members of UHL's team speaking out and sharing their stories. They celebrate the diversity of our workforce and encourage us all to act with kindness and respect. The stories capture the essence of our staff – dedicated professionals working in different parts of our hospitals, who are proud to care for everyone who needs us.

Part 1
Performance Report

Operational Performance

The Trust measures a range of key performance indicators ('KPIs') in order to ensure the services we provide to patients are the best they possibly can be. These are reported to Board Assurance Committees, and to the Trust Board each month through our Integrated Performance Report (IPR).

Our performance for the year towards these targets is shown in the table below:

Performance Against National Standards

Performance Indicator	Target	2023/24	2022/23	2021/22	Trend
A&E (UHL) – Total Time in A&E (4hr Wait)	75%	57.1%	54.6%	59.4%	↑
A&E (UHL+ LLR UCC) – Total Time in A&E (4hr Wait)	75%	72.5%	68.9%	70.3%	↑
12 Hour Trolley Waits In A&E	0	13,379	11,916	3,836	↓
MRSA (All)	0	5	4	1	↓
Clostridium Difficile	92	165	119	116	↓
% Of All Adults Who Have Had VTE Risk Assessment On Admission To Hospital	95%	96.9%	97.8%	98.4%	↓
Never Events	0	4	8	9	↑
SHMI Mortality	<=100	102	104	103	↑
Urgent Operations Cancelled Twice	0	18	10	8	↓

Green = Target Achieved
Red = Target Failed

Green upward arrow = Improvement against previous year (Target Achieved)
Green downward arrow = Deterioration against previous year (Target Achieved).
Red upward arrow = Improvement against previous year (Target Failed)
Red downward arrow = Deterioration against previous year (Target Failed).

Urgent and Emergency Care

We have made significant improvements in our emergency care pathway during the 2023/24 and continue to work with partners across Leicester, Leicestershire and Ruland to improve pathways of care.

In 2023/24 we have:

- Expanded our discharge lounge at the LRI doubling the current capacity for bedded patients.
- Improved our discharge processes to get people home, or to the right place for their onward care, more swiftly
- Built additional bedded capacity at the Glenfield Hospital
- Expanded Same Day Emergency Care Services at the Leicester Royal Infirmary and developed the new unit at Glenfield Hospital
- Opened a high-quality escalation facility for times when we are under significant pressure
- Opened rehabilitation capacity at the Leicester General Hospital

Every month in 2023 has seen fewer hours lost to ambulance handovers than winter 2022 resulting in improved category 2 response times, and we have safely discharged an average of 700 more patients per month than in 2022.

During the last few months of 2023/24 we were challenged with ambulance handover times – our ability to take patients from ambulances and into our emergency department – due to challenges of demand for our services putting pressure on capacity and patient flow in our services.

This demonstrates the need to further improve our UEC performance. We failed to meet the Emergency Department 4-hour standard in 2023/24, with performance of 57.4% (type 1 and 2) and 72.7 (type 1-3 across LLR) against a target of 76. Emergency Department attendances (type 1 and 2) was higher than 2022/23 with an increase of 10291 attendances (type 1 and 2) compared with 22/23 with a 5763 increase in Q4. 12-hour trolley waits saw an increase from 10% in April 2023 to 12% in March 2024 due to the increased pressures in our UEC pathways, and capacity and flow challenges meaning patients often waited for a bed in our emergency department for much longer than we would have liked.

Our strategy for improving emergency care performance remains focussed on ensuring patients always receive the right care in the right place. This includes:

1. Flow into UHL: ensuring that patients only present at our hospitals when they need to and ensuring appropriate provision of services outside hospital to meet patient needs.
2. Flow through UHL: ensuring a quick access to diagnostics and specialities, so that patients can get the care they need to be readied for discharge.
3. Flow out of UHL: ensuring timely discharge when patients are ready to go home or to onward care.

In 2024/25 we will:

- Create a single point of contact for non-specialist referrals supporting our GP colleagues to refer patients to the right services first time
- Further develop our emergency care services including the Glenfield Chest Pain Centre
- Develop our medical day case services reducing length of stay and offering treatment on a day care basis to appropriate groups of patients.
- Implement and embed digital solutions such as e-beds – a more efficient bed management system
- Continue to work with our partners on all aspects of UEC including improving access to Urgent Treatment Centres
- Mobilise a new transport provider for renal services, transfers across our sites and discharge.

Within our organisation, progress is overseen by the Operations and Performance Committee.

Planned Care

Our performance
In 2023/24 we have continued to build on the progress we made in 2022/23 in reducing our total waiting list and the time it takes to receive definitive treatment at UHL. For context, the elective waiting list grew by 65,000 (87%) in first two years of Covid which was the largest proportional increase in the NHS. Our focus on reducing our waiting list has led to achievements including:

- Our waiting list has decreased again over the year (March 2023-March 2024) and is now standing at **109,027**.
- Zero 104 week waiters by July 2023 and we have maintained this position through the rest of the year.
- In March 2024 our final reported 78 week waiter position was **18**.
- In March 2024 our final reported 65 week waiter position was **259**. In January 2022 UHL's 65+ week waiters accounted for 7.9% of our total waiting list. By comparison, in January 2024 we have dropped our 65+ week waiters to just 0.7% of our total waiting list.
- In March 2023 there were over 68,500 people on the UHL waiting list who would have waited over 65 weeks for their care if not treated by the end of March 2024. At the end of March 2024 there were just **259** – which means we have delivered definitive treatment to over 68,000 people who would otherwise have been waiting over 65 weeks in March 2024.
- In the calendar year 2023, Leicester, Leicestershire and Rutland Integrated Care System showed a 77% reduction in the number of people across LLR waiting more than a year for treatment, the biggest reduction of any system in England. We also saw the largest reduction in people waiting 65 weeks or more, and the second largest overall reduction in people waiting for treatment.

These are achievements we are proud of given the backdrop of unprecedented industrial action that has taken place throughout the year. However, we also accept that people are still waiting for longer than we would like on our waiting lists.

What we did

The key tenets of the operational plan for planned care falls into three key themes; improving productivity (making our processes as efficient as possible), increasing capacity (ensuring we have the right services and facilities in place) and partnership (building strong links with our partners).

Within this, areas of focus included:

- Excellence in basics - maintaining a strong focus on productivity, data quality, validation, clinical prioritisation and maximising booking rates
- Performance and long waits - continue to reduce waits of over 52 weeks as well as our overall waiting list
- Outpatients - maximise potential in our outpatient system including productivity and utilisation of capacity
- Choice – enabling patients to have informed choice in where they receive their treatment, by continuing to utilise mutual aid offered by our NHS partners and the Independent Sector (IS)

UHL has worked on all these priorities and more to reduce the length of time patients are waiting for their diagnosis and treatment.

We have also focused on digital improvement initiatives in 2023/24, including moving to a single platform for text messaging. Initiatives have included:

- two-way patient messaging; the introduction of two-way text messaging has meant that we can send an automated text to patients at 7, 3, 1 days before appointment (in line with national standards) with functionality for patient to reply with cancel/cancel and rebook, this has made it easier for patients to communicate with our services and replaced the need for administration teams to send out appointment reminders manually
- appointment reminders
- options for a digital Patient Initiated Follow-up (PIFU) which provides patients with a link to instantly message their care team when they have a query or need support
- waiting list validation, ensuring improved waiting list accuracy
- further types of communications with patients include the roll out of pre - procedure questionnaires helping to resolve any patients' needs or queries before their procedure, and a DNA Florey launched in August 2023 which has seen an average response rate of 40%, and has provided our services with a valuable insight into why patients do not attend their appointments, and provided us with an opportunity to make any necessary changes and improvements

Plans for 2024/25

Areas of focus for 2024/25 – continuing from 2023/24 – include:

Inpatient/Admitted Pathways

- Improve overall theatre utilisation to 85% and focus on High Volume Low Complexity specialties and associated GIRFT best practice targets
- Increasing Day surgery rates to 85%

- Reducing On the Day Cancellations (OTDC)
- Improving the average number of cases per list (ACPL)
- Delivery of effective Pre-operative Assessment (POA) processes

Outpatient Pathways

- Transforming outpatient services with a focus on addressing inequalities in our waiting lists.
- Improve PIFU (Patient Initiated Follow Up) rates in line with GIRFT guidance and locally implemented stretch targets
- Reduce outpatient DNA and cancellation rates, with a focus on health inequalities
- Reduce outpatient follow up relative to first appointments
- Clinical and administrative waiting list validation
- Review of outpatient clinic utilisation and admin processes, implementing best practice clinic guides

Across all pathways

- Ensure that available resources are utilised effectively and efficiently across all elective programmes, delivering value for money (VFM).
- Improve patient experience for all by responding to patient feedback and extending engagement with our service users
- To build on the strong elective partnerships built across UHL and the LLR system and to continue to work closely with NHS partners, including University Hospitals Northamptonshire
- To maximise the additional capacity coming fully online in terms of the East Midlands Planned Care Centre (EMPCC).
- To improve utilisation of the community hospital capacity in LLR, Hinckley CDC and the Endoscopy capacity at the LGH opening in late 24/25.

By March 2025 we aim to have no one waiting over 52 weeks for their care.

Cancer

There has been significant progress in cancer waiting times in 2023/24, whilst there remains much more to do in 2024/25 and beyond. We exit the year having reduced our backlog of patients waiting longer than 62 days from its highest point in November 2022 by more than 70% and at half the amount since the start of 2023/24. We have also improved access to cancer diagnosis and have been consistently achieving the faster diagnosis standard to diagnose more than 75% of patients within 28 days of urgent suspected cancer referral since September.

At the beginning of the year 503 patients had waited beyond 62 days and this has fallen to 239 by the end of the year. Three specialties continue to hold the proportion of the backlog; urology, lower gastroenterology, and skin, however all have made significant progress in reducing patient delays and are ahead of internal improvement trajectories.

In March 2024 57.8% of patients with a confirmed diagnosis of cancer were treated within 62 days. The focus has been to increase the number of patients diagnosed within 28 days and to continue to treat patients in order of clinical prioritisation and wait time. Within this, a key area of focus is the aim to treat people within 31 days of a

decision to treat. This is an area where we must improve, and a key part of this is the radiotherapy linac replacement programme due to complete in 2024/25.

Cancer Pathway Improvements in 2023/24

- With support from our partners, including East Midlands Cancer Alliance we continue to invest in our cancer services for the population of Leicester, Leicestershire and Rutland. This has included being able to provide some additional insourced capacity to support dermatology diagnostic and urology outpatient demand, reducing wait times for patients. This collaborative approach led to a HSJ Partnership Award Win in 2024 for the most effective contribution to improving cancer outcomes.
- A second DaVinci surgical robot has been gifted through charitable funds from the Samworth Foundation. This is located at the Leicester Royal Infirmary and supports surgical treatment for patients under the care of colorectal and head and neck
- As part of increasing personalised care, there are now almost 5000 patients on a Personalised Stratified Follow Up Pathway (PSFU). This supports remote monitoring of patients post cancer diagnosis and treatment, ensuring timely access to re-attend our services should the need arise.
- Through the use of digital solutions in partnership with AccurX, within the chemotherapy SACT suite we have been able to communicate on-the-day delays to individual patients helping to reduce the stress caused by waiting for treatment as well as batch messaging to remind patients to get their pre-treatment bloods. AccurX is also used to support patients on PSFU pathways for test reminders and to support patient-initiated contact using QR codes.
- Skin teledermatology capacity increased across our hospitals to support increased demand in and reduction in wait times for dermatology skin referrals
- Lynch surveillance has been embedded for all colorectal and gynaecology patients which supports earlier detection and prevention of cancer through risk reduction treatment and appropriate surveillance
- We have increased the timeliness of tracking patients through their pathway, by improved processes and additional administrative support. 97% of all patients are tracked within 7 days as a minimum
- The cancer outcomes and services dataset (COSD) staging compliance was achieved in Q3
- There has been an increase in the use of colon capsules and cytosponge diagnostic tests which support earlier diagnosis of lower and upper gastrointestinal cancers
- The brain pathway was re-designed this year with primary care taking a lead role. This has reduced waits and ensured appropriate timely onward referral to Nottingham for appropriate treatment
- Immunotherapy capacity has been increased through the use of a mobile treatment centre based at the Glenfield Hospital, with plans to extend this to chemotherapy treatments in 2024/25
- We continue to work in collaboration with the East Midlands Acute Providers Network for Oncology, Radiotherapy and Head and Neck Pathways
- In partnership with Macmillan a Health and Wellbeing community event was held to increase awareness, offer support and signpost patients and their families. The charity also provided a grant to refurbish the Macmillan Information and Support Centre at the Leicester Royal Infirmary.

Diagnostics

UHL has seen significant improvement in diagnostic performance in 2023/24. The overall waiting list has reduced by 20% from 31,477 to 25,672, the number of patients waiting six weeks or more has reduced by just under 60% from 14,278 to 6,077 and patients waiting 13 weeks or more has reduced by 64% from 7,265 to 2,611. This was delivered despite workforce challenges in some areas and increased pressure from supporting Referral to Treatment (RTT) long waits, cancer and emergency pathways.

Nationally the expectation in 2023/24 was for organisations to ensure 85% of patients waited less than six weeks for a diagnostic test, UHL's figure was 56.1% in April 2023 improving to 76.3% for March 2024. We recognise that there is more that we need to do to reduce the waiting time for diagnostic services to deliver the 2024/25 standard of 95% of waits within six weeks by March 2025.

Key achievements throughout the year included

- Significant reduction in the volume of patients waiting for an ECHO, non-obstetric ultrasound and DEXA test
- The average number of tests increased by over 4,000 more per month when compared to the previous year
- Secured £24million capital investment for the Hinckley Community Diagnostic Centre and the Endoscopy New Build at the Leicester General Hospital
- Supported an additional modular endoscopy unit at the Leicester General from July 2023
- Successful international and local recruitment to the Imaging teams

Plans for the year ahead

Our strategy for improving diagnostic performance remains aligned to the overall planned care strategy focusing on getting our process fundamentals right, increasing productivity, using our new capacity and continue to work in partnership with other providers. Our plans include:

- Opening of the Hinckley Community Diagnostic Centre in January 2025 and New Build Endoscopy Unit February 2025
- Continue to reduce the overall waiting list and time to wait in Endoscopy and Imaging
- Achieve target of 95% patients receiving a diagnostic test within 6 weeks of referral

Quality

Improving Quality

Our aim is to provide safe, outstanding care whilst ensuring we treat each patient as an individual. We continuously strive to deliver the best outcomes, the best experience and one which is free from hospital acquired harm. This ambition underpins our goals, guides our values and is reflective of our continued approach to Quality Assurance and Improvement.

We are extremely proud of our staff who have continued to demonstrate courage,

resilience, care, and compassion whilst often facing significant operational pressures for not only providing care for our patients but for also continuing to care for each other as unique teams.

Although challenging, our achievements over the last 12 months have continued to flourish. We have many successes to be proud of and continue to develop, sustain, and nurture improvements in quality care.

We have continued to work to reduce Hospital Acquired Harms, specifically Falls and Hospital Acquired Pressure Ulcers and Catheter associated Urinary Tract Infections. Whilst there are still improvements to be made, our teams have continued to develop specific quality assurance and improvement approaches to reduce these avoidable harms.

Our Tissue Viability team has collaborated with a National Wound care specialist team, offering a multidisciplinary approach to the reduction of Hospital Acquired pressure ulcers. A new Telehealth service has also been established supporting our evolving digital journey and accessibility to specialist wound care. Our Tissue Viability team have also introduced the use of highly specialised virtual operational glasses to not only develop our digital journey but encourage education and collaborative working in the provision of enhanced wound care technology. Our Teams journey has also continued as a multidisciplinary team approach has been developed and embedded across all ward areas to deliver a senior weekly review of pressure changes so that immediate care and learning can be reviewed and acted upon. This continuous improvement approach will continue throughout 2024/25 and underpin the team's approach to embracing advancing technology, wound care techniques and collaborative working as we continue to reduce Hospital Acquired Pressure Ulcers and provide improved wound care support and advice.

Inpatient falls continue to remain below the national average and our Falls Team continually strive to reduce avoidable falls. Throughout 2023/24 the team have delivered an annual programme of road shows focusing on lying and standing blood pressures as a key focus of early recognition of falls risk, allowing preventative measures such as enhanced observations to be proactively identified. High visibility blankets have been trialled across our emergency department and developing technology falls sensor devices are now being procured to reduce the risk of falls for our patients. Throughout 2024/25 our Falls team will be focusing on post fall care and will be delivering a programme of falls recovery training including neurological observations whilst also working alongside an external researcher to consider further falls reduction measures.

Our Continence Team have continued to deliver a portfolio of quality improvement initiatives, driving forward a reduction of indwelling catheter and associated urinary tract infections. Our specialist nurses have been nominated and attended an external national nursing award ceremony for their continued initiatives in continence alternatives. This followed the teams successful launch of the “Taste the difference” campaign which was launched at Leicester Hospitals with the aim of promoting decaffeinated teas and coffees in the healthcare setting to reduce the effects of incontinence. The team have worked hard to assess innovative technologies in continence and have successfully launched two new devices to reduce the use of indwelling catheters and to minimise the risk of infection in patients who require these.

Throughout 2024/25 continence will continue to be transformed as our specialist team are going to lead a research initiative that supports a quality improvement and assurance approach to our continued reduction of Catheter Associated Urinary Tract Infections and improved continence outcomes for patients.

Our Assessment and Accreditation programme previously launched in 2019 aimed to ensure that patients receive safe, high-quality care, through the provision of a set of agreed standards and quality indicators, with the aim of ward areas achieving “Blue Ward” status. However, it was recognised that this process required a modernised approach to include the use of digital data and technology and needed a focus on continuous improvement. The assessment and accreditation process is therefore being developed further based upon a successful model created and implemented at University College London Hospitals NHS Foundation Trust.

In August 2023 we began a programme of Quality Assurance Visits to ensure a continuous approach to quality assurance, whilst we developed collaboratively with stakeholders our newly anticipated Leicester Excellence Accreditation Framework model of Improvement. During this time our Quality Team have undertaken 93 Quality Assurance visits, considering 54 elements of quality and safety to ensure the provision and assurance of safe, quality care is assured across our hospitals.

As we move in to 2024 our newly formed Leicester Excellence and Accreditation Framework (LEAF) will combine an in depth, interactive quality management dashboard with a continuous quality improvement process to provide an overarching accreditation process which will continue to ensure patients receive safe, high-quality care delivered by a multidisciplinary team of Nurses, midwives and Allied Health Professionals. This will be piloted, launched and embedded across our hospitals throughout 2024/25.

LEAF’s integrated approach to Nursing, Midwifery and Allied Health Care Professional Excellence will aid the creation of capacity and capability utilising data from digital systems to underpin continuous improvement. Our evolving Harm Free teams and Pathway to Excellence Journey which is now within its fifth year of development will underpin the foundation to support this.

It is our intention to ensure that LEAF and Pathway are synonymous across the organisation, supporting us to create a culture of engagement, inclusion and improvement across all staff groups bringing corporate priorities together.

The Pathway Team have been instrumental in engaging with all staff groups during 2023/24 to support our Pathway journey ambitions. Achieving designation will help support the organisation to show a commitment to creating the foundations of a healthy workplace.

Our greatest achievement in 2023/24 has been gathering, editing, and sending the specified evidence to the ANCC (American Nurses Credentialing Center). This was to support our pre-intent programme to apply for designation at Glenfield Hospital.
The team have led a campaign of promotion and engagement with all 6 of the standards across the Trust. We have adopted a space theme for our Pathway theme to acknowledge Leicester’s link with Space. This has been a factor in designing materials and getting teams engaged with the Pathway journey.

Shared Decision Making The team have provided training to members of the shared decision-making councils and facilitate the transition to a model of Shared Decision Making throughout the organisation encouraging a true multidisciplinary team (MDT) approach. There are now more than 80 Shared Decision-making Councils across the Trust.

Leadership The team have created and distributed monthly newsletters for the Pathway stars and shared decision-making councils. The Pathway star initiative has been implemented to support front line staff delivering pathway messages in their clinical areas.

Safety The team have collaborated with clinical teams who support the safety agenda to ensure that the messages to staff are joined up. For example, promoting the safety standard alongside sepsis awareness week.

Quality The team have supported staff to plan and initiate quality initiatives to support patient care. They have undertaken quality improvement training to help support the Trusts' continuous improvement journey.

Wellbeing The team have supported several staff well-being initiatives and have implemented the BEE award in 2023/24 to be inclusive of all staff groups, as well as the ongoing DAISY programme which achieved its ambition of more than 24 DAISY honourees for the year.

Professional Development The team have held 3 Pathway themed conferences during 23/24 for frontline staff to support staff development. These have evaluated very positively and have given staff an opportunity to highlight their excellent work and to network with colleagues.

Creating a positive practice environment inspires frontline staff and has a direct impact on improving job satisfaction, staff retention, patient safety, and quality outcomes. We have seen this positive impact of this through engaging with staff groups through our shared decision-making councils and pathway stars forum.

Sustainability

UHL is working proactively with the ICB to develop a joint sustainability plan across healthcare in Leicester, Leicestershire and Rutland (LLR). As one of the largest NHS Trusts in the UK we recognize our responsibility to the people we serve, our staff, our communities, and the planet. We want to be ambitious with our sustainability program as part of our journey to Net Zero Carbon.

We recognise the scale of the challenge, not least the financial constraints the Trust faces, particularly with capital funds. However, we do have an opportunity to improve our revenue position through invest to save schemes and investment in more efficient buildings. The New Hospitals Programme affords a unique opportunity to make a step change in this direction.

The sustainability programme covers many workstreams and will require collaborative work across the local health economy linking all key stakeholders within our Trust, across all levels of seniority, on all sustainable matters. Embedded within this

programme will be work streams that will trial and test new ways of working, both in clinical and non-clinical environments. There will be challenges and maybe setbacks along the way but with corporate backing and the commitment of our leaders and staff, we will continue to move forward towards our goals.

At the heart of our strategy sits our Trust Board approved green plan. This plan addresses key objectives set by NHS England (NHSE) and the Greener NHS Team

The Green plan sets targets for achieving net zero carbon emissions at UHL. There is a need to be innovative in our approach to sustainability in order to hit these targets. UHL is seeking to achieve an 80% reduction by 2028-32. The need for a significant shift in mind set around sustainability management in the NHS is clear if we are to achieve carbon net zero by 2040.

The sustainability agenda is multi faceted and will touch every aspect of our operation. The Green Plan identifies key areas which are being targeted, these are listed below:

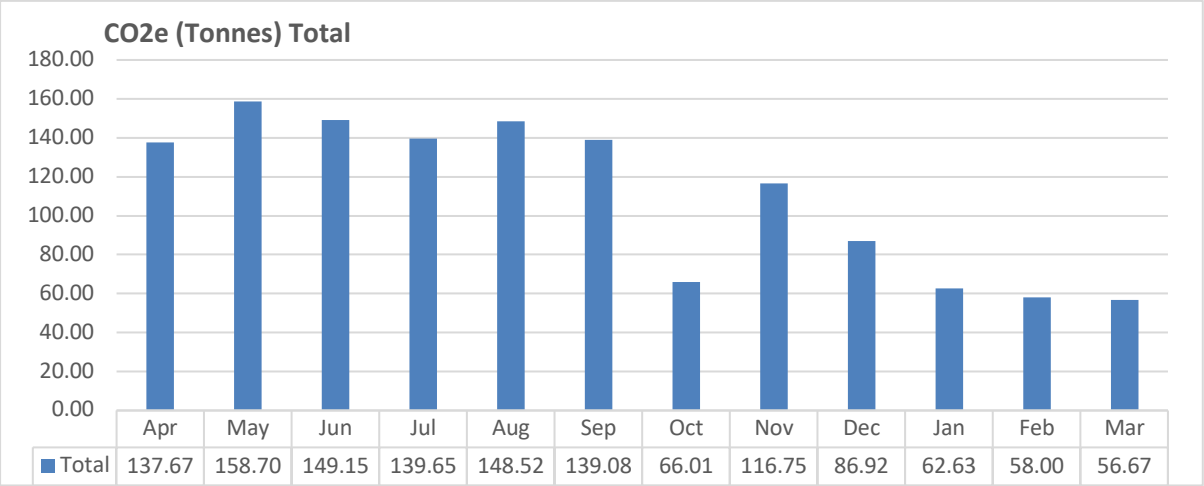
- Workforce and system leadership
- Sustainable models of care
- Digital transformation
- Sustainable Travel and transport
- Estates and facilities sustainability
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation to Climate Change
- Carbon Footprint
- Communicate the Green plan and Reporting progress

Key achievements this year

Waste Management

One of the biggest areas of focus for us this year has been improving the management of waste across our sites. The success of this workstream demonstrates that sustainability objectives can be achieved through business as usual activity which was driven by compliance rather than sustainability objectives. With joined up thinking and good planning multiple gains can be made.

UHL requires clear, concise data, and new data collection methods are being developed in conjunction with NHSE to enable a more granular calculation of our carbon footprint to allow us to provide a baseline from which progress can be understood, this combined with additional phased resource will support this task noting that we have 358000 sq. metre of aged estate, this is compounded by the fact that elements of UHL estates areas are over 60 years old. The data below is what we hold for waste management and shows our carbon reduction of 47.34% for waste.



Achievements delivered this year include:

- Segregation of waste into appropriate waste streams to allow cost efficient disposal.
- Achieving compliant disposal of our waste meeting statutory obligations.
- Behavioural change team training front line staff at ward and department level
- Starting to maximise the opportunity for recycling and reuse.
- Zero waste to landfill target met. Giving a carbon reduction of 47.34%
- Completion of capital works to provide modern, safe, compliant, waste handling facilities on all 3 sites.
- Trust wide Waste Management Committee now firmly established.
- Waste and carbon tracker created and held on SharePoint
- Duty of Care obligations all completed and in date
- Pre acceptance Waste audits all completed and in date

Not achieved this year include:

- Appointment of a dedicated waste manager.

Plans for 2024/25:

- Appoint a dedicated waste manager
- Consolidation of compliance across all waste streams
- Achieve waste volume reduction relative to clinical activity
- Launch recycling schemes across UHL
- Introduce furniture re-use programme Trust wide

Travel and access

Traveling to work is not all about car parking. Whilst we recognise that for some it may be the only viable means of accessing our hospitals, we need to work to develop alternative and more sustainable options.

Achievements delivered this year include:

- Committing to a extending the Hopper bus contract for a further year pending a full tender exercise
- Extending the service with six additional pick-ups at peak times

- The continuation of the weekend service funded by Leicester City Council (LCC)
- Employment of Optibus to map the areas where our staff live and compare it with the bus provision. Thus, enabling informed dialogue with LCC
- Opened meaningful dialogue with LCC on extending the Park and Ride (P&R) service to meet LLR health workers' needs.
- Refurbishment of changing facilities for cyclists.
- Provision of cycle maintenance sessions to all sites
- Cycling UK providing training sessions to staff
- Working with LCC to provide free e-bike loans to staff
- Staff have access to travel discount scheme
- Travel survey completed – we are now creating a heat map so we can identify where we need to apply our energy for improvements
- Full review of Hopper bus and the timetable
- Completion of phase one of the car parking permit and control system

Not achieved this year include:

- Appointment of Head of Travel

Plans for 2024/25:

- Appoint a Head of Travel
- We hope to increase the frequency of the Hospital Hopper to every 15 minutes
- Extend the opening hours of park and ride sites
- Replacement ebike dock scheme
- Overhaul of car park permit system with the introduction of new automated car park management system
- Improve communications for all travel including new area on the hospital website
- Complete Phases two and three of the car parking permit and control system

Energy update

In our efforts to enhance operational efficiency and to adhere to the wider NHS England Green Plan, we continue to make every effort to decarbonise our operations. We have embarked on a new journey towards energy efficiency across the three hospitals under UHL. We reviewed our energy infrastructure and identified gaps that we seek to amend from our energy fuels, machinery, heat generation and distribution network and consumption.

Presently, we are ensuring that our current assets such as the Boiler house are infrastructure aligned with defined market standards while we perfect our decarbonisation and transition plans to a more sustainable future. We have worked closely with the National Gas Metering team to review the suitability of our present infrastructure while considering our future consumption. Repairs have been identified and already being effected to mitigate the risk of supply. Furthermore, we have also discussed our distribution infrastructure aspirations with the National grid which doesn't seem too promising due to grid availability, cost and time for construction hence there is a dire need to consider decentralisation (local production and consumption of energy) where appropriate.

We are continuing to review sustainable energy options to help us mitigate our C02 emissions, as we have been one of the highest emitters in the Midlands region. We are in discussion with our present energy partners such as 2G to consider Hydrogen options etc. We are also in application for grant support to fund studies to identify and understand the feeble state of our heat network. There is a dire need to look beyond the heat distribution network to the façade of our buildings ability to retain heat and offer thermal comfort to occupants given that our buildings are quite old. Investment will be needed to address the heat efficiency of our existing buildings.

At the epicentre of every transition are dedicated people to enable the desired change, hence we have set up our energy champion scheme to foster behavioural change in our team from energy and water use. These programmes will be led by members of the green meeting with the primary objective to communicate and lead the implementation and adoption of green initiatives across UHL.

Achievements delivered this year include:

- We released a green plan video to educate our colleagues on the efforts of Estates and Facilities department
- Created Green Plan on a page to aid staff understaff the benefits
- Secured £1.7m funding to replace old lighting with LED lighting

Not achieved this year include:

- Appointment of an energy manager

Plans for 2024/25:

- Appoint of an energy manager
- Launch energy saving campaign through Behavioral Change, we expect this to reflect a 5% reduction in energy consumption
- Drive a reduction in energy consumption relative to clinical activity
- Hold sustainability workshops / drop in clinics
- Carry out heat network study
- Identify project financing options to afford the transition
- Installation of £1.7m of LED lighting across the sites

Task force on climate-related financial disclosures' (TCFD)

The Department of Health and Social Care Group Accounting Model (GAM) has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be fully incorporated into sustainability reporting requirements on a phased basis up to the 2025-26 financial year, with the exception of the requirement to disclose scope 1, 2 and 3 greenhouse gas emissions and the related risks as part of the metrics and targets pillar.
The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024-25. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications."

Governance for 2024/25

- Quarterly Trust Leadership Team update
- FIC and board – 6 monthly & annual sustainability report
- Audit committee update on plan and Internal Audit
- Set up steering group
- Wider publicity of UHL green plan

Strategy

In order to address the sustainability agenda a number of workstreams have been established. These are collated in the table below and will be taken forward by lead departments together with key stakeholders:

Delivering Net Zero
UHL Sustainability Plan
Workforce and Leadership
Sustainable Models of Care
Digital Transformation
Sustainable Travel and Transport
Estates and Facilities
Medicines
Supply Chain and Procurement
Food and Nutrition
Waste
Adaptation to Climate Change
Carbon Footprint

Risk Management

There are a number of risks identified on the Trust risk register. These are generated as a result of lived experience and are therefore mainly concerned with overheating during hot weather. The table below captures the recorded risks.

Subject	Risk Ref	Risk Rating	CMG/Directorate	Risk
Climate	3204	9	CSI	Environment
Temp +/-	1295	12	CSI	Environment
Temp +/-	3363	12	CSI	Environment
Temp +/-	3090	12	UHL in Community	Environment
Temp +/-	4110	8	IMT	Environment
Temp (Heatwave)	3292	20	Corporate	Demand and Capacity
Temp (Cold)	3284	9	Corporate	Demand and Capacity
>Illness / pandemic	3296	12	Corporate	Demand and Capacity
Flood	3959	12	IMT	Environment
Natural Resource	3291	6	Corporate	Demand and Capacity

Further risks will be recorded as they emerge from the workstreams. There is an awareness of risks around infrastructure relating to the pipes and wires required to move to Net Zero Carbon (NZC). This will relate to the on-site infrastructure and that of the supplying authorities.

Metrics/Targets

NHS England Objective	UHL Objective	Target
Estate and facilities	Reducing emissions from hospitals	Started
Travel and transport	Electrification of the NHS transport fleet	2025/26
	Cycling, walking and shifting modes of transport	On Target
Supply chain	Decarbonising the supply chain	Started
	Food, catering and nutrition	Started
Medicines	Low carbon inhalers	On Target
	Anaesthetic gases	Started
Sustainable models of care	A new service model for the 21st century	2025/26
	Further progress on care quality and outcomes	2025/26
	NHS action on prevention and health inequalities	2025/26
	A digital, low-carbon transformation	Not Started
Workforce, networks & system leadership	Building capability in all staff	On Target
	Spreading and scaling what works across our LLR	Started
	Embedding sustainability across the NHS	Started
Funding and financial mechanisms	Improving information and data, including common measures of carbon to enable fair decision-making	Started
Data and monitoring	Evidence-based targets and data to underpin the analysis and	Started

Embedding Research and Innovation 2023/24

This year, we recruited 13935 participants into research: of these, 12354 we recruited to National Institute for Health and Care Research (NIHR) portfolio studies and 416 took part in commercial trials. While the total number of participants has decreased in the last year, the complexity and intensity of studies has increased.

There were 618 open studies, including 96 commercial trials. Our researchers have published 996 papers in peer-reviewed journals.

Research and Innovation generated £47million of income in 2023/24, of which £3.6 million came from commercial research. In line with the UK Government strategy for the Life Sciences, we have prioritised the rebuilding and expansion of our portfolio of commercial trials. Our recruitment to these studies is almost equal to all other trusts in the East Midlands combined, meaning that more UHL patients can access potentially life-changing treatments. Furthermore, these commercially funded interventions have a cost saving because they are not paid for by the NHS (National Health Service).

UHL have been awarded £4.7million of capital monies from the NIHR to support the development of our research infrastructure. Projects include a new MRI scanner at Glenfield Hospital, a new instrument based at Leicester Space Park for discovery science in respiratory medicine and equipment for a Lifestyle Research Laboratory at Leicester General Hospital. This is the second time in 10 years that NIHR have made such an award nationally and this investment will provide a significant boost to the type

and quality of research we can conduct at UHL, making us more attractive to national and international partnerships.

More than £14million has been awarded to Leicester Lifestyle and Health Research Group over the next five years who are based within the Leicester Diabetes Centre at LGH. The funding award will help to expand research which could help those from multi-ethnic communities with chronic conditions (such as type 2 diabetes, obesity and heart disease) live longer and better lives.

In terms of patient experience, over 5% (519) of our research participants shared their feedback on taking part in research. More than 90% said they would take part in research again. 97% agreed or strongly agreed that research staff treated them with courtesy and respect.

Some research highlights for the year include:

- A Leicester study looking at the longer-term impact of COVID-19, published in The Lancet Respiratory Medicine, found that nearly a third of patients displayed abnormalities in multiple organs five months after infection, some of which have been shown through previous work to be evidence of tissue damage.
- The findings come from the C-MORE (Capturing the MultiOrgan Effects of COVID-19) study, a multi-centre MRI follow-up study of 500 post-hospitalised COVID-19 patients, which is a key element of the national PHOSP-COVID platform, led by the University of Leicester within the NIHR Leicester BRC, investigating the long-term effects of COVID-19 on hospitalised patients.
- The NIHR Leicester Biomedical Research Centre's PHSOP-COVID team's tireless work to understand the long-term health implications of COVID-19 has seen it shortlisted as a finalist for the Outstanding Team Impact Award by the Medical Research Council. The team's research, which has taken place across UHL since the pandemic, has made some important discoveries on issues associated with COVID-19, including patient recovery outcomes; lung damage; breathlessness; organ abnormalities and the role of blood clots in cognitive problems.
- The UHL team who developed a 'virtual ward' to safely treat patients with an abnormal heart rhythm from their own homes were recognised with the 'Acute Sector Innovation of the Year' Award from the Health Service Journal. In the NIHR Leicester BRC study, patients with a fast heart rate due to atrial fibrillation or atrial flutter provided measurements at home via an app and monitored by clinicians remotely; delivering hospital level care for patients in the comfort of their own home.
- The number of cancer patients who can benefit from pioneering robot-assisted surgery will quadruple thanks to a £1.5million grant to the Leicester Hospitals Charity from the Samworth Foundation. More than 900 patients a year will be treated at the planned Sir David Samworth Robotic Theatre. Around 300 patients a year currently receive the cutting-edge treatment, primarily for kidney and prostate cancer. A second robot will mean a greater range of people – including gynaecological patients and those with rectal, pelvic and head and neck cancers – will now be able to access the ground-breaking technology and its benefits

Health inequalities:

Delivering high quality care for all is a strategic goal for UHL. We have continued to make steady progress against health inequalities with a growing body of work focused

on addressing specific inequalities alongside a strategic commitment to embed health equality and inclusion in all we do. The positive progress that has been made over the past twelve months sets strong foundations on which to continue to drive and lead change in this area.

NHSE Statement on Information on Health Inequalities

NHS England's Statement on Health Inequalities was published in November 2023. This describes the information that is required to be collected, analysed and published by NHS organisations with respect to health inequalities, the full details of which can be found here. Five key indicators are directly applicable to UHL; these are outlined below.

- Elective activity vs pre-pandemic levels for under 18s and over 18s
- Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under
- Emergency admissions for under 18s
- Proportion of adult acute inpatient settings offering smoking cessation services
- Proportion of maternity inpatient settings offering smoking cessation services

While the Trust does not regularly publish all of this data (the exception being smoking cessation services via the NHSE tobacco dashboard), it is available within UHL and can be disaggregated by ethnicity and deprivation. This data has been used in four of the five indicators to inform targeted work to address health inequalities. This is summarised below:

- Elective activity vs pre-pandemic levels for under 18s and over 18s: improving non-attendance at outpatients for patients over 18 has led to consistent improvement in non-attendance rates for the most deprived (IMD1 and 2) patients.
- Emergency admissions for under 18s: the paediatric emergency team delivered outreach sessions to patients in the most deprived (IMD1 and 2) communities where data had demonstrated higher than average attendance at the paediatric emergency department.
- Smoking cessation services (adult inpatient and maternity inpatient): data confirms that most people who smoke are from the most deprived communities. In the past 12 months, significant focus has been on increasing referrals of patients into the service to ensure as many patients as possible are accessing the service.

UHL Health Inequalities Improvement Programme of Work

UHL has continued to embed and develop the Health Inequalities Improvement programme throughout 2023/24. With over 30 individual projects in the programme, improvement work in health inequalities is proactively happening in all clinical management groups. The aim of this programme of work is to ensure there is oversight of the breadth of work that is happening across UHL whilst providing support to colleagues working in this field. The programme covers a wide scope for example, projects include establishing robust datasets for service improvement to improving access to screening programmes to developing apps to support patients for whom English is a second language. The learning from these projects is shared regularly with the Trust's Health Inequalities taskforce and through internal governance processes the Trust Board.

Working With Partners

'Partnerships for impact' is a further strategic goal for UHL and will be crucial for embedding health equality and inclusion in all we do. Key to this are the partnerships that UHL has with our communities and local partners. Throughout 2023-24 UHL has

worked proactively and productively with several key partners, including but not limited to:

- The Centre Project
- Shama Women's Centre
- Jamilla's Legacy
- South Asian Health Action
- Action Deafness

Key areas of focus have included access to outpatient services for under-represented groups, prevention and health literacy, implementation of the Accessible Information Standard. There has been significant progress this year.

Recognising the importance of these partnerships and following several months of engagement with communities and partner organisations the UHL Health Equality Partnership (UHEP) was launched in February 2024. UHEP exists to drive change, strengthen community links, enhance our cultural competence, and inform the actions we take to progress from inequality to equality and equity. Its membership comprises individuals and representatives of groups that are known to experience additional barriers and health inequalities. The group has three core functions:

1. Intelligence and Insight
2. Outreach and Connection
3. Perspective and Advice

In its performance of the above, the group ensures that UHL is accountable to local groups and communities that are known to experience discrimination and poorer health outcomes. Its overarching goal is to guide and influence our trajectory to fairer, safer, and inclusive hospital services.

Effective partnerships across the health and social care partnership are also key to the improvement of health inequalities through joined up working to address the impacts of the wider determinants of health. UHL has continued to proactively work with Integrated Care System (ICS) colleagues on a range of projects specifically focused on addressing health inequity, for example ongoing work to address ethnicity related disparities in maternal health. The outcomes of this are shared across the Health and Care Partnership to ensure a shared approach to addressing disparities.

Research and Education

Constructing the evidence base for and understanding the impact of change to address health inequalities is dependent on excellent research and education, the third goal in UHL's strategy. Collaboration between UHL, University partners and research partners such as the Biomedical Research Centre (BRC) has continued to evolve over the past year.

Key examples of this include close working between UHL and BRC patient and public engagement, collaboration between UHL and the University of Leicester's MedRACE group to address workforce experiences of discrimination and work to explore the social and cultural constructs that underpin mistrust in maternity services in Leicester city.

Prevention

Prevention and health inequalities are intrinsically linked with evidence showing that the people most likely to live with long term, preventable conditions, and those most likely

to engage in poor health behaviours are those in the most socio-economically disadvantaged groups.
In a first of its kind for an acute trust, UHL published our inaugural Prevention Report, launched at an event hosted in partnership with The Centre Project. This collaboration between UHL clinicians, services and Public Health colleagues gives an overview of current prevention services and efforts, the current population need (including workforce) and important next steps. Recognising the fourth goal of UHL's strategy, 'A great place to work' the prevention report sets out an ambition to increase and improve Making Every Contact Count conversations as a means by which to raise awareness of the importance of prevention for both colleagues and patients.

Medical Education

UHL provides undergraduate and postgraduate medical training, working closely with Leicester Medical School and NHS England- Workforce, Training, Education (NHSE-WTE). We strive to be the best training provider across the East Midlands and further afield, with a strategic vision to 'develop a skilled and compassionate workforce, within a supportive and inclusive learning environment'. The current Medical Education Strategy is currently being reviewed in line with the UHL Strategy.

The Trust receives income from NHSE-WTE to support the provision of medical training and the recently revised Education Contract requires greater transparency regarding the utilisation of this funding within the Trust. Funding is intended to cover a wide range of activity including supervision, assessment, resources and overhead costs. In recognition of the increasing cost of resources, the Trust allocated a proportion of capital funding for educational purposes in 2023 which enabled a number of simulators to be purchased and teaching areas to be refurbished. Educational Facilities will be improved as part of the wider New Hospital Build Programme but in the meantime refurbishment of the LGH Education Centre and Library has enabled some structural alterations and improvements to common areas and some teaching rooms. A second phase of improvements in 2024 will further upgrade the building, improve access routes into the Centre and modernise the lecture theatre technology.

The 2023 Medical Educator Awards were presented at an Education Update event in November 2023. The awards are presented to senior and junior medical staff who teach both undergraduate and postgraduate medicine. There are also a number of awards to acknowledge the crucial role played by those who support the delivery of medical education. There were over 200 nominations for the awards and winners were from across a number of professions and specialties. Over 100 UHL educators attended the 2023 event which included updates from NHSE-WTE and Leicester Medical School. Workshops on technology in education, presentations on crisis management, the role of the Physicians Associate and updates from UHL Clinical Teaching Fellows were all well evaluated.

In September 2023, NHSE launched a Sexual Safety Charter and the Director of Medical Education represents the interests of medical students and Postgraduate Doctors' in Training on the UHL working group. The Trust expects to commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and ten core principles and actions, by the deadline of July 2024.

The Department of Clinical Education also provide support to UHL Medical Aligned Professions, including Physician Associates (PA). A UHL forum has been recently established for PAs to discuss their wants, needs and current issues.

The Clinical Librarian team have undertaken 286 literature searches this year to support patient care decisions, and UHL audit and research. Sixty-five of these were specifically for systematic reviews, and members of the Clinical Librarian team have been named as authors on ten systematic reviews published from April 2023 to March 2024.

Undergraduate Medical Education

Leicester Medical School (LMS) is now ranked within the top three for all domains and UHL continues to be the largest education provider for LMS students. National Foundation Programme data shows that the number of Leicester graduates who are staying locally for their Foundation training is approximately 25%. This decrease from 2022 figures is related to a change in national allocation processes.

The number of medical students is increasing nationally to support the future medical workforce, and UHL will continue to accommodate additional University of Leicester medical student placements. As the number of students increase, the success of the Surgical Teaching Fellows has been explored by other specialties to support the pressure on senior medical staff to supervise and teach increasing numbers of learners. As part of the work to increase financial transparency, service level agreements have been written and shared with all clinical areas where medical students are hosted. The agreements describe the teaching and assessment expectations alongside the amount of educational income for the relevant area.

Postgraduate Medical Education

An additional number of trainees were allocated to UHL in 2023 as part of the ongoing redistribution and expansion of trainee posts and the Trust benefited from an increase in Foundation and Specialty trainees across a range of services. Numbers are likely to increase again in 2024, subject to financial approval. Challenges with supervision for increasing numbers are acknowledged and proposals are in place to support and expand the numbers of Supervisors.

UHL has a number of dedicated Clinical Tutors for doctors who are returning to training after a prolonged break, for less than full time trainees and for GP trainees who are working in UHL as part of their training. Clinical Tutors for SAS doctors and Locally Employed doctors (LEDs) are also part of a wider collaboration with the Medical Workforce team. Clinical Tutors have trust wide responsibility for their nominated groups of trainees to address concerns and ensure a high quality, safe working and learning environment is in place.

The GMC Workplace Experience report (2023) highlighted the increasing challenges of high workload, understaffing and burnout, all of which have a negative impact on retention and organisational culture. Initiatives have been introduced to promote effective trust level engagement with Postgraduate Doctors' in Training (PGDiT), recognising the valuable contribution of this group of staff and that the rotational nature of training posts can impact on engagement. In 2024, this initiative will be developed further by the UHL Doctors' In Training Committee with support from a dedicated Engagement Officer.

The Trust continues to use data from a number of local and national surveys to review UHL's medical education provision. Where NHSE-WTE raises concerns about provision, the Trust is required to investigate and provide a formal response +/- an action plan. The Department of Clinical Education works closely with services where training challenges are identified to monitor progress and offer support.

Patient experience: Involving patients and the public, and Improving the patient experience

Strengthening the voice of patients and families

The patient voice is a powerful driver for improving and evaluating our services. Insights from those with lived experiences can identify positive and negative aspects of how we deliver care and services and provides us with a unique viewpoint to address familiar challenges and improve outcomes.

The patient's voice provides us with an objective understanding of our strengths and weaknesses, and crucially how the care and treatment we provide impact patients and families. The voice of patients and families will help us promote a common purpose and galvanise out improvement actions.

Objective 1: We will respond to our patient and relatives concerns through:-

(a) Call for Concern/ Marthas Rule / Ask me campaign maternity:
These initiatives provide an extra layer of vigilance for patients whose condition may be deteriorating, through recognising the concerns of families and friends and providing a fresh eyes approach and a timely clinical review of the patient. Families can contact the services directly to activate the service if they are worried that their concerns are not being heard by the clinical team.

Where we are now
Work has commenced for both Call for Concern and the Ask me campaign and in 2024-25. Martha's Rule for Paediatrics will be implemented by end of quarter 1 2024/2025. Engagement has taken place with adult services and maternity services in the development of the standard operating procedures to enact Marthas Rule. We will undertake a full evaluation to measure the impact of these services, to ensure we are continually learning and improving.

What are we aiming to achieve / what success will look like?
To provide a service for adults and children to ensure that patients and relatives concerns are acted on in a very responsive way. This service will help to support at risk patients at the earliest opportunity, preventing continued clinical deterioration. These services will provide an extra layer of assurance for patients and their families and shows out commitment to providing safe, compassionate, and joined up care.

(b) The Pals service (Patient advisory and Liaison service)
The Patient Advice and Liaison Services (PALS) offers confidential advice, support and information on health-related matters and provide a point of contact for patients, families, and carers. They can help with health-related questions; help resolve

concerns or problems people experience using our services and can help you people get more involved in their healthcare.

Where we are now (Our current performance strengths and weaknesses)
PALS was implemented at LRI in October 2023 as a new service, and the PALs base in LRI opened at the end of January 2024. This service will carry out thematic reviews each month and these themes will be populated into the new patient experience dashboard.
The tables below show a snapshot of the PALs position to date. The overall aim is to respond to patient and families' concerns raised through the PALS service within five working days.

Table 1

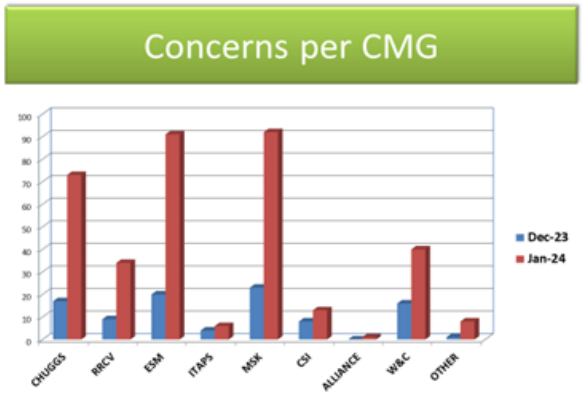


Table 2

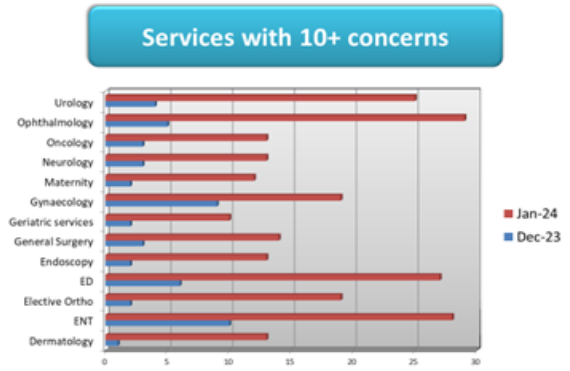
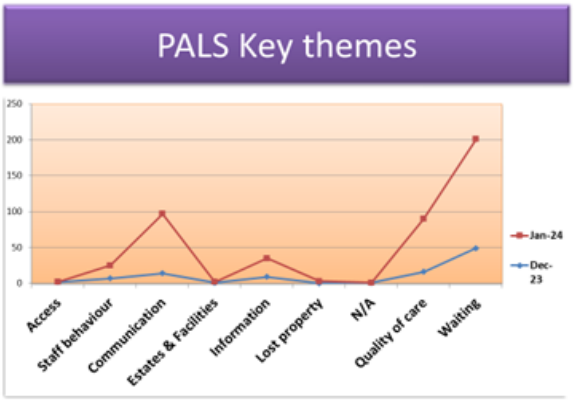


Table 3



What are we aiming to achieve / what success will look like
In year two and three we will look to extend PALS service to GH and LGH and develop a 7-day service. Patients and families will receive a timely response and resolution, to their concerns within 5 working days or less. We would expect a decrease in the number of overall formal complaints as the PALS service becomes embedded and concerns are responded to in a timely way.

(c) Implementation of Carers passport:

Where we are now, and our current performance strengths and weaknesses

UHL has had a Carers' Charter in place for many years and we have now complemented this with a system wide approach for carers and the introduction of

The UHL Carers Passport to support carers whilst the person they care for is in hospital. This enables carers to continue supporting the person that they care for if they wish to do so. UHL also recognises the Leicester, Leicestershire, and Rutland Carers' Passport.

The passport is building on the work of the Carers Charter and the passport provides carers with improved communication between them and providers. It will formalise visiting and support at mealtimes for carers, and ensures carers receive nutrition and hydration during their visits.

What are we aiming to achieve / what success will look like
The Carers passport has a number of benefits including:-

- Being able to visit outside of normal visiting hours.
- Being able to aid with personal care, meals and drinking if you wish to.
- Being actively involved in discussions about the person you care for.
- Being involved in discussions and planning for discharge from hospital.

Objective 2: We will strengthen the experience that patients receive within our hospital through:

(a) Develop a noise at night quality improvement project: We want to improve patient experience at night as sleep is an essential component to recovering from illness. We will establish a working group to identify themes from our patient feedback and develop initiatives to make improvements. For example, development of sleep packs, implementation of slow closing doors for treatment rooms, soft closing bins and muffle boards.

Where we are now
Feedback from our patients tells us that our hospitals are not always quiet places for patients at night when they are trying to sleep.

Our current performance strengths and weaknesses
Our ward patient experience surveys show that Noise at Night is a significant concern for patients. Noise meters are currently monitoring noise levels to establish a baseline.

What are we aiming to achieve / what success will look like?
Patient feedback will show that noise levels are reduced, the quality of patient sleep at night has improved.

(b) Improving the Friends and Family Test (FFT): scores for our services The NHS Friends and Family Test was developed and launched in 2013 to help all areas of the NHS understand if patients were happy with the services and where improvements were needed.

Where we are now.
We are currently meeting the standard for the Friends and Family Test of 95% of patients reports a positive satisfaction score.

Our current performance strengths and weaknesses
At UHL we have set improvement trajectories in table four below for our FFT scores to strive for additional feedback from patients using our services to drive improvements based on their experience

Table 4

	%Positive Targets				
FFT Area	2023-24	2024-25	**2025-26**	**2026-27**	Notes
Inpatients	95.0%	**95%**	95.5%	96.0%	Target held at 95% in anticipation of SMS rollout - new baseline/trajectory may be established after qtr. 1 results known
Outpatients	95.0%	**95%**	95.5%	96.0%	
Emergency Department	77.0%	**80%**	81%	82%	New target trajectory to aspire to exceed national performance average
Maternity	95.0%	**95%**	95.5%	96.0%	Performance on current target was partially achieved however does exceed national/peer group performance - so maintained

(c) Undertake a continuous programme of '15 steps' and providing feedback to celebrate good practice and identify learning for improvement. 15 steps highlights what good quality care looks and feels like from a patients and relatives' perspective by looking at looking at how safe, good quality care is delivered in a welcoming and clean environment. 15 steps provide a toolkit to look at a care environment through the eyes of patients and relatives.

Where we are now.
All inpatient areas have had a baseline 15 steps visit from the patient experience team and people who volunteer in our hospitals.

Our current performance strengths and weaknesses
Our top three positive themes form the visits highlights that the wards are calm environments for patients, care is patient centred and that the 'Hot Board' information was of good quality. Areas identified for improvement include, patient call bells are not responded in a timely way, hand gel to clean hands is not readily available throughout wards and that patients do not always have an identity bracelet in place.

What are we aiming to achieve / what success will look like?

As 15 steps is undertaken for a second time, that wards will demonstrate improvements have been put in place.

(d) Improving Patient Nutrition: Ensure patients receive meals in a timely manner, which are nutritionally correct to meet their needs and provide a choice of meals. Enact improvement actions through the multi-disciplinary group overseeing this

workstream. Good nutritional intake is an integral component of patient care, poor nutrition and hydration affects patients' overall health and wellbeing and reduces their ability to recover from illness.

Where we are now.
Baseline feedback from PLACE visits, patient catering surveys and patient feedback is being triangulated and process mapped.

Our current performance strengths and weaknesses
Some of the feedback that patients gave identified a need to improve include food including texture of food, poor menu choices and lack of menus at the bedside and individual catering needs are not being met. However, patients have told us they have enough time to eat their meals.

What are we aiming to achieve / what success will look like?
Patients will receive a meal that is their choice and meets all their nutritional requirements.

Objective 3: To ensure patient receive appropriate communication and information.

(a) Patient information

Where we are now
We have commissioned an external review into how we provide patients with appropriate information. Feedback from colleagues has highlighted that developing, publishing, and reviewing of patient information needs to be simplified and more widely available in different formats.
Communication with patients at ward level will include a daily update of their plans for today, tomorrow and for discharge. Outpatient and diagnostics services will keep patient updated and informed of their treatment plans and any subsequent follow ups.
Translation and interpretating services can be used sporadically and are time consuming to put in place when information needs to be conveyed to patients and families.

Our current performance strengths and weaknesses
We currently have patient information sitting within multiple platforms, access to these platforms for patient sis part of the external review.

Our communication to patients during their stay/visit needs to be improved and we will revitalise the today, tomorrow and discharge plans to standardise this communication for all patients.

Complaints and concerns from patients have identified that patient not being treated with empathy is a significant concern.

A new tender is in progress for translation and interpretation services; this will be monitored for agreed designated key performance indicators.

What are we aiming to achieve / what success will look like?
Patients will have the information they need to support their decision making and their recovery. Information will be provided in the most appropriate format, including written, audio and video and in languages to meet each patients need.
Each ward will have a brand developed; patients will have access to a video about keeping themselves well.
Translation and Interpretating services will be widely available and used 24/7 and the key performance indicators will be met.

Communication with patients will improve and each patient and their family will be aware and kept informed of their treatment plan during their stay/Visit.

Patient feedback will show that they have been communicated with in an empathetic way.

Resolving complaints, and patient feedback

Complaints are an essential source of information on the quality of our services and standards of care from the perspective of our patients, families and carers. We are keen to listen, learn and improve using feedback from the public, HealthWatch, local GPs and other providers as well as from national reports published by the Parliamentary Health Service Ombudsman.

Learning from complaints takes place at several levels. The service, department or specialty identifies any immediate learning and actions that can be taken locally.

Complaint data is triangulated with other information such as incidents, serious incidents; freedom to speak up data, inquest conclusions and claims information to ensure a full picture of emerging and persistent issues is recognised and described. Many of the themes and actions identified from complaints form part of wider programmes of work such as improving the fundamentals of care.

Improving complaint handling

The Independent Complaint Review Panel was reinstated this year post-Covid-19. The panel reviews a sample of complaints and reports back on what was handled well and what could have been done better. This feedback is used for reflection and learning with the PILS and CMG teams and reported through our TLT (Trust leadership Team).

The complaints and patient safety team split into two corporate functions. The PILS function is now a component part of the PALS service, with the PALS service being the front-end service dealing with concerns and a formal complaints team.

Between 1 April 2023 and 31 March 2024, we received 1,717 formal complaints and 921 concerns. This compares to 2,162 formal complaints and 2,134 concerns in 2022/23.

The most frequent primary complaint themes are medical care, appointments including delays and cancellations, and waiting times.

We achieved 65%, 62%, and 77% for the 10 day, 25 days and 60-day formal complaints performance respectively.

Complaints activity: (formal complaints, verbal complaints, requests for information and concerns) by financial year – 1 April 2016- 31 March 2024

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Formal complaints	1,467	1,886	2,260	2,534	1,476	2,264	2,165	1,717
Requests for information	321	143	118	168	113	210	317	84
Concern (excludes CCG & GP)	1,288	1,146	1,170	1,488	1,001	1,515	1,937	399
Total	4,228	4,031	4,040	4,382	2,808	4,297	4,616	2,200
Trend	0.2 % increase	4.7 % decrease	0.2 % increase	8.6 % increase	35.9 % decrease	53.02 % increase	7.42 % increase	52% decrease

Reopened complaints

Table Number of formal complaints received, and number reopened by quarter April 2021 to March 2024:

	2021 /22 Q1	2021 /22 Q2	2021 /22 Q3	2021 /22 Q4	2022 /23 Q1	2022 /23 Q2	2022 /23 Q3	2022 /23 Q4	2023 /24 Q1	2023 /24 Q2	2023 /24 Q3	2023 /24 Q4
Formal complaints received	498	560	580	631	605	561	493	503	423	504	457	333
Formal complaints reopened	77	59	70	63	37	27	23	21	16	16	19	5
% Resolved at first response	85%	89%	88%	90%	94%	95%	95%	96%	96%	97%	96%	98%

Pleasingly we have seen a reduction in the number of our reopened complaints this year.

Parliamentary Health Ombudsman Service

This year, we have again had less upheld cases by the Parliamentary Health Service Ombudsman, further details are provided below.

Table: Parliamentary Health Service Ombudsman complaints - April 2017 to March 2024:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Investigated - partially upheld	3	3	3	1	2	0	0	12
Investigated - not upheld	6	4	0	0	0	0	0	10
Enquiry only - no investigation	1	0	1	4	3	0	0	9
Awaiting outcome validation	0	0	1	0	1	3	1	6
Apology/explanation	0	0	0	0	1	0	0	1
Total	10	7	5	5	7	3	1	38

Patient Advice and Liaison Service (PALS)

The Development of the PALS Service was a key development within this year. The purpose of the PALS team is to provide a vital role in the early resolution of patient or visitor concerns with UHL. The aim of the service is to provide support and advice to those that seek help with accessing or using UHL services and reduce the number of formal complaints received by the trust.

The UHL PALS service launched in October 2023 and currently opens five days per week. Since the service opened it has received 2081 concerns

Subject (Primary)	Q3 2023/24	Q4 2023/24	Total
Waiting (delay)	352	456	808
Quality of care	178	319	497
Communication	197	252	449
Information	35	160	195
Building relationships (Behaviour)	38	38	76
Lost Property	9	16	25
Estates & Facilities	7	9	16
Access	6	6	12
Equality		2	2
(blank)		1	1
Grand Total	**822**	**1259**	**2081**

The PALS team are receiving and average of 18.7 patient concerns per day (93.5 per week) via email and telephone. This is projected to increase by a further 15 enquiries

per day with face-to-face contacts now that the PALS hub has opened at the LRI.

A business case has been submitted to expand the PALS team and to improve our patient experience by opening seven days per week at the LRI and have additional PALS hubs at both the LGH and GH.

The PALS matrons are also working in partnership with both UHL and community services to support and develop effective patient pathways and ensure an equitable service for all.

In 2024/25, we will:

- Process map our complaints and PALS function to ensure the streamlining of our systems so that patient's and their families get an early resolution to their Concerns and timely response with their complaint
- Work with the University of Leicester to ensure our responses are compassionate and empathetic
- Develop a newly aligned Complaint Policy
- Continue to focus on timely response to complaints

Patient Feedback

Leicester's Hospitals actively seek feedback from patients, family members and carers. The feedback received is reviewed by the clinical and senior management teams, this then helps to shape services for the future. The overall aim of the collection of feedback is to improve the experience of our patients and visitors.

"Patient Feedback Driving Excellence" boards are used in the clinical areas to display the changes or actions staff have taken in response to feedback received. This can be when there are suggestions for improvement or when the feedback is positive, and this outstanding practice needs to be shared and reinforced.

We are delighted to say that during 2023-24 circa 222,609 feedback forms / surveys were received from patients. These surveys included the Friends and Family Test question and of the 222,609 responses, 207,751 contained a positive response, 8,493 included suggestions for improvement and 6,365 were neither positive nor negative. This is a tremendous achievement.

Feedback is collected from patients, families and carers using the following well established methods:

- Patient Experience Feedback forms, both paper and electronic
- SMS/texts, sent to patients who attend outpatient appointments either virtually or in person. This system expanded to include Alliance Outpatient departments during 2023-24
- In Maternity services SMS/texts were introduced in 2023-24 to invite ladies of gestational age 36 weeks or nine days post birth to collect the Antenatal and Postnatal Community FFT response
- SMS/texts sent to patients who attend our Emergency Department
- Message to Matron Cards
- NHS Choices / Patient Opinion

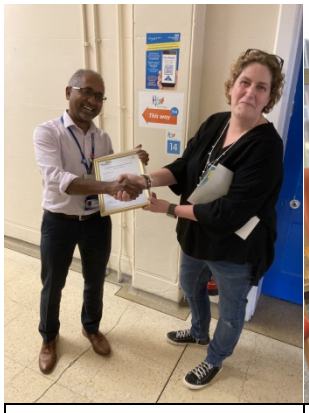
- Compliments and complaints provided to the Patient Advice and Liaison Service (PALS).
- Trust website
- Patient stories
- Community Engagement – completed virtually
- Family, Carers and Friends feedback, paper and electronic

Feedback from Families and Carers

During 2023-24 there have been 1,287 completed Family, Carers and Friends feedback forms received within the Trust and this feedback has been shared with the clinical teams. Patient Experience has introduced a Carer's Passport and a Carer's strategy during 2023-24. This will be piloted in clinical areas and has been taken to several professional review meetings in the Trust.

Patient Recognition Awards

This award recognises staff who patients, family, and carers have mentioned by name in the Friends and Family Test feedback comments. These comments detail the positive impact the staff member has had on their experience while they have been in hospital. During 2023-24 there have been fourteen winners: three nurses, three health care assistants, three consultants, three midwives, one housekeeper, and a maternity support worker. Some examples of 2023-24 winners are pictured below.




Consultant	Health Care Asst	Midwife	Staff Nurse
Dr Francis	Aulto Peeris	Rujna Ahmed	Audrey Holyland

Volunteer Services

Volunteer Services continues to work towards recruiting increasing numbers of committed volunteers to provide a range of services within UHL. As is the case for many other organisations we are in competition to offer interesting and rewarding roles that provide volunteers with the motivation and satisfaction to remain with us and continue to provide support to patients, staff and the Trust.

Our teams of volunteers have grown and developed with around 66 volunteers helping in a Meet and Greet role in public areas of the sites helping patients and visitors find their way to their destination and providing support for those preferring help to or needing assistance to make the journey. In order to maximise both the satisfaction for volunteers and the impact their role has six of our more experienced volunteers have taken on the role Shift Leader. This enables them to train and guide new volunteers and help direct valuable volunteer resources to the areas of greatest need during any shift.

This enables a better quality of customer service for our patients, visitors and staff. Our patient Visiting Service has developed to offer visits from volunteers across all three sites to those patients who may not have many relatives or friends available to visit or who are just feeling lonely and isolated in hospital and enjoy a chat.

We have 19 volunteers who offer around 90 of hours of visiting to around 300 patients each month. Many of our volunteers speak a second language such as Polish, Gujarati and Italian and have been able to interact with patients who also speak and understand those languages. This can really help to relieve social isolation. These volunteers are also able to identify patients who may benefit from other types of volunteer support and help them to access this.

Our Time for a Treat Service is now back offering patients hand massage, manicure and hairdressing. Although we currently only have eight volunteers, since January they have provided around 250 treatments to patients across the Trust. Recruitment of new volunteers for this service is priority and there are training sessions with new volunteers in place over the next few weeks.

One of the more unusual services is visits from our Pets as Therapy dogs and their human volunteers. We now have six PAT Dog volunteers who visit regularly and who also respond to specific requests for visits or support in all areas of the Trust. Cilla (pictured below) won our Volunteer of the Year Award 2024.

Cilla the PAT dog volunteer

Working with partners

Partnerships for impact is one of the four key strategic goals within the new organisational strategy (leading in healthcare, trusted in communities). To make a difference at scale across Leicester, Leicestershire, and Rutland, UHL acknowledges the need to develop partnerships for impact with local, regional and national partners.

Throughout 2023/24, UHL has collaborated within the local Integrated Care System

(ICS) to deliver improvements across elective and emergency care pathways. Underpinning the collaborative engagement between UHL & the wider ICS, has been the relentless focus on understanding as well as reducing health inequalities.

Within elective care, throughout 2023/24 capacity across UHL, primary care and the independent sector has been managed together, to ensure the maximum number of patients are treated and a sustained reduction in the waiting list takes place. Advice and guidance have been expanded across all Primary Care Networks and departments within UHL, to reduce unnecessary demand for outpatient appointments. Through the proactive use of Consultant Connect across key elective services, real time GP-Consultant calls take place with between 30-80% of referrals subsequently being avoided.

Across Emergency Care pathways, UHL and the LLR ICB have collaborated to introduce 175 new virtual ward beds. Virtual ward beds support both admission avoidance, through the provision of intensive support to keep patients in their place of residence as well as a reduced length of stay, through supporting the last few days of treatment taking place in the home.

UHL and the three Upper Tier Local Authorities have collaborated in 2023/24 to identify and improve the overall health of the population. This collaboration is overseen by the Health & Wellbeing Board and committees such as the Staying Healthy Partnership. Prevention and the identification of the key determinates of health has been a key focus of this collaboration in 2023/24. An example of this is the joint focus on understanding and addressing the causes of Obesity and the funding of Tier 3 Weight Management clinics. These clinics have supported individuals to make the changes in lifestyle required to sustainably reduce their weight (and reducing the risk of long-term conditions such as diabetes).

During 2023/24, the Trust Boards of UHL and University Hospitals of Northamptonshire formally approved the development of a new group structure. This new group structure provides a unique opportunity to review all clinical pathways across the partners, to ensure patient pathways are in place that deliver the highest quality of care in the most efficient way.

There are many opportunities for quality improvement and the release of efficiencies through working at scale across the East Midlands. Through the East Midlands Acute Providers Network (EMAP), we have collaborated working to reduce the fragility of services across the East Midlands, such as Oncology and Head & Neck Cancer. Digital innovation and automation present an opportunity for collaboration across the East Midlands. With the agreement of providers across the region to utilise NerveCentre as the central Electronic Patient Record (EPR) provider, these opportunities are enhanced.

Throughout 2023/24, we have collaborated with academic partners across Leicester, Leicestershire, and Rutland to further develop the region as an international leader of Academic Health Research. Specifically, UHL has made the strategic commitment to ensure that by 2028, all NHS patients are offered the ability to participate in a suitable research trial. A key achievement for the organisation in 2023/24, was the successful awarding of Regional Research Delivery Network (RRDN) host status. RRDN's have been established to provide support to research sites, to enable the effective/efficient initiation and delivery of funded research across the health & care system in England. The focus of the new RRDN includes the enabling of the strategic development of new and more effective research delivery capability and capacity. This will include bringing

research to under-served regions and communities with major health and care needs.

We have actively collaborated with third sector/charitable organisations to understand the drivers of differential experiences in accessing services and clinical outcomes achieved. Specifically, the Shama Women's centre based in Leicester City and UHL have collaborated to improve the health literacy of women in Leicester City and reduce non-attendance rates to key Outpatient services.

Chaplaincy

The Trust's Chaplaincy team provides round-the-clock support, seven days a week, offering pastoral, spiritual, and religious care to patients and their families throughout their hospital stay. We support anyone experiencing emotional or spiritual distress related to questions about life, death, ill-health and the meaning of existence.

Our team of Chaplains is diverse including Catholic, Christian, Hindu, Jewish, Muslim, Non-religious, and Sikh. We believe that our diversity strengthens our ability to deliver exceptional care, enriching the experiences of patients from various communities who access care in our hospitals. In the past year alone, we've made over 7,600 visits to patients and responded to over 330 urgent out of hours requests for Chaplaincy support.

Collaborating with internal healthcare professionals and external statutory organisations, we've provided both general and urgent support to patients and families during critical situations, including facilitating hospital weddings, conducting hospital and baby funerals.

"The funeral was undoubtedly the hardest day, but you conducted a beautiful service we will remember forever. We often talk about the wonderful memories you helped us make in the short time we had with our son. (Card from a patient relative)

Substantial staff support has been delivered with significant interventions during staff bereavement and traumatic incidents; supporting both staff and managers, individually and collectively we have provided rapid response, organised staff memorials and provided ongoing pastoral and spiritual support. Across UHL our multi-faith chapels and prayer facilities have been maintained with significant use by patients, visitors and staff.

We've proactively celebrated religious festivals and nationally significant days within the hospital and beyond, fostering a greater sense of inclusion. This has included special, Easter, Eid, Diwali, Chanukah and Christmas celebrations, a National Sikh Prayer Day service and leading the first joint UHL, LPT and LLR Remembrance Service in the Secret Garden. Additionally, we serve as a point of reference for the broader faith and belief communities with Chaplaincy provision for the Leicestershire Partnership NHS Trust; reaching patients and families across mental health units and community hospitals in Leicester, Leicestershire, and Rutland.
Our Chaplains continue to contribute nationally to the wider Chaplaincy profession through the College of Healthcare Chaplains, the National Chaplaincy Forum and Network for Pastoral Spiritual and Religious Care in Health.

The Chaplaincy Team was honoured to receive the Valuing Equality, Diversity and Inclusion Award and Chairman's Award at the UHL Awards 2023. We continue to

develop relationship with wider community stakeholders and actively contribute to wider community discussions, events and engagements with a particular drive towards strengthening awareness of Chaplaincy services in the diverse communities of Leicester and contributing to the UHL Health Equality Partnership

Aims for 2024/25

- To enhance the delivery of Chaplaincy staff support across UHL working closely with staff wellbeing services to provide excellent holistic care as part of the Trust's commitment to be a great employer.
- To work collaboratively with healthcare professions and services to further embed the provision of integrated Chaplaincy services as part of excellent holistic care.
- To improve access to Chaplaincy services for patients, staff and relatives by increasing awareness and visibility of the service across UHL and beyond.

Digital and IM&T

We set out five key areas of focus for 2023/24 for our digital and IM&T programmes with the aim of improving UHL as a place to work and receive care, whilst ensuring our staff and patient data is safe and secure. Over the last year:

1. Ensure that everyone working for the Trust has the right equipment to do their job

- We upgraded or replaced more than 2,400 laptops and PCs to give staff a faster and better experience
- We replaced 554 iPads and iPhones which had reached the end of their usable life
- We purchased 1,462 additional laptops, PCs and mobile devices to ensure colleagues are fully equipped to perform their roles to the best of their ability

2. Continue to invest in modernising and improving our wifi and network, including mobile phone signal

- We upgraded the Trust's internet connections to improve speed and reliability
- We installed new, fast NHS wifi to help staff and patients remain connected across our sites
- We enabled Wi-Fi calling across the Trust and installled 20 x 4G mobile phone boosters at the Glenfield site to help in areas where signal is problematic
- Wireless and cabled networking upgrades continued across our sites including new wireless access points and network switch upgrades

3. Modernise our IT service and make support more visible

- We have regular proactive IT 'bus routes' running through clinical areas to identify any IT issues early and resolve more rapidly, more than 250 incidents were resolved directly
- We have increased the proportion of IT incidents resolved on first contact by a factor of 10 vs 2022/23, reducing time taken to resolve and removing unnecessary call backs
- In response to staff survey feedback, we have initiated regular visits to frontline areas by senior IT team members. Our engineers are working in a more mobile manner and are highly visible with branded trolleys, building improved

relationships with teams and improving the experience of colleagues of working with the service.

- We have set up and moved the first groups of servers to our new off site data centre, reducing risk and improving performance
- We have implemented new tools to help us improve our cyber security and information governance processes and monitoring in order to keep our staff and patient data safe and secure
- We completed 43 IT projects over the last 12 months. with numerous system upgrades and several new systems implemented to assist our teams to work smarter and more efficiently.

4. Progress our EPR plan to reduce dependency on paper records across all our care settings

- 2023/24 was a busy year for our electronic patient record programme with a number of new capabilities launched as part of our groundbreaking, first of type development partnership with Nervecentre software. Progress included:
    i. We tested digital documentation at the bedside on our stroke wards, making these our first ‘paperless’ wards
    ii. We implemented electronic prescribing and medicines administration in our critical care unit at the Glenfield site
    iii. We implemented a new electronic diagnostic requesting system in our Emergency Department to allow our clinicians to have a more joined up view of a patient’s record
    iv. We began use of ‘Optimed’, our unit dose medicines administration system on two of our wards, reducing risk of medicines errors and drug wastage
    v. We are using digital consent and preoperative assessment tools to allow patients to complete their documentation with access to information online to support informed decision making
    vi. We have installed our new data platform to support improved ways of using data for decision making from 2024. 3 billion rows of data have been loaded so far.

5. Improve our ability to share records with ICS partners in both directions

- We completed development work to share medication details with our system partners for patients discharged to community hospital sites
- We completed development and testing activities to support the LLR shared care record being available to colleagues at UHL from May 2024

Emergency preparedness

The Trust is identified as a category 1 responder Under the Civil Contingencies Act 2004 – meaning that it is an organisation at the core of the response to most emergencies. Therefore we are legally required to have plans and policies in place to maintain, or mitigate impacts to its core services during emergencies. Our responsibilities are further defined through the Emergency Preparedness, Resilience & Response (EPRR) Framework, where the Trust is required to have risk assessments, emergency and business continuity plans, as well as provide training and exercising to ensure effective arrangements are in place to respond to disruptive events.

An annual self-assessment against NHS England's Core Standards for EPRR was completed in August 2023, where following reviews from the Integrated Care Board and NHS England, it was confirmed the Trust is substantially compliant against the standards.

Over the past year, the Trust facilitated a system-wide mass countermeasures table-top exercise, which identifies support and processes available for the whole health partnership for dispensing medical countermeasures at speed during an incident. The Trust also released a new Incident Response Plan to strengthen the command, control and communication structures and processes to respond to any disruptive event and has delivered associated training to its on-call staff ensure they are protected and supported whilst responding to such events.

In January 2023, the Trust was involved in responding to a hazardous materials event, where several self-presenters required decontamination following an accidental exposure to a contaminant. The response from teams were effective as both patient and staff safety were maintained. The response to industrial action across 2023 formed a significant part of the emergency preparedness work, through supporting and coordinating the response to planned industrial action. This included providing guidance and a framework for industrial action periods, as well as and managing internal and external communications.

In the forthcoming year, the Trust is developing a new CBRNe Plan, alongside a review of the Trust's Mass Casualty Plan ahead of a system-wide live exercise planned in March 2025. This all aims to continue developing processes and relationships with system colleagues to support the response to any incidents and emergencies.

Richard Mitchell

Chief Executive

27 June 2024

Part 2
Accountability Report

Directors'/Members' report

Information about our current Trust Board members (including their experience and skillset) from 2023/24 is available at this link:

Trust Board and Senior Directors who attend the Board (leicestershospitals.nhs.uk)

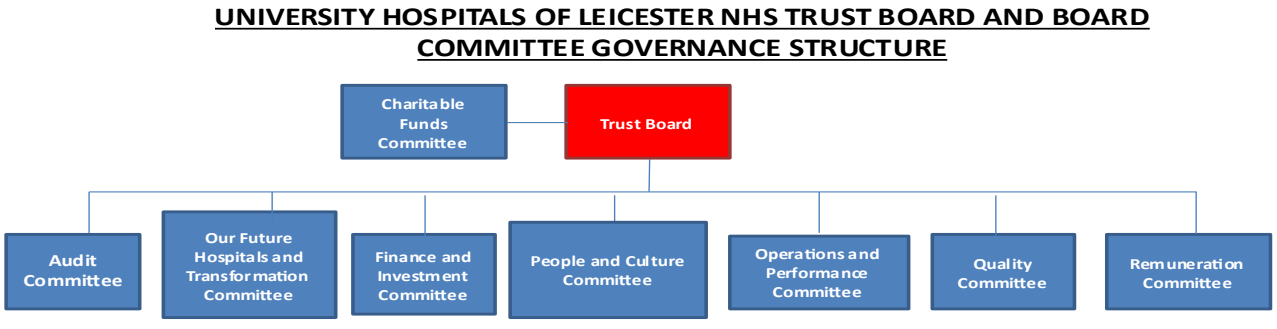
In addition, the following were also part of the Trust Board for some of 2022/23:

- Dr Gopal Sharma, Associate Non-Executive Director

The Trust Board functions in accordance with corporate governance best practice. The Trust Board is a unitary Board with collective accountability for all aspects of Trust performance, from clinical quality to financial performance and sustainability. The key responsibilities of the Trust Board consist of:

- Setting strategy
- Setting the culture of the organisation
- Overseeing delivery of Trust plans
- Overseeing performance – ensuring local and national targets are met
- Ensuring the Trust has robust systems and processes in place for managing risk
- Seeking to continuously improve
- Embedding research and innovation

The Trust Board is responsible for exercising all of the powers of the Trust. However, delegation of powers to senior management and other committees has been arranged. The Trust Board committee structure is as follows:



The Standing Financial Instructions, Scheme of Delegation and Standing Orders are reviewed annually, and are scrutinised by the Audit Committee and approved by the Trust Board.

Board composition

The Trust Board comprises thirteen voting members: a Trust Chair, seven Non-Executive Directors, and five Executive Directors. A number of other Executive Directors also attend Board meetings in a non-voting capacity.

The expertise and skillset is appropriate for the for the current requirements of Trust business.

The Trust's Executive Directors, Directors and Very Senior Managers are appointed by the Remuneration Committee on behalf of the Trust Board. The Chief Executive carries out annual evaluations of each Executive Director. A summary report is provided to the Remuneration Committee to assure the Non-Executive Directors of the performance of the Executive Team.

The Chair's appraisal is led by the Senior Independent Director and follows the NHSE guidance. The necessary reporting into NHSE has taken place for the Chair's appraisal for 2023/24.

The Chair carries out all Non-Executive Director evaluations and the outcome of those are provided to NHSE in line with guidance. A summary of the outcome is shared by the Chair with Board members.

The Chair and all Non-Executive Directors are considered to be independent in character and judgement.

The composition of the Board during 2023/24 is set out in the table below including, Trust Board and Board Committee attendance, commencement/ending of post (if after 1 April 2023) and voting status:

Name	**Public Trust Board** (max = 11)	**Audit Committee** (max = 8)	**Finance and Investment Committee** (max = 12)	**Operational Performance Committee** (max = 12)	**People and Culture Committee** (max = 6)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee (formerly RTC)** (max = 9)	**Remuneration Committee** (max = 9)	**Charitable Funds Committee** (max = 6)
John MacDonald – Chairman	10/11 (91%) **(Chair)**	N/A	N/A	7/12 58%	N/A	N/A	N/A	5/9 56%	5/6 83%
Vicky Bailey – Non-Executive Director	10/11 91%	7/7 100%	N/A	N/A	5/6 83%	7/9 78% **(Chair until end Dec 2023)**	0/5 0%	6/9 67%	5/6 83%
Ivan Browne – Associate Non-Executive Director *(from 1.12.23)*	3/3 100%	N/A	N/A	N/A	1/2 50%	2/3 67%	N/A	N/A	N/A
Gaynor Collins-Punter – Associate Non-Executive Director *(until 31.12.23)*	3/9 33%	N/A	5/9 56%	6/9 67%	2/4 50%	N/A	2/6 33%	N/A	N/A

Name	**Public Trust Board** (max = 11)	**Audit Committee** (max = 8)	**Finance and Investment Committee** (max = 12)	**Operational Performance Committee** (max = 12)	**People and Culture Committee** (max = 6)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee (formerly RTC)** (max = 9)	**Remuneration Committee** (max = 9)	**Charitable Funds Committee** (max = 6)
Mark Farmer – Associate Non-Executive Director *(from 1.1.24)*	2/2 100%	N/A	N/A	N/A	1/1 100%	3/3 100%	N/A	N/A	N/A
Professor Aruna Garcea – Associate Non-Executive Director *(from 1.12.23)*	3/3 100%	N/A	N/A	1/3 33%	N/A	N/A	N/A	N/A	N/A
Steve Harris – Non-Executive Director	7/11 64%	5/7 71%	9/12 75% **(Chair until March 2024)**	N/A	N/A	N/A	0/5 0%	N/A	N/A
Dr Andrew Haynes – Non-Executive Director	9/11 82%	N/A	N/A	9/12 75%	5/6 83%	9/12 75% **(Chair from January 2024)**	8/9 89% **(Chair)**	N/A	N/A
Andrew Moore – Non-Executive Director *(from 12.3.24)*	1/1 100%	1/1 100%	1/1 100% **(Chair from March 2024)**	N/A	N/A	N/A	N/A	N/A	N/A
David Moon – Non-Executive Director *(from 1.3.24)*	1/1 100%	1/1 100% **(Chair from March 2024)**	1/1 100%	N/A	N/A	N/A	N/A	N/A	N/A
Ballu Patel – Non-Executive Director	11/11 100%	8/8 100%	11/12 92%	9/12 75%	6/6 100% **(Chair)**	N/A	6/9 67%	7/9 78%	N/A
Professor Tom Robinson – Non-Executive Director	6/11 55%	N/A	N/A	N/A	0/6 0%	6/12 50%	1/6 17%	N/A	4/6 66% **(Chair)**
Dr Gopal Sharma – Associate Non-Executive Director *(until 30.4.23)*	0/1 0%	N/A	N/A	N/A	0/1 0%	0/1 0%	N/A	N/A	N/A
Mike Williams – Non-Executive Director *(until 29.2.24)*	10/10 100%	7/7 100% **(Chair until February 2024)**	9/11 82%	11/11 100% **(Chair until November 2023)**	N/A	N/A	2/4 50%	9/9 100% **(Chair)**	N/A

Name	**Public Trust Board** (max = 11)	**Audit Committee** (max = 8)	**Finance and Investment Committee** (max = 12)	**Operational Performance Committee** (max = 12)	**People and Culture Committee** (max = 6)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee (formerly RTC)** (max = 9)	**Remuneration Committee** (max = 9)	**Charitable Funds Committee** (max = 6)
Jeff Worrall – Non-Executive Director	8/11 73%	N/A	7/12 58%	12/12 100% **(Chair from November 2023)**	N/A	9/12 75%	2/4 50%	N/A	N/A
Richard Mitchell – Chief Executive	11/11 100%	N/A	N/A	3/12 25%	N/A	N/A	0/2 0%	N/A	N/A
Dr Ruw Abeyratne – Director of Health Equality and Inclusion	11/11 100%	N/A	N/A	N/A	4/6 67%	9/12 75%	N/A	N/A	N/A
Simon Barton – Deputy Chief Executive	10/11 91%	N/A	8/12 66%	N/A	N/A	N/A	9/9 100%	N/A	N/A
Andy Carruthers – Chief Information Officer	9/11 82%	N/A	10/12 83%	N/A	4/6 67%	N/A	8/9 89%	N/A	N/A
Becky Cassidy – Director of Corporate and Legal Affairs	11/11 100%	8/8 100%	8/12 66%	N/A	4/6 67%	8/12 67%	5/5 100%	N/A	6/6 100%
Mr Andrew Furlong – Medical Director	8/11 73%	N/A	8/12 66%	12/12 100%	N/A	11/12 92%	5/9 56%	N/A	N/A
Julie Hogg – Chief Nurse	10/11 91%	N/A	N/A	12/12 100%	2/6 33%	9/12 75%	N/A	N/A	5/6 83%
Lorraine Hooper – Chief Financial Officer	10/11 91%	7/8 88%	11/12 92%	6/11 55%	N/A	N/A	6/9 67%	N/A	N/A
Jon Melbourne – Chief Operating Officer	10/11 91%	N/A	10/12 83%	10/12 83%	6/6 100%	11/12 92%	N/A	N/A	N/A
Mike Simpson – Director of Estates and Facilities	10/11 91%	N/A	9/12 75%	N/A	3/6 50%	N/A	5/9 45%	N/A	4/6 66%
Michelle Smith – Director of Communication and Engagement	11/11 100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1 0%
Clare Teeney - Chief People Officer	10/11 91%	N/A	N/A	N/A	5/6 83%	N/A	N/A	N/A	N/A

*Voting members

Corporate Governance report

The table below provides information on the declarations of interests entries made by Trust Board members and attendees for the year 2023/24:

NAME	POSITION	INTEREST(S) DECLARED
John MacDonald	Trust Chairman	• Chair, Derbyshire Integrated Care Board (until 30.6.23) • Derbyshire Healthcare NHS Foundation Trust (until 30.6.23) • Member of the UHL Corporate Trustee Board • *declaration added at the 8.6.23 public Trust Board:* Chair of the University Hospitals of Northamptonshire NHS Group (UHN: Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust) boards from 1 July 2023 in addition to his role as Chair at UHL
Ruw Abeyratne	Director of Health Equality and Inclusion	• Shareholder in Larks Ameus Ltd • Paid speaker at events on topics relating to coaching and wellbeing. Value less than £500 per annum • Board Committee member, Trent College and The Elms
Vicky Bailey	Non-Executive Director	• Council Member, University of Nottingham • Chair of University of Nottingham Audit and Risk Committee • Member of the University of Nottingham Remuneration Committee • Fellow of Queen's Nursing Institute • Family member is employed by Pricewaterhouse Coopers (PwC) • Member of the UHL Corporate Trustee Board
Simon Barton	Deputy Chief Executive	• Confirmed no declarations to be made
Ivan Browne *(from 1.12.23)*	Associate Non-Executive Director	• Director of Reformation Health (private company set up in the event of any consultancy work or paid speaking engagements – none undertaken to date) • Research work as part of De Montfort University and the Willows Health Group • early Identify myself as a researcher of those organisations, with no reference to my role within UHL • Spouse is a GP at the Victoria Park Medical Centre
Andrew Carruthers	Chief Information Officer	• Community Governor, Sir Jonathan North Girls College, Leicester (June 2023)
Becky Cassidy	Director of Corporate and Legal Affairs	• Company Secretary for Trust Group Holdings Ltd (September 2023)
Gaynor Collins-Punter *(until 31.12.23)*	Associate Non-Executive Director	• Outside employment with Rolls Royce plc
Mark Farmer *(from 1.1.24)*	Associate Non-Executive Director	• Chair Fibromyalgia Friends Together (Volunteer) • Voting Member of NHS England Board's Quality Committee (Worker) • Co-lead of the Adult Mental Health Network at NHS England (Worker) • Advisor to the Postgraduate CBT program for Severe Mental Health problems at the University College of London (Worker) • Patient and Carer Representative Royal College of Psychiatrists and the National Collaborating Centre for Mental Health (Worker)

NAME	POSITION	INTEREST(S) DECLARED
		• Board Member Healthwatch Leicester and Leicestershire (Volunteer) (until January 2024) • Chair of the People's Council Leicestershire Partnership NHS Trust (Bank employee) • Member of the Shadow Collaborative for Mental Health-Leicester, Leicestershire and Rutland Integrated Care System (Volunteer) • Royal College of Physicians Patient and Carer Representative (Volunteer) • range of roles with the Royal College of Psychiatrists (which contracts for NHS services) as a patient and carer representative with worker status
Mr Andrew Furlong	Medical Director	• Member of the UHL Corporate Trustee Board
Professor Aruna Garcea *(from 1.12.23)*	Associate Non-Executive Director	• Director, Garcea Ltd, Garcea Holdings Ltd, Victoria Health Partners Ltd • Shareholder in Victoria Health Partners Ltd (to cease in December 2024) • Chair of NHS Confederation Primary Care Network • Spouse is employed as a Deputy Medical Director at UHL • ICB Clinical Lead Gynaecology and Women's Health, ICB Medical Advisor Primary Care Workforce Group and GPwER • NHS Confederation Representative LLR Patient Care Locally CIC
Steve Harris	Associate Non-Executive Director *(from March 2024 – Non-Executive Director prior to that)*	• Outside employment with Travis Perkins (and shareholder) • Company Directorships: The BSS Group Ltd; Keyline Civils Specialist Ltd; CCF Ltd; • Director of Trust Group Holdings (TGH) • Member of the UHL Corporate Trustee Board
Dr Andrew Haynes	Non-Executive Director	• An advisor to the Faculty of Medical Leadership and Management (FMLM) working 1 day a week (Paid) • Registered as an expert (Principal Clinical Adviser) with Academic Health Solutions • Special Advisor to Sherwood Forest Hospitals Trust on a 12-month contract 3 days a month (paid) • Member of the UHL Corporate Trustee Board
Julie Hogg	Chief Nurse	• Trustee, Elizabeth Garrett Anderson Hospital Charity • Chief Nurse representative, CNO England safe staffing faculty, NHSE/I • Shelford Group Safe Staffing Faculty Planning Group - Non Shelford CN representative • Member, Safer Nursing Care Tool Steering Group, Shelford Group • Research Fellow, Centre for Nursing, Midwifery and AHP led Research (CNMAR), University College London Hospitals NHS FT (until December 2022) • Associate, Birmingham City University • Member, National Digital Nursing Oversight Board, NHSE/I • Family member employed by KPMG • Chair, National Quality Board Safe Staffing Midwifery Review Group, NHSE • Member of the UHL Corporate Trustee Board
Lorraine Hooper	Chief Financial Officer	• Member of the UHL Corporate Trustee Board
Jon Melbourne	Chief Operating Officer	• Company Director of (and shareholder in) Ten Five Four Homes Ltd

NAME	POSITION	INTEREST(S) DECLARED
		• Member of the UHL Corporate Trustee Board
Richard Mitchell	Chief Executive	• Member NHS IMPACT: National Improvement Board (from 11.9.23) • Chair, East Midlands Acute Providers Network (from 1.9.23) • Deputy Chair, National Cancer Leadership Forum Steering Group (from 1.6.23) • Chair, East Midlands Pathology Network (from 1.4.23) • Chair, East Midlands Cancer Alliance (from 1.4.23) • Chair, Regional Talent and Leadership Board (from 1.4.23) • External consultancy work not exceeding £500-£1000 per year • Member of the UHL Corporate Trustee Board • CEO of University Hospitals of Northamptonshire (UHN) Group (from 30.10.23)
David Moon (from 1.3.24)	Non-Executive Director	• Non-Executive Director, Black Country Healthcare NHS Foundation Trust • Trustee (Treasurer), Shipston Home Nursing • Consultant (part-time) for SWFT Clinical Services Ltd (wholly owned subsidiary of South Warwickshire University NHS Foundation Trust) • Member of the UHL Corporate Trustee Board
Andrew Moore (from 12.3.24)	Non-Executive Director	• Vice Chair Breast Cancer Now (charity) • Non-Executive Director, Kettering General Hospital NHS Foundation Trust • Member of the UHL Corporate Trustee Board
Ballu Patel	Non-Executive Director	• Management Committee member, Leeds Asian Blind Association • Associate Non-Executive Director, KGH NHS Trust • Member of the UHL Corporate Trustee Board
Professor Thompson Robinson	Non-Executive Director	• Outside employment with University of Leicester (Pro Vice-Chancellor and Head of the College of Life Sciences, Dean of Medicine) • Trustee of the Stroke Association (voluntary post) • Member of the UHL Corporate Trustee Board (and Chair of the UHL Charitable Funds Committee)
Dr Gopal Sharma *(until 30.4.23)*	Non-Executive Director	• Medical Examiner *(wide-ranging discussions were held with all concerned parties, a statement of assurance was provided and also robust processes were agreed to monitor and support any potential conflicts of interests)* • Outside employment with Fosse Medical Centre • Sits on various First Tier Tribunals (War Pensions, Social Security & Primary Health Lists) • Member of the UHL Corporate Trustee Board
Michael Simpson	Director of Estates and Facilities	• Adviser to Lincoln College Group
Michelle Smith	Director of Engagement and Communications	• Confirmed no declarations to be made
Clare Teeney	Chief People Officer	• Confirmed no declarations to be made
Mike Williams (until 29.2.24)	Non-Executive Director	• Trustee Midlands Arts Centre Limited • Chair and Board member of Midlands Arts Centre Trading Company Limited • Board Member and Trustee Chamberlain Highbury Trust Limited

NAME	POSITION	INTEREST(S) DECLARED
		• Trustee Badley Memorial Trust • Member of the UHL Corporate Trustee Board
Jeff Worrall	Associate Non-Executive Director	• Chair of TGH Holdings Ltd • Senior Adviser to Newton Europe • Non-Executive Director of East Midlands Ambulance Service

Non-Executive Directors chair key Board Committees that provide accountability. Individual Non-Executive Directors are members of specific Board Committees, although papers of all those meetings are available to all Non-Executive Directors if they wish to see them.

These are the Board Committee Chairing roles that our Non-Executive Directors carried out over the last 12 months:

Board member	Chairs
John MacDonald (Trust Chair)	Trust Board
Vicky Bailey	Quality Committee (until January 2024)
Steve Harris	Finance and Investment Committee (until March 2024)
Dr Andrew Haynes	Our Future Hospitals and Transformation Committee Quality Committee (from January 2024)
David Moon	Audit Committee (from March 2024)
Andrew Moore	Finance and Investment Committee (from March 2024)
Ballu Patel	People and Culture Committee
Professor Thompson Robinson	Charitable Funds Committee
Mike Williams	Audit Committee (until March 2024) Operations and Performance Committee (until November 2023) Remuneration Committee
Jeff Worrall	Operations and Performance Committee (from November 2023)

Non-Executive Directors hold additional champion roles on the Board and these are detailed as follows:

Non-Executive	Role
Vicky Bailey	• Senior Independent Director • Board champion for Maternity Safety • Board lead for Maintaining High Professional Standards
Dr Andrew Haynes	• Vice Chair (from February 2024)

Mike Williams	• Vice Chair (until February 2024)
Ballu Patel	• Board champion for Freedom to Speak Up
Jeff Worrell	• Board champion for EPRR

The internal committee structure strengthens our focus and scrutiny on quality, finance, people, performance, and reconfiguration and transformation. The committees carry out detailed work of assurance on behalf of the Trust Board which in turn allows the Board to spend significant proportion of time on strategic decisions. The Board gives delegated authority to its sub committees which are described below:

The Audit Committee has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of our strategic objectives. The Committee receives and considers reports on all aspects of the organisation's systems of internal control, including reports from internal audit, reviews the organisation's accounting policies and statutory accounts for submission to the Board. This is supported by the work of internal audit to ensure that delivery of services takes place within a sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently.

The Finance and Investment Committee oversees performance management across all domains with the Board retaining corporate responsibility for overall performance. The Finance and Investment Committee meets monthly to oversee the effective management of our financial resources and financial performance across a range of measures. The Committee on behalf of the Board, monitors the achievement of the organisation's statutory financial duties, seeking assurance on the progress of the Cost Improvement Programme, monitoring the organisation's monthly financial performance, and supports the development of the annual plan and receives and considers business cases prior to approval to the Board.

The Quality Committee meets monthly and seeks assurances that there are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients.

The People and Culture Committee focuses on workforce issues, organisational culture, and organisational systems and processes. This Committee meets bi-monthly and amongst the standing items which feature on its agenda are workforce issues including regular review of the Workforce Strategy (UHL People Plan) and the Trust's progress against its equality and diversity plan.

The Operational Performance Committee focuses on scrutinising operational performance including planned care, urgent and emergency care, diagnostics, and elective care.

The Our Future Hospitals and Transformation Committee plays an assurance role in the delivery of the programme to reconfigure services across the UHL estate and deliver transformation. This Committee sets the direction for and oversees the our future hospitals and transformation delivery programme, whilst providing leadership and advice. This Committee also oversees strategic digital transformation and delivery.

Following ratification at their next meeting, the minutes of each Board Committee meeting above are then submitted to the next available Trust Board meeting for their

oversight. A written escalation report is provided to the Trust Board following each Committee with the Non-Executive Director Chair of each Committee personally presenting a summary of the Committee's assurance deliberations and highlighting material issues arising from the work of the Committee to the Trust Board. Each of these Board Committees also presents an annual report on their work, to the Trust Board, and reviews their terms of reference on an annual basis to ensure they remain appropriate and up to date.

The Remuneration Committee is responsible for identifying, appointing and agreeing the remuneration and conditions for Executive Director positions and those classed as 'very senior managers'. It's membership is made up of 4 Non-Executive Directors, which includes the Trust's Vice Chairman as Remuneration Committee Chair. In 2023/24 the UHL Remuneration Committee met on 9 occasions – it was quorate on each of those occasions, and the meetings included taking decisions (as required) on pay awards for the Trust's 'very senior managers'; reviewing national pay uplift proposals for other staff groups, and being appropriately sighted to UHL's Executive Directors' objectives.

Policies and key corporate governance documents

We have in place a suite of corporate governance policies which are reviewed and updated as required on an annual basis.

We comply with counter fraud standards for providers as detailed by the NHS Counter Fraud Authority in accordance with section 24 of the NHS Standard Contract and we participate in the National Fraud Initiative led by the Cabinet Office under the Local Audit and Accountability Act 2014. Staff are trained in fraud awareness and we actively promote the mechanism for staff to report any concerns about potential fraud, bribery or corruption. All concerns of fraud, bribery and corruption are investigated by the Counter Fraud Specialist and the outcome of all investigations are reported to the Audit Committee.
The Trust subscribes to the NHS Code of Conduct and Code of Accountability, has adopted the Nolan Principles, 'the seven principles of public life', and is appropriately sighted to the Code of Governance for NHS Provider Trusts (see appendix for assessment of 2023/24 compliance against those elements required to be evidenced in the Annual Report). We have also adopted the Code of Conduct: "Standards for NHS Board members and members of Clinical Commissioning Group governing bodies in the NHS in England" (Professional Standards Authority: November 2012).

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 University Hospitals of Leicester 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 University Hospitals of Leicester 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 University Hospitals of Leicester NHS Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Risk management is recognised by the Trust as an integral part of good management practice. Our Board approved Risk Management Policy describes the roles and responsibilities of the Trust Board, its Board Committees, management, and all staff, as well as an organisation-wide approach to identifying, assessing, treating, monitoring, and reporting on risk to make sure the organisation achieves its objectives/goals.

The Director of Corporate and Legal Affairs is the Trust Board lead Director for risk management and is supported in this role by the Head of Risk Assurance. All Executive and Clinical Directors have responsibility for the delivery of a robust risk management and governance process in their roles.

Our Board of Directors are responsible for establishing the Trust's strategic objectives/goals and provide leadership for ensuring that there are robust and effective systems and processes in place to identify and manage the risks associated with the achievement of these objectives/goals as part of the overall governance agenda.

All significant risk exposures are reported to the Trust Board and Risk Committee. All new significant risks, including management plans, are escalated to the Risk Committee for discussion and approval. The Trust Board regularly scans the horizon for emergent opportunities or threats and considers the nature and timing of the response required to ensure risk is always kept under control.

The Trust Board receives reports and assurance from Board Committees and discusses and notes progress with strategic risks on the Board Assurance Framework

and operational risk management actions as necessary. Each Board Committee has responsibility for the oversight of strategic risks associated to their respective remit.

On the Trust Board's behalf, the Risk Committee, chaired by the Chief Executive or Deputy Chief Executive, has maintained, and kept under review the policy for the management of risk. The annual Risk Committee work plan included all CMGs attending to present their top risks which are reflected on the Trust's Risk Register. In addition, new significant risks entered on the Risk Register are reported to the Risk Committee for review and challenge regarding content to improve clarity about the controls in place, risk scoring, and key next steps to treat the risks. The Risk Committee meets monthly and provides assurance to the Audit Committee that it continues to operate effectively.

Stage 2 of the Head of Internal Audit Opinion (2023/24) focused on how the BAF has been used during the year as live tool for the Trust Board. Findings describe that the BAF is reported to the Trust Board meetings on a quarterly basis with reports detailing any significant changes; that all BAF risks are aligned and reported to a Board Committee for oversight and reporting arrangements are in place for the escalation of risks through escalation reports presented to the Trust Board; and that there is an established process for adding, removing and changing risk scores on the BAF with evidence noted relating to closure of BAF Risk 5.

During the year there has also been an Internal Audit review of the risk management arrangements in place at Clinical Management Group (CMG) level. The review focused on Clinical Support and Imaging CMG and Renal Respiratory and Cardiovascular CMG. and the final opinion is significant assurance ("there is a generally sound framework of governance, risk management and control designed to meet the objectives of the system under review, and controls are generally being applied consistently. Our opinion is limited to the controls examined and samples tested as part of this review").

The Audit Committee receives a regular risk management and BAF report and provides the Trust Board with an independent and objective review of risk management in the Trust. The Audit Committee also has oversight of the BAF risks by Board Committees.

The review of the Trust risks on the operational risk register is a standing item on the agenda at the CMG Boards, as well as at Performance Review Meetings held between the Executive Directors and leaders in the CMG.

Practical implementation and integration of risk management requires an appropriate level of knowledge and the Corporate Risk Team provide advice and support to CMGs and corporate areas to manage risk in a way appropriate to their authority and duties via the risk management awareness training programme.

Incidents, complaints, claims, patient feedback and audit findings are routinely analysed to identify risks and single points of failure and learn from them. Lessons for learning are disseminated to colleagues using a variety of methods including customised briefings, safety alerts, and personal feedback where necessary.

The risk and control framework

The risk management policy sets out the Trust's risk and control framework.

The framework supports the Trust to:

- protect patients from harm and poor outcomes
- support staff to protect their health and wellbeing and ability to do their job
- protect the Trust from unplanned financial outcomes and drive action to address any financial governance issues
- have greater resilience to operational and strategic risks
- meet stakeholders' and Regulators' expectations

Good risk management encourages organisations to take well-managed risks that allow safe development, growth and change. However, it is impossible to eliminate all risks, and every organisation has to live with a degree of risk.

Through its established risk management framework, the Trust Board has undertaken work to understand mitigating risk, tolerating risk and accepting risk which is not mitigated to agree the Trust's risk appetite in relation to the strategic risks on the BAF. The Trust Board accepts that further work is necessary to disseminate and raise awareness of risk appetite and to roll out the framework for operational risk.

Risks are identified at both a strategic and operational level from various sources including pro-active risk assessments, strategic planning, performance data, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, inquests, patient and public feedback and assurance from stakeholders and regulators.

Strategic Risk

Risks which threaten the achievement of our Trust's strategic objectives/goals feature on the Board Assurance Framework, are assigned to an Executive Director as the risk owner and are reviewed at the relevant Board Committee meeting. The Corporate Risk Team meet monthly with each Executive Director or nominated deputy to examine the content and update the BAF as required. Key controls in place and assurance sources, as well as gaps in controls and assurances, and key next steps are discussed at each Board Committee meeting and summarised in an escalation report to the Trust Board. A risk report, including the Board Assurance Framework, is reported to, and scrutinised by, the Trust Board on a quarterly basis.

The Trust's strategic risks in 2023/24 (as featured on the Board Assurance Framework) are set out below:

Risk event	Executive Lead owner	Oversight Committee
Failure to maintain and improve patient safety, clinical effectiveness and patient experience	CN / MD	Quality Committee
Failure to meet national standards for timely urgent, cancer and elective care	COO	Operations & Performance Committee
Insufficient capital funding to address statutory requirements such as health and safety standards and legislation, and address backlog maintenance requirements (concerning	CFO	Finance Investment Committee

medical equipment, estate and IM&T)		
Failure to deliver the MTFP and achieve long term financial sustainability	CFO	Finance Investment Committee
IT Infrastructure unfit for the future, may result in being unable to provide safe, high quality, modern healthcare services	CIO	Finance Investment Committee
Estate Infrastructure unfit for the future, may result in being unable to provide safe, high quality, modern healthcare services	DEF	Finance Investment Committee / Our Future Hospitals & Transformation Committee
Insufficient workforce capacity, capability and lacking diversity	CPO	People & Culture Committee

There is an established process to add new risks, remove risks, and alter ratings on the BAF, which involves the relevant Board Committee receiving assurance and escalating the change(s) to the Trust Board for endorsement. The table below shows any in-year changes to the 2023/24 strategic risks:

Strategic BAF Risk Theme	Executive Leads	Board Committee	Highest Current Rating	Tolerable Rating	Target Rating	2023/24 in-year changes
Strategic risk 1 - Quality Governance	CN, MD	Quality Committee	20	12	6	
Strategic risk 2 - Activity (UEC, Elective, Cancer)	COO	Operations & Performance Committee	20	15	9	
Closed: Strategic risk 3 - Finance (Balance Sheet)	CFO	Finance Investment Committee	Closed in May 2023 - Extraordinary FIC, 02.05.2023 agreed to close the treated risk. This was escalated in the FIC report and closure approved by Trust Board in May 2023.			
Closed: Strategic risk 4 - Finance (Governance)	CFO	Finance Investment Committee	Closed in February 2023 - FIC, 27.01.2023 agreed to reduce the rating and to incorporate the residual risk regarding culture (training & development) into operational risk 3922. This was escalated in the FIC report and closure approved by TB in Feb 2023.			
Closed: Strategic risk 5 Finance (Grip & Control)	CFO	Finance Investment Committee	Closed in August 2023 - FIC, 28.07.2023 agreed to close the risk and to incorporate the residual risk into the operational risk register. This was escalated in the FIC report and closure approved by Trust Board in August 2023.			
Strategic risk 6 - Finance (Capital)	CFO	Finance Investment Committee	20	12	9	
Closed: Strategic risk 7A - Finance (Annual Plan)	CFO	Finance Investment Committee	Closed in May 2023 - Extraordinary FIC, 02.05.2023 agreed the risk has met its target rating and to incorporate the residual risk into the operational risk register. This was escalated in the FIC report and approved by Trust Board in May 2023.			
Strategic risk 7 Finance (Sustainability)	CFO	Finance Investment Committee	20	12	8	
Strategic risk 8 - Digital	CIO	Finance Investment Committee Our Future Hospitals and Transformation Committee	16	12	9	
Strategic risk 9 - Estates & Facilities	DEF	Finance Investment Committee Our Future Hospitals and Transformation Committee	16	12	9	
Strategic risk 10 - People	CPO	People & Culture Committee	20	12	9	

Following the launch of the new Trust Strategy at Trust Board in October 2023, 'leading in healthcare, trusted in communities', the strategic risks have been revised where necessary to align to the new strategic objective/goals.

Operational Risk

Operational risks are assessed and recorded in line with the procedure set out in our Risk Management Policy. The Trust use a common five-by-five risk scoring matrix to quantify and prioritise risks identified through the risk assessment procedure. Scoring is based on the frequency or likelihood of the risk event occurring combined with the possible severity or impact of that event. The arrangement determines at what level in the organisation a risk should be managed and who needs to be assured that appropriate management arrangements are in place.

The operational risk register provides detail about clinical and non-clinical operational risks relating to the organisation's on-going day-to-day business delivery in CMGs and corporate directorates.

Operational risk assessments are managed at Clinical Management Group and Corporate Directorate level and, when they give rise to a significant residual risk, they are reported on the Trust risk register.

Significant risk themes on the operational risk register include:

- Workforce gaps – including recruitment, retention and skill mix of clinical and non-clinical staff groups
- Patient activity and flow – including managing demand and capacity in our urgent and emergency care services, managing the elective care backlogs, and managing cancer patients
- Estate and environment – including managing ageing infrastructure and climate
- Equipment and supplies – including managing ageing equipment and addressing IM&T infrastructure works and digital risk
- Finances – including managing capital funding and increased costs

In the coming year, we will complete the transition to the web-based organisational risk register, making it easier for staff to access and report their risks. The Risk Committee work plan will include a focus on the management of significant risks reported on the operational risk register; review of corporate risks with a Trust-wide impact; and deep dive reviews of strategic risks.

Workforce strategy

The NHS People Plan was published on 30 July 2020 and includes a programme of initiatives to support the growth and development of the NHS Workforce, with national and local actions to be undertaken, to enable services to recover from the pandemic and to move forward and transform.
It includes specific commitments around how we will continue to:

- Look after our people.
- Ensure belonging in the NHS.
- Deliver new ways of working and delivering care.
- Grow for the future.

The NHS long term workforce plan was launched in 2023 and focuses on the training, retention and reform of our NHS workforce. The People Promise elements are aligned to the NHS long term workforce plan and both provide a framework for our people agenda.

Our UHL People Plan is being refreshed to align with a new Trust strategy and new Trust values, which have been co-produced with colleagues, patients, and partners. Our UHL People Plan will align to the national programmes of work and the Leicester Leicestershire and Rutland ICB People Plan. We will also work with other NHS Providers in collaboration to ensure we deliver the best employment opportunities for all of our colleagues.

We want UHL to become the employer of choice and a Great Place to Work for existing staff and new colleagues. We will do this by living our values, being explicit about career development opportunities and supporting people to be their best. We strive to achieve excellence in equality, diversity, and inclusion in all that we do whilst acknowledging the workforce challenges our Trust is experiencing.
We will:

- Prioritise the care of our colleagues and ensure joined up approaches to health and wellbeing across health and social care and other NHS Providers. We will align occupational health provision and psychological support
- Mobilise to share our workforce across health, social care, higher education institutions, other healthcare providers and provide colleagues with different work opportunities
- Develop our training and education provision
- Focus on pro-equity and inclusion to improve the experiences of all our colleagues at work
- Utilise virtual and digital technology
- Support the attraction and recruitment of our future workforce and development of our current workforce
- Recognise and reward colleagues through a range of schemes

Care Quality Commission

The Trust is required to register with the Care Quality Commission, and its current registration status is ‘Requires Improvement’.

University Hospitals of Leicester Overall CQC Rating

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement → ← Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022

In February 2023, the Care Quality Commission (CQC) conducted inspections of our maternity services at Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH), and St Mary’s Birth Centre in Melton. The inspections led to a reclassification of our services' ratings, highlighting areas needing immediate attention, particularly in safety and leadership. Following these findings, the Trust received a Section 29A warning notice to improve maternity care.

University Hospitals of Leicester NHS Trust currently has 2 live warning notices from the CQC Inspections undertaken in Emergency and Urgent Care in April 2022 and Maternity Services in February 2023. Responding robustly to the CQC's feedback, UHL implemented a series of strategic initiatives aimed at strengthening existing systems and processes. These initiatives reflect our proactive approach to addressing areas of concern and enhancing overall patient safety and care.

On January 10th and 11th, 2024, the CQC revisited our facilities to assess the impact of the improvements made. While awaiting the publication of these new findings, preliminary feedback has been encouraging, and we are optimistic about a positive reflection of our efforts.

Continuous improvement remains a priority, with ongoing reviews and updates to our processes. Our commitment extends beyond compliance to genuinely enhancing patient experiences and outcomes.

The past year has been a period of significant challenge and change. However, it has also been a time of opportunity and improvement. We are proud of the progress we have made and are committed to continuing our journey towards excellence in patient care.

Maternity Services Ratings

Leicester Royal Infirmary

2023	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Maternity	Inadequate	Not inspected (Previously rated Good)	Not inspected (Previously rated Good)	Not inspected (Previously rated Good)	Requires Improvement	Requires Improvement

Leicester General Hospital

2023	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Maternity	Inadequate	Not Inspected (Previously Good)	Not Inspected (Previously Good)	Not Inspected (Previously Good)	Requires Improvement	Requires Improvement

St Mary's Birth Centre

2023	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Maternity	Good	Not Inspected (Previously Good)	Not Inspected (Previously Good)	Not Inspected (Previously Good)	Requires Improvement	Good

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

Well Led

The Trust continues to progress the 'should do' actions from the 2022 CQC Well Led inspection, which will ensure we are operating to the expected standards of the Well Led framework. There were no 'must do' actions for the Trust from that inspection ('requires improvement' rating). The Trust is scheduling an external Well Led assessment in 2024/25.

Register of interests, gifts and hospitality

The Trust publishes on its website a register of interests, gifts and hospitality for decision making staff (as defined within our Managing Conflicts of Interests in the NHS Policy, in line with national guidance) within the past twelve months. This is done in accordance with the *'Managing Conflicts of Interest in the NHS'* guidance. The register can be found here

Green plan

At the heart of our strategy sits our Trust Board approved green plan. This plan addresses key objectives set by NHSE and the Greener NHS Team

The Green plan sets targets for achieving net zero carbon emissions at UHL. There is a need to be innovative in our approach to sustainability in order to hit these targets. UHL is seeking to achieve an 80% reduction by 2028-32. The need for a significant shift in mind set around sustainability management in the NHS is clear if we are to achieve carbon net zero by 2040.

The sustainability agenda is multi-faceted and will touch every aspect of our operation. The Green Plan identifies key areas which are being targeted, these are listed below:

- Workforce and system leadership
- Sustainable models of care
- Digital transformation
- Sustainable Travel and transport
- Estates and facilities sustainability
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation to Climate Change
- Carbon Footprint
- Communicate the Green plan and Reporting progress

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

As Accounting Officer, I have responsibility for ensuring economy, efficiency and effectiveness of the use of resources and I am supported by my executive team who have responsibility for overseeing the day-to-day operations of the Trust. Performance against the operations of the Trust are monitored by the Board through regular reporting of the integrated performance report covering operations, finance, quality and people related areas. The Board discussed and approved the Trust's strategic and annual plans.

As Accounting Officer, I am responsible for ensuring that the Trust has arrangements in place for securing value for money in the use of its resources. To do this the Trust have maintained systems to:

- Set, review and implement strategic and operational objectives.
- Engage actively with patients, staff, members and other stakeholders to ensure key messages about services are received and acted upon.
- Monitor and improve organisational performance.
- Establish plans to deliver efficiency and productivity improvements.

Performance against objectives is monitored and actions identified through several internal channels, these include:

- Operational and financial plan approval by Trust Board
- The Board committee meetings receive monthly reporting on key performance indicators relevant to their remit including; finance, productivity; activity, quality and safety and workforce
- All business cases follow a robust process to ensure informed decision making
- Regular reporting to the Trust Leadership Team on key factors effecting the Trust's financial position and performance
- Performance Review Meetings for each Clinical Management Group take place monthly covering performance against key objectives

As a Trust we are committed to providing best value for the taxpayers' money and the most effective, fair and sustainable use of resources. Our accountability to the public, communities and patients we serve is taken seriously.

Information Governance

The Trust recognises the importance of robust information governance. The Chief Information Officer is our designated Senior Information Risk Owner, while the post of Medical Director is designated as our Caldicott Guardian.

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Data Security and Protection Toolkit. This contains 10 standards of good practice, spread across the domains identified below and, for 2023/24, we declared "all standards met" as our compliance:

1. Personal Confidential Data
2. Staff Responsibilities
3. Training
4. Managing Data Access
5. Process Reviews
6. Responding to Incidents
7. Continuity Planning
8. Unsupported Systems
9. IT Protection
10. Accountable Suppliers

We can confirm for the financial year 2023/24 we logged no concerns with ICO that

were deemed suitable for escalating. This means that the severity of the incidents we have had at the Trust thus far have been within organisational tolerance to manage and remediate.

The Privacy Unit have continuously worked towards forming robust ongoing IG assurance and have automated business as usual information governance processes via our Dashboard Tool. This will ensure that we continue to meet the ever growing demands of supporting the Trust and in particular the patient systems used.

The Privacy Unit is supporting the wider IM&T cybersecurity objectives to ensure that we are aligned to Trust and NHS Digital requirements on an evolving and ongoing basis.

Data quality and governance

University Hospitals of Leicester NHS Trust undertakes the following actions to ensure data quality:

The Data Quality Forum is chaired monthly by the Chief Information Officer to provide assurance on the quality of data reported to the Trust Board. The forum is a multi-disciplinary panel from the departments of information, safety and risk, clinical quality, nursing, medicine, finance, clinical outcomes, workforce development, performance and privacy. The panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance by best endeavours that it is of suitably high quality. The NHS England-endorsed Data Quality Framework provides scrutiny and challenge on the quality of data presented against the dimensions of accuracy, validity, reliability, timeliness, relevance and completeness. Where such assessments identify shortfalls in data quality, the panel make and track recommendations for improvements to raise quality to the required standards. They also offer advice and direction to clinical management and corporate teams on how to improve the quality of their data.

For the management of patient activity data, we have a dedicated corporate data quality team. They respond to any identified issues and undertake daily processes to ensure singularity of patient records and accurate GP and commissioner attribution. We have reduced GP inaccuracy by implementing automated checking against the Summary Care Record. Our monthly corporate data quality meetings challenge inaccurate and incomplete data collection direct with administration leads in the specialty teams.

The Trust also has a dedicated elective care validation team comprising of a group who validate patient elective care pathways against the Referral to Treatment standards and another group that perform technical validation relating to weekly and monthly submissions against national targets. This second group also trains staff across the organisation in how to manage pathways in order to avoid incorrect outcomes that impact on performance and patient care. The Trust has recently implemented a refreshed Elective Care Training Strategy aimed at further improving the quality of data in this area, which includes national elective care rules, the Trust's Elective Care Access Policy and standard operating procedures underpinning the policy. It is role based and applies to both non-clinical and clinical staff.

The NHS Digital Data Quality Maturity Index is used for benchmarking against 17 peer

Trusts. Data quality and clinical coding audit is undertaken in line with Data Protection and Security Toolkit and mandatory standards are achieved. For clinical coding the Trust have several assurance processes in place to ensure that patient complexity is accurately captured. Since 2019 we have improved the information supply chain for clinical coding which has resulted in more documentation being available for the Clinical Coding process. We are making full use of electronic systems as source documentation for Clinical Coding.

The Trust Leadership Team receives quarterly reports on the Data Quality and Clinical Coding. Our updated Elective Access Policy and elective care waiting list management plan are in place to further focus on this crucial area of our work.

The Trust has written an Elective Care Training Strategy, with several training sessions delivered in 2023/24. The content included national elective care rules, the Trust's Elective Care Access Policy and standard operating procedures underpinning the policy. For 2024/25, further training is being planned to include competency testing and compliance monitoring will be key features – which will further improve data quality across the Trust. It will apply to both non-clinical and clinical staff and will be role based.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, risk committee and quality committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board, supported by the Audit Committee, has routinely reviewed the Trust's internal control system and governance framework. The assurance framework provides the Board with evidence that the effectiveness of controls that manage the risks to the Trust achieving its objectives have been reviewed.

Internal Audit has conducted reviews upon the Trusts control environment, governance and risk management processes, based on an audit plan approved by the Audit Committee. The work included testing the effectiveness of the controls in place with a particular focus on the basic standards of good governance and a functioning Board Assurance Framework. During 2023/24, 10 audits were completed and the status of those audits at the end of the year were:

Audit	Opinion
Workforce planning*	Significant Assurance
Performance and Accountability Framework*	Significant Assurance
Transactional services – governance review	Significant Assurance
Business planning	Significant Assurance

Infection prevention and control BAF	Significant Assurance
CMG risk management	Significant Assurance
Policy management framework	Moderate Assurance
Financial ledger and reporting	Moderate Assurance
Data security and protection toolkit (NHSE opinion level)	Moderate
Safeguarding governance and controls	Limited Assurance
Financial Systems – Pay Expenditure	Moderate Assurance
Financial Systems – Asset Register	Moderate Assurance

**audit carried over from 22/23 internal audit plan*

Leadership and Strategy
Outside of our formal meetings, the Board has continued to hold development sessions throughout the year. Amongst the topics considered were:

- Procurement
- Staff survey results
- 24/25 Capital plan
- PSIRF
- Estates and Facilities strategy
- Heath inequalities
- 24/25 planning
- Clinical strategy
- UHL values and behaviours

Head of Internal Audit Opinion

A "*moderate assurance*" opinion was provided concluding that *"there are areas of improvement in the framework of governance, risk management and control and some inconsistent application of controls puts the achievement of the organisation's objectives at risk".*

The internal audit opinion is made up of three key areas including the Board Assurance Framework (BAF), outturn of the in year internal audit plan, and the implementation of agreed audit actions. In addition to this, there is consideration given to third party assurance.

For transparency and comparison, below shows the basis of the opinion over the last two years.

Area	Opinion 22/23	Opinion 23/24
BAF	Moderate	Significant
Plan outturn	Limited	Moderate
Implementation of actions	Limited	Moderate

The BAF and strategic management element of the opinion demonstrates the Trust utilises the BAF as a 'live' tool to support the management of strategic risk and achievement of organisational objectives. The audit states "*significant improvements*" have been made since 22/23 and "*the BAF is now operating effectively as a management tool and arrangements have embedded during 2023/24*".
The implementation of internal audit actions was an area the Trust identified in 22/23 to

improve. For 23/24 an implementation rate of 73% (2% off significant assurance) was reached, compared to 55% in 22/23. The overall implementation rate for 23/24 reached 89%. This shows the improvements that have been made to address identified risks within audit reports, albeit not always by the original agreed date. There have been zero high risk actions issued in 2023/24.

The 2023/24 internal audit plan outturn completed 12 opinion-based audits and two advisory audits (non-opinion). During 2023/24, 6 received “significant assurance” and 5 received “moderate assurance” and 1 received “limited assurance”. In 2022/23, 6 audits received “limited assurance”.

Financial oversight

Following an intensive amount of work in a concentrated period of time, at the same time as continuing to deliver and embed improved financial governance and financial reporting processes, The Trust has produced five years sets of Accounts (19/20, 20/21, 21/22, 22/23 and 23/24) in under 2 ½ years. These have all been adopted and published, with successive improvements in the audit opinion (following the historical financial misreporting that took place in 18/19 and 19/20) as follows:

- 19/20 – Disclaimer of Opinion
- 20/21 – Adverse Opinion
- 21/22 – Qualified Opinion with 11 qualifications
- 22/23 – Qualified Opinion with 2 Qualifications
- 23/24 – Unqualified Opinion

The Trust has received an unqualified opinion for 2023/24, after addressing and removing the qualification on the existence testing of non-land and building assets. The Trust has finalised its exercise to track and locate its plant & equipment assets during the year, responding to the weaknesses highlighting in previous periods. It was a detailed exercise and has involved a large amount of staff from across the Trust as well as support from external specialists to log and tag over 16,000 of individual plant & equipment assets across the trust. The existence of these assets will now be reviewed and confirmed by individual departments on an annual basis. The exercise resulted in plant & equipment assets (including assets under construction) with a Net Book Value of £6.4m as at 31 March 2024 being written off, as well as £11.9m of fixed previously included as tangible fixed assets as at 31 March 2024 being reclassified as intangible assets to better reflect their underlying characteristics. Both of these adjustments have been posted within the year to 31 March 2024 as management’s assessment confirmed that any required adjustment to prior year accounts would be immaterial. This represents a significant step for the trust in its journey of improvement and this is reflected in the external audit opinion that no longer includes a qualification relating to the lack of controls over asset existence, which has been a key focus for the Board.

The Trust submitted its 23/24 accounts in accordance with the national timetable to ensure consolidation with the National NHS accounts.

The financial regime in 23/24 reflected national policy expectations that the NHS would continue progress to business as usual and operate within a normal financial and operating regime with overall funding levels reduced from those experienced during the Pandemic period, with elective patient care and cancer activity recovered and restored

to pre-pandemic levels. Health systems were expected to operate within their agreed financial envelopes. Recovery has led to an increase in costs, particularly relating to pay costs to support efforts to restore activity levels, address waiting lists and increase productivity.

The financial plan for 23/24 forecast a £10m deficit. However, there were known risks at the time the plan was prepared and further unknown risks that materialised after the plan was prepared, such that the final outturn achieved was a £52.8m deficit, which represented a deviation from the plan of £42.8m. The drivers of this adverse position included unfunded inflation, urgent and emergency care pressures, elective recovery fund spend above target, unfunded industrial action, re-banding of healthcare assistants and a reduction in planned income to cover the costs of nationally funded capital schemes.

The Trust achieved its other statutory duties of maintaining capital spending and cash limits set by DHSC.

The Trust is committed to achieving sustained financial recovery and using its resources productively to optimise care for its patients as a strategic objective, recognising the size of the financial challenge is unprecedented. An Associate Director Financial Sustainability, accountable to Chief Financial Officer, leads a Transformation Team, working with the clinical management groups to identify, develop and implement cost improvement plans.

The Trust delivered its efficiency target of £64.2m in 2023/24, which had ratcheted up substantially from £39m in 2022/23, as the NHS and Trust returned to a 'normalised' operating regime. The Trust worked with its system partners across the LLR Integrated Care System (ICS) and engaged in the Leicester wide sustainability and transformation plan to this end. The Trust is developing a medium-term financial plan aligned with system partners spanning 5 years that focuses on return to a sustainable financial position.

The Trust has developed 13 work programmes which are proposed to help deliver financial sustainability through strengthened grip and control, delivering the basics and improving productivity by 10%. These cover Trust Strategic Initiatives and additional programmes needed to support financial sustainability, including elective care (theatres, outpatients), urgent and emergency care (UEC), patient safety, continuous improvement. digital & data, new hospitals, operational change & embed, grip and control, workforce, activity coding, data and benchmarking. admission avoidance and population health (ICB) and procurement & clinical enablers. Each of these work programmes (including the Strategic Initiatives) directly or indirectly enables operational and corporate areas to deliver their targeted financial improvement.

The Trust has agreed an operational plan for 24/25 in conjunction with its system partners which continues to include a challenging CIP requirement of £92 million representing circa 9% of opex.

Financial Governance

Work continued throughout 23/24 to further strengthen the financial control environment. Improved governance has been achieved through progressing a

roadmap to sustainable financial governance and an operational financial improvement plan, including starting to embed the grip & control as business as usual within the organisation. Grip and control has and continues to improve, but the Trust recognises it has more to do to secure full coverage and compliance with the very highest standards of financial control. The roadmap is also mapped to actions and outcomes required to achieve Recovery Support Programme exit. The Trust achieved an improved moderate opinion from its internal auditors in relation to its key financial systems, with all recommended actions had been implemented by 31 March 2024.

Financial controls have been strengthened to improve the quality of financial reporting and minimise and reduce expenditure in 23/24, building on the work of previous years. This has included:

- Continuing to develop and embed controls outlined in the national NHS Grip & Control checklist within the organisation. Grip and control has and continues to improve, but the Trust recognises it has more to do to secure full coverage and compliance with the very highest standards of financial control.
- Temporary staffing (including agency) controls and the vacancy control processes have been reinforced to provide more scrutiny and challenge to requests for substantive and non-substantive posts. Reducing expenditure on NHS agency staff remains a priority on the back on an increase in recruitment into substantive roles and to achieve compliance with agency controls. This includes ending the use of off-framework providers and improving compliance with NHS agency price caps.
- Controls over discretionary non pay expenditure implemented, including cessation/pausing of specific types of non-critical expenditure.
- Implementation of a new purchase to pay process including 100% PO coverage, to minimise discretionary spend.
- Scrutiny of directorate positions and forecast positions, through clinical management group performance reviews and executive led meetings, including CFO setting out expectations around forecast targets and the action required to achieve these.

Financial reporting and oversight and scrutiny of the Trust's financial controls, expenditure and capital and revenue investments is overseen by an established committee structure, including the Audit Committee, Capital Investment and Monitoring Committee, Finance and Investment Committee and Trust Leadership Team, with the latter allowing for appropriate clinical engagement and senior operational oversight of financial decision making. The Our Future Hospitals Steering Group provides appropriate oversight of the Trust's New Hospitals Programme and major reconfiguration projects.

The Finance and Investment Committee provides overall value for money assurance, including approving and performance monitoring of the organisation's financial position, efficiency and recovery plans and reviewing clinical management groups financial and business performance. These reports contain both financial and non-financial performance information.

Independent assurances on the operation of financial controls are commissioned and reviewed by the Audit Committee and, where appropriate, other Committees of the Board of Directors as part of their annual cycle of business. The Trust outsources the

internal audit function to 360 Assurance. External audit is undertaken by KPMG, with 2023/24 being the third year of an initial three year contract. The implementation of recommendations made by Internal and External Audit are overseen by the Audit Committee.

Conclusion

I believe the 2023/24 annual governance statement has demonstrated the improvements which have been made in continuing to strengthen the grip and internal control at the Trust. I fully acknowledge there is further improvements to be made, and I am committed to this and ensuring our risk environment is robust and our systems of internal control are sound.

As Accountable Officer I have accepted the moderate assurance opinion issued for the 2023/24 Head of Internal Audit Opinion. I believe the progress made in year is noticeable and this will continue into 2024/25.

Richard Mitchell
Chief Executive

27 June 2024

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

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

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

Richard Mitchell
Chief Executive

27 June 2024

Staff Report:

Staff numbers (Headcount)

	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16
Summary									
Medical and Dental	2409	2091	2009	1,898	1,825	1,805	1,682	1,725	1,641
Administration and Estates	5442	4355	4143	4,162	4,126	4,071	3,977	3,825	2,501
Healthcare Assistants and other support staff	3780	3065	2705	2,540	2,500	2,388	2,265	2,185	2,007
Registered Nursing and Midwifery	5405	4525	4046	3,941	3,869	3,692	3,577	3,583	3,571
Scientific, Therapeutic and Technical	2091	1752	1628	1,581	1,526	1,504	1,465	1,397	1,323
TOTAL	19127	15,788	14,531	14,122	13,847	13,460	12,966	12,714	11,044

Staff composition (by gender)

Senior Manager Gender Split by Pay Band as at 31st of March 2024

					Totals	
	Headcount		WTE		Headcount	WTE
	Male	Female	Male	Female		
Band 8A	150	484	139.18	437.81	**634**	**576.99**
Band 8B	58	114	57.48	110.40	**172**	**167.88**
Band 8C	27	67	26.50	64.35	**94**	**90.85**
Band 8D	10	29	10.20	28.11	**39**	**38.31**
Band 9	14	22	13.65	21.80	**36**	**35.45**
Very Senior Manager (VSM) Pay Band	6	9	6.00	8.60	**15**	**14.60**
Senior Manager Totals	**265**	**725**	**253.02**	**671.07**	**990**	**924.08**

Sickness absence data

Clinical /Corporate	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Cumulative Position
358 Clinical CMGs	5.19 %	4.76 %	4.75 %	4.74 %	4.82 %	4.95 %	5.15 %	5.51 %	5.49 %	5.42 %	5.38 %	4.87 %	5.09%
358 Corporate	3.20 %	2.84 %	2.82 %	3.02 %	3.06 %	3.62 %	3.69 %	4.27 %	4.14 %	3.90 %	4.23 %	4.00 %	3.58%
UHL	5.00 %	4.57 %	4.56 %	4.57 %	4.64 %	4.81 %	5.00 %	5.38 %	5.35 %	5.26 %	5.26 %	4.78 %	4.94%
Sickness Target	3.00 %	3.00 %	3.00 %	3.00 %	3.00 %	3.00 %	3.00 %	3.00 %	3.00 %	3.00 %	3.00 %	3.00 %	3.00%

Staff turnover (6%)

	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16
Summary									
Medical and Dental	2,271	2,091	2,009	1,898	1,825	1,805	1,682	1,725	1,641
Administration and Estates	4,667	4,355	4,143	4,162	4,126	4,071	3,977	3,825	2,501
Healthcare Assistants and other support staff	3,254	3,065	2,705	2,540	2,500	2,388	2,265	2,185	2,007
Registered Nursing and Midwifery	4,792	4,525	4,046	3,941	3,869	3,692	3,577	3,583	3,571
Scientific, Therapeutic and Technical	1,855	1,752	1,628	1,581	1,526	1,504	1,465	1,397	1,323
TOTAL	**16,839**	**15,788**	**14,531**	**14,122**	**13,847**	**13,460**	**12,966**	**12,714**	**11,044**

Staff engagement – the NHS National Staff Survey

The NHS Staff Survey was carried out in October and November 2023, on behalf of NHS England and the results form a key part of the Care Quality Commission's assessment of NHS Trusts in respect of its regulatory activities such as registration, the monitoring of on- going compliance and reviews.

A full census survey was undertaken, which means every member of staff (17,990) that was eligible to take part and would have received a survey to complete. 10,434 responses were returned, giving a response rate of 58% per cent. This was an increase of 10 percentage points from the previous year; the national average (median) for Acute and Acute & Community Trusts stands at 47 per cent, which means we were above average for the second year running.

There are two key indicators in the survey that contribute to a colleague's experience at work:

	Trust 2022	Trust 2023
q25c. Would recommend organisation as place to work	55%	64%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	63%

Our results mirror the National trend of improvement in both questions, noting our margin is greater. This year we saw a 9% improvement in colleagues recommending the Trust as a place to work. The national average score increased by 4 percentage points to 60 percent. We also saw a 5 percentage point increase for colleagues who were happy with the standard of care, compared to a national improvement of 2 percent to 64 percent for this question.

Two new questions addressing sexual safety were introduced into the 2024 survey. Our result are marginally better than the benchmark median group.

- Q17a, In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service

users, their relatives or other members of the public. Our score was 6.41 percent compared to a benchmark median group result of 7.73 percent.

- Q17b, In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues. Our score was 3.80 percent compared to benchmark median group result of 3.82 percent.

In other questions colleagues indicated a positive improvement in 96 of the 103 questions posed, meaning that the statistical significance of our improvement has been deemed significantly higher compared to our 2022 results.

Our aspiration for 2024 is to make UHL a great place to work and our promise is to continue to build on our progress in 2023 and to work together to make UHL a place where more people feel:

Recognised: radically improving the way we recognise and celebrate all colleagues.
Included: ensuring everyone at UHL can contribute equally, safely, and proudly.
Supported: putting practical and compassionate steps in place to support you at every stage.
Equipped: ensuring people have the right tools to carry out their roles and becoming an organisation you can rely on.

Implementing our fair and equitable People Strategy

The NHS People Plan was published on 30 July 2020 and includes a programme of initiatives to support the growth and development of the NHS Workforce, with national and local actions to be undertaken, to enable services to recover from the pandemic and to move forward and transform.

It includes specific commitments around how we will continue to:

- Look after our people.
- Ensure belonging in the NHS.
- Deliver new ways of working and delivering care.
- Grow for the future.

The NHS long term workforce plan was launched in 2023 and focusses on the training, retention and reform of our NHS workforce. The People Promise elements are aligned to the NHS long term workforce plan and both provide a framework for our people agenda.

Our UHL People Plan is being refreshed to align with a new Trust strategy and new Trust values, which have been co-produced with colleagues, patients, and partners. Our UHL People Plan will align to the national programmes of work and the Leicester Leicestershire and Rutland ICB People Plan. We will also work with other NHS Providers in collaboration to ensure we deliver the best employment opportunities for all of our colleagues.

We want UHL to become the employer of choice and a Great Place to Work for existing

staff and new colleagues. We will do this by living our values, being explicit about career development opportunities and supporting people to be their best. We strive to achieve excellence in equality, diversity, and inclusion in all that we do whilst acknowledging the workforce challenges our Trust is experiencing.

We will:

- Prioritise the care of our colleagues and ensure joined up approaches to health and wellbeing across health and social care and other NHS Providers. We will align occupational health provision and psychological support
- Mobilise to share our workforce across health, social care, higher education institutions, other healthcare providers and provide colleagues with different work opportunities
- Develop our training and education provision
- Focus on pro-equity and inclusion to improve the experiences of all our colleagues at work
- Utilise virtual and digital technology
- Support the attraction and recruitment of our future workforce and development of our current workforce
- Recognise and reward colleagues through a range of schemes

Highlights for 2023/24

Considerable work has been delivered across core workforce areas over the last 12 months, which have been discussed and reported on separately to various Executive groups and Trust Committees, specifically:

Looking after our people

Wellbeing

- Our Health and wellbeing offer has been continuously developed including the addition of the 'Recognising and Responding to Compassion Fatigue' course which over 375 colleagues have benefitted from.
- 316 colleagues have been offered Trauma Risk Management (TRiM) support with a 20% uptake rate.
- We set up the NHS TRiM network and have 102 members from across the UK and Ireland
- 548 colleagues are Health and Wellbeing Ambassadors.
- 810 colleagues have benefited from Health and Wellbeing talks
- A further 80 colleagues have been trained to hold Wellbeing Conversations
- 60 colleagues now feel confident to hold a REACT MH conversation with a colleague who may be struggling.
- Amica Staff Counselling and Psychological Support Services are available for all UHL colleagues 365 days a year. The need for our services has risen by approximately 20% in the last year. The team, alongside quality one-to-one services, have provided more than 600 hours of in-reach work across the three UHL sites, in Critical Care, Theatres and the Emergency Department. Amica has also supported teams experiencing extra challenges, with drop-in/support sessions, when requested.
    - **Accessibility and Support**: Amica continues to operate 365 days a year, 24 hours a day, ensuring availability to all UHL colleagues. Our website hosts a variety of support services such as training videos/courses,

access to the Silver Cloud self-help CBT platform, personalized online support through live chat, and a comprehensive repository of resources covering diverse mental health topics.

- **Service Utilisation**: The referral rate into our counselling services has seen an 18% increase since 2022-23, resulting in over 3330 one-to-one client sessions. The feedback from clients indicates significant and substantial reductions in distress levels. Additionally, we have facilitated 337 online support conversations.

- **Client Satisfaction**: Feedback from our clients reflects a remarkable overall satisfaction rate of 4.9 out of 5.

- **Resource Utilisation**: The Amica website's resource page has been visited 3,945 times. Furthermore, our 24/7 phone support line, accessed over 5000 times, ensures continuous mental health surveillance and safety. The Silver Cloud online program has been utilized in 619 sessions with a 94% satisfaction rate.

- **Outreach and In-person Support**: In 2023-24, Amica has delivered over 720 hours of outreach services across the three UHL sites. Our dedicated team of counsellors and Clinical Psychologist have extended specialized support to various departments, including the Emergency Department, Maternity, and Neonatal teams.

Occupational Health

- Over 7,000 employment checks have been undertaken for UHL staff. This has resulted in a significant increase in 'New Starter' appointments (2,400) being provided by Occupational Health
- Approximately 2,600 management referral appointments have been provided. These important assessments of fitness for work and provision of advice surrounding disability and reasonable adjustments helps support both staff and managers.
- Approximately 13,800 Flu and Covid vaccinations
- The OH service retains its external quality assurance kitemark (SEQOHS) following independent inspection.
- The OH service continue to contribute to the Trust's wider Health and Safety and Infection Prevention and Control agenda, including contributing to new efforts improve the monitoring of, and to reduce the risk of musculoskeletal injury in the healthcare workforce.

Training & Development

- We have supported learning, assessments, and exams for around 484Trust apprentices with 42 training providers; there have been 270 Centre apprentices some of which were also UHL colleagues.

- Design and development of the Active bystander awareness and e-learning packages to address issues of attitudes and behaviours. This is in progress and will have video clips from Richard Mitchell and Clare Teeney outlining the expected standards of behaviour across the Trust.

- We recognise that our colleagues are the most valuable resource we have and they are vital to us delivering high quality services for the benefit of the population of Leicestershire, Leicester and Rutland. We have focused on recognition and appreciation recognising the service and contributions of our colleagues. We will continue and build on our initiatives through the introduction of EDI Awards, that celebrate the contribution of healthcare by our diverse colleagues.

- Our new UHL Recognition awards were launched in 2023 replacing our previous UHL Caring at its Best awards. This has enabled us to recognise and reward more employees than ever before with more than 500 nominations over 16 new categories. We had the usual external judging panel which included sponsors and local dignitaries. In September we were able to host our first in-person event since 2019 and this was attending by circa 500 colleagues.

- Our 'Above and Beyond' informal recognition scheme, launched in November 2016, continues to go from strength to strength with more than 63,000 nominations from its launch, including in excess of 9,166 since April 2023. The scheme provides employees to be recognised by colleagues or peers as going 'above and beyond'. They receive a special thank you in the form of a pin badge and card.

- In April 2023, we launched the new long service recognition scheme. The new awards expanded the recognition of long service, from 250 people per year, to over 3,000; recognising colleagues at every 5-year milestone of their NHS service from 5 years. Depending on the milestone celebrated, all recipients received a thank you card, certificate and badge, those celebrating from 10-year milestones were invited to an afternoon tea or celebration breakfast and after 25-years, a gift voucher. In 2023/24 Learning and Development invited 3,408 colleagues to afternoon teas, planned the events and hosted these events for UHL in partnership with colleagues, sent vouchers and long service packs to 1,731 colleagues and issued 11,857 colleagues with long service badges and certificates.

- Our investment into staff for development through the apprenticeship levy has seen £3.9m invested during 2023/24 across 514 learners with 43 training providers. 612 colleagues have completed an apprenticeship to date which has supported them in progressing their careers.

Delivering new ways of working and delivering care and Growing for the future

- Nursing and Midwifery Workforce plan – supporting branding campaign and recruitment strategies such as International Recruitment resulting in reduction in vacancies. Expanding undergraduate student nurse and midwifery placement capacity within the system across health and social care setting. Increasing new roles, recognition, and retention initiatives. Significant progress in closing the gap for support to nursing vacancies.
- Medical Workforce plan – to increase workforce supply we developed recruitment initiatives, new roles and introduced rotational programmes.

- Clinical Fellowship Programme - Medical. The Clinical Fellowship Programme aims to reduce agency spend, improve retention post-fellowship and to improve the overall experience of the 500 Locally Employed doctors employed at UHL.

The programme encompasses a comprehensive pre and on-boarding arrival support for all Locally Employed Doctors at UHL, including tailored induction for International Medical Graduates. 76 Clinical Fellows have started at UHL since January 2024. The programme provides a comprehensive offering to Locally Employed and SAS doctors with, education, training and tailored progression routes.

- Development of workforce plans at service level focusing on restoration and recovery of both our people and activity levels. This included the development of new and innovative roles include pharmacy roles to support care homes, Physician Associates and Apprenticeships for Pharmacy Technicians.
- Our externally accredited UHL Apprenticeship and Development Centre are committed to providing learning and development opportunities to new to Trust or staff in UHL through blended learning approaches across a range of programmes and gained OFSTED rating of 'good' during 2021. The Centre delivers 6 apprenticeships through the Learning and Development Team; Business Administration Level 3, Team Leader Level 3, Customer Services Level 2, Health Level 2, 3 and 5. The Centre also delivers Employability in Health, to trainees on the UHL Kickstart programme, and nationally accredited screening qualifications e.g. Newborn Hearing, Diabetes Eye Grading. The Centre delivers 1 apprenticeship through the Nursing Development Team; Nursing Associate Level 5 and the Department for Education work to support this, comes via the Learning and Development team
- Launched the Chef Academy and Medical Career schemes with local schools as well as continues with Project Search, Princes Trust and Kickstart employability schemes. Taken a pilot T level student and scoped demand for further placements to support entry into the UHL workforce. These all support attracting our workforce of the future. Furthermore, we are ensuring that people who successfully complete placements through all our employability schemes, including Project Search students, are supported to transition into vacancies within the Trust for a 12-month period where they will continue to be supported, with a view to securing permanent employment with us. New termly catch ups with schools, career advisors and Health and Social Care Career Ambassadors are now held in addition to termly newsletters. This compliments the range of career events UHL support; there were 55 events in 2023/24.
- Development of Recruitment open days for various staff groups, such as Estates & Facilities, apprentices, Admin, Pharmacy and HCAs to attract and recruit into our vacancies, including promoting UHL as a great employer.
- Development of tailored attraction and recruitment into local communities, working with our Job Centre and Job Club colleagues. Retained MATRIX accreditation for career information, advice and guidance and held a number of career cafes and career discussions for existing colleagues.
- Our unspent apprenticeship levy can be transferred to other organisations outside the UHL Apprenticeship and Development Centres customer base, up to a nationally provided amount of 25%. This has supported 153 non UHL employees across 26 employers who are either from a health and social care field, our stakeholder groups or the investment will impact on health and wellbeing. The total commitment in this area is £1,254,437.

- The IT Training team have supported colleagues with 1804 IT training in classroom face to face training places, 104 website training places and 496 eLearning completions. This skillset will enable them to work efficiently and competently to support patient safety.
- 163 eLearning modules have been kept up to date to ensure staff have access to knowledge to support their role and a further 18 programmes written and launched to meet Trust needs. 280,000 eLearning completions occurred in 2023/24.
- Skills for life are vital and UHL hold a tool called BKSB to support development of maths, English and essential digital skills. It also holds scoping tools for dyslexia and dyscalculia to enable colleagues to identify strategies to support their learning.
    - Following the changes within Health Education England, Learning and Development started hosting and utilising the national tool in 2023/24 to check the equivalency of maths and English qualifications for UHL colleagues who took exams outside of the UK. This helps them to join e.g. apprenticeships and progress their careers.
    - Partnership working is in place with Leicester College supports all UHL colleagues' access core functional skills classroom based development and qualification in English and maths. This ranges from entry level 1, 2 or 3 development up to Level 2 qualifications (GCSE equivalent). These skills help not only their working lives and career prospects, but home lives, their families and local communities too.

Staff policies

You Matter: Colleague Support UHL Policy
In partnership with our Staff Side colleagues, a range of UHL family-friendly and other leave polices have been updated and amended, to reflect our ongoing commitment to support our colleagues and reflect our new Trust Values.

The new policy pulls together eight policies into one, including the special leave policy, family-friendly policies (maternity etc) and work-life balance policies (i.e. retirement, annual leave and flexible working) to create a clear and user-friendly document that makes it easier to find the right information. Other key changes to note are below.

Revised policy areas:
- Bereavement/Compassionate Leave (increased leave)
- Parental (child) Bereavement Leave (increased leave)
- Leave for Fertility Treatment (revised)

New policy areas:
- Supporting Colleagues with Pregnancy/Baby Loss (paid leave entitlement)
- Supporting Colleagues with Premature Birth and Neonatal Care (paid leave entitlement)
- Foster Carer's Leave (paid leave entitlement)
- Support for Breastfeeding (guidance)
- Planned Carer's Leave (unpaid leave entitlement)

Further policy work is taking place around planned carers leave and menopause support in order to further increase support to colleagues.

Amendment to the Special Leave Policy: Armed Forces

In June 2023 we also pledged the support of Leicester's Hospitals to our Armed Forces community by re-signing the Armed Forces Covenant.

We have reviewed (and increased) paid leave arrangements to reflect 12 paid days for reserves, 6 paid days for cadets and 2 paid days for regular spouses to accommodate unforeseen military delays.

Sexual Safety

In September 2023, we signed up to NHS England's Sexual Safety Charter. The charter, which was co-created with those with lived experience, and trade union colleagues, is a 10-point agreement that includes pledges to provide staff with clear reporting mechanisms, training, and support by July 2024. The UHL Sexual Safety Policy was launched in January 2024.

People Policies & Just & Restorative Culture
The Trust has continued to implement a revised and improved approach to Employee Relations case work management, data and reporting, processes and documentation, aligned to 'Just and Restorative Culture' approaches.

We will continue with the review and relaunch of employee relations policies in 2024/2025, prioritising the following policies and ensuring alignment to the "Just & Restorative Culture" approach;

- Maintaining High Professional Standards in the NHS,
- Disciplinary,
- Resolution,
- Performance Management (Capability)
- Promoting Attendance & Managing Sickness Absence

Freedom to Speak Up

Ensuring UHL has a positive speaking up culture is one of our key priorities. We want all our colleagues to feel psychologically safe to speak out when things are not right so we can ensure the best possible care for our patients, and the best possible working environment or our workforce. In September 2023 the Trust made a decision to change the way it provided its speaking up service. The Trust wanted to enhance the service so that it had ultimate independence and could offer contact to colleagues 24/7, 365 days a year. The Guardian Service is an independent and confidential liaison service which was established in 2013 by the National NHS Patient Champion in response to The Francis Report. They provide colleagues with an external, impartial, independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, bullying, harassment, discrimination and all work grievances.

The Freedom to Speak up Guardians role is to act in an independent capacity, to support the Trust to become a more open, transparent place to work, creating a culture

based on learning and not blaming, and to listen and support all workers to raise concerns.
Speaking up enhances all our working lives and improves the quality and safety of care. Listening and acting upon matters raised means that Freedom to Speak Up will help us be the best place to work.

We have internal reporting arrangements through the People and Culture Committee and then onward to the Trust Board. The Guardians attend and present their own reports to the committee and the Board on quarterly basis. Reporting looks at a wide range of areas including themes across staff groups, response times, cases of detriment,

The Guardians have direct access to the Chief Executive and meets with them formally on a quarterly basis. The Guardians meet monthly with the Director of Corporate and Legal Affairs where they discuss themes and escalate any specific concerns.

The Trust has reviewed its speaking up policy aligned to the national guidance and this was approved at the Trust Board in April 2024. In addition, the self assessment and monitoring tool was completed with a number of key actions assigned to further improve the speaking up service and learning across the organisation. These actions will be completed over 2024/25.

Below is a table showing the number of concerns raised annually since the inception of the speaking up service.

	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Totals	135	131	128	249	231	190	246

There has been a steady increase over the years in the number of concerns raised and this shows that there is improvement in the psychological safety of staff to speak up. There was a steep increase during 2022/21 and 21/22 over the period of Covid-19 pandemic. The Trust has also seen an increase in 2023/24 which is likely due to the new provider of the speaking up service offering an independent service 24/7.

NHS England and NHS Improvement's Single Oversight Framework

NHS Trusts are subject to oversight by NHS England who use the Single Oversight Framework for this purpose. The Oversight Framework bases its oversight on the NHS provider licence. The Trust remains in "segment 4" which means there is "*actual or suspected breach of the NHS Provider Licence (or equivalent for NHS Trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support".* The Trust has been in receipt of support from the Recovery Support Programme since being placed in segment 4. An action plan has continued to be successfully progressed throughout 2023/24 to put right issues which will lead the Trust to financial sustainability and an agreed exit criteria from segment 4.

Segmentation

The Trust continues to be classified by NHS England/Improvement as being in segment 4. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website.

Modern Slavery Act

The Trust complies with the Modern Slavery Act, specifically section 54 'Transparency in supply chains' which is the section directly relevant to the corporate sector. The Trust undertakes ongoing assessment of our contracts which have the highest risk of modern slavery. Use of MSA compliant supplier Pre-Qualification Questionnaire (PQQ), is used to support assurance that our suppliers comply with MSA. In addition, products purchased through third party distributors, such as NHS Supply Chain, have the assurance of national frameworks to ensure compliance with the Act.

Equality, Diversity and Inclusion

We are committed to the Equality, Diversity and Inclusion (EDI) agenda and recognise the value it brings in delivering healthcare services that meet individual needs.

We have worked hard to embed and mainstream the agenda by embedding and mainstreaming EDI as part of everything we do; our strategy, values and behaviours framework.

We have collected data and analysed the information to raise awareness of the positivity's but also recognise the work we need to do to address the negative experiences some groups of staff have, in comparison to others. Our activities include:

- Working in collaboration with our partners and stakeholders to embed EDI through programmes such as Developing Diverse Leadership programme (cohort 2 in 2024), Cultural Competency programme, Reverse Mentoring programme and Active-Bystander programme (we will enhance this with a video clip, e-learning and face to face delivery by internal staff).
- Working with our staff Networks to improve staff experiences. We will enhance this in 2024 with support from an Executive sponsor, driving forward positive change.
- Development of policies and practices that support staff and improve their working lives such as our flexible working policy.
- Establishing the Equality Analysis process to mitigate any adverse impact on diverse groups of people.

We will continue to review our practices and processes to ensure that they are inclusive. Although, we have worked relentlessly to progress our work, we have had to take a step back to ensure we get the basics right.

The launch of the national NHSE EDI Improvement Plan 2023, will be our baseline to improving outcomes for staff from diverse groups, supported by the data and evidence collected against our Staff Survey, Workforce Disability equality Standard (WDES), Workforce Race Equality Standard (WRES) and Gender Pay Gap (GPG).

We recognise that as a Trust not all staff have the same positive experiences. We have ambitious plans ahead to drive forward change that supports a positive culture for all; making UHL the best Trust to work for locally, regionally and nationally.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

Our WRES and WDES information can be found here on our public website: Equality reports and data (leicestershospitals.nhs.uk)

Remuneration Report:

Remuneration Committee

The Remuneration Committee has responsibility for setting the remuneration of the Chief Executive, The Executive Directors and other Very Senior Managers.

The attendance record for 23/24 can be found on pg 51.

The Chief People Officer and the Chief Executive are regular attendees of the committee and provide advice to the committee in their considerations of the terms and conditions of senior managers. For the year 23/24, the committee met its responsibilities as set out in its terms of reference by:

- Setting appropriate remuneration and terms of service for senior managers, including the Chief Executive and Executive Directors;
- Ensuring that senior executives/managers are fairly rewarded for their individual contribution to the Trust having proper regard to the Trust's circumstances and performance;
- Ensuring a robust system is in place to monitor and evaluate the performance of senior managers

Salary and pension entitlements of Senior Managers

We classify our Directors and Senior Managers as Very Senior Managers (VSM). These members of staff are deemed to be on a VSM pay scale which is non agenda for change. The remuneration of these individuals is set by our remuneration committee and each case is considered on an individual basis. On an annual basis the remuneration committee decides on any pay uplift or pay award for VSM for the forthcoming year.

- Taxable expense payments are rounded to the nearest £100 in the Remuneration table below. Pension related benefits are shown in bands of £2,500. All other remuneration is shown in bands of £5,000.
- Salary includes all amounts paid and payable in respect of the period the individual held office, including any salary sacrifice elements.
- There are no long-term performance pay or bonuses for senior managers in the current or preceding financial years.

All pension-related benefits are calculated using the HMRC method as set out in Section 229 of the Finance Act 2004. The Department of Health and Social Care have clarified that for NHS bodies this is the "Real increase in pension multiplied by 20 plus

the real increase in lump sum less contributions made by the individual equals Accrued Pension Benefits". The NHS Pension Scheme is a "defined benefits" scheme based on final salary and/or career average earnings. Thus where a senior manager's salary increases this results in a larger movement in the overall value of their pension entitlement. Similarly, where there is a limited increase in the value of the pension payable relative to inflation and the employees' contributions, then the HMRC calculation can show a "negative pensions benefits" figure for the year which is then shown as a "nil" figure in the table. These factors mean that year on year there can be significant volatility in the reported pensions' benefits for an individual.

The Trust is a member of the NHS Pension Scheme which is a defined benefit Scheme, though accounted for locally as a defined contribution scheme. The Trust does not operate nor contribute to a stakeholders' pension scheme other than contributions to the National Employment Savings Trust (NEST) scheme for a small number of qualifying employees who have opted out of the NHS Pension Scheme. Non-Executive Directors are not members of the Trust pension scheme. Disclosure is made in respect of pension benefits for those Directors who were active members of the NHS Pension Scheme during 2023/24.

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 pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Salary and pension entitlements of senior managers – salary 2023/24 (subject to audit)

Name	Salary	Expense Payments (Taxable if applicable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total	Salary	Expense Payments (Taxable if applicable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total
	Bands of £5,000	To the nearest £100	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £5,000	To the nearest £100	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000
Executive Directors												
A Furlong, Medical Director	245-250	- 500	-	-	0-0	**240-245**	225-230	400.00	-	-	55-57.5	**285-290**
A Carruthers, Chief Information Officer	130-135	- 7,500	-	-	0-0	**120-125**	120-125	3,300.00	-	-	17.5-20	**140-145**
R Cassidy, Director of Corporate and Legal Affairs	125-130	- 200	-	-	107.5-110	**230-235**	120-125	-	-	-	147.5-150	**265-270**
L Hooper, Chief Financial Officer	170-175	- 1,100	-	-	0-0	**165-170**	160-165	-	-	-	47.5-50	**210-215**
J Melbourne, Chief Operating Officer	180-185	- 500	-	-	222.5-225	**405-410**	175-180	300	-	-	55-57.5	**230-235**
R Mitchell, Chief Executive	190-195	300	-	-	0-0	**190-195**	210-215	100	-	-	200-202.5	**415-420**
L Abeyratne, Director for Health Equality and Inclusion	95-100	- 500	-	-	157.5-160	**255-260**	50-55	400	-	-	95-97.5	**150-155**
M Simpson, Director of Estates and Facilties (until 31 Mar 2024)	140-145	- 500	-	-	35-37.5	**175-180**	130-135	700	-	-	32.5-35	**165-170**
C Teeney, Chief People Officer	165-170	- 10,000	-	-	0-0	**155-160**	130-135	2,800	-	-	190-192.5	**320-325**
J Hogg, Chief Nurse	175-180	- 200	-	-	0-0	**175-180**	155-160	-	-	-	7.5-10	**165-170**
M Smith, Director of Communications and Engagement	120-125	- 200	-	-	30-32.5	**155-160**	50-55	-	-	-	35-37.5	**85-90**
S Barton, Deputy Chief Executive	165-170	- 100	-	-	0-0	**165-170**	130-135	-	-	-	102.5-105	**235-240**
Non-Executive Directors												
J MacDonald, Trust Chairman	60-65	4,000	-	-	0-0	**65-70**	65-70	-	-	-	-	**65-70**
B Patel, Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	-	**10-15**
V Bailey, Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	-	**10-15**
M Williams, Non-executive Director (until 29 Feb 2024)	10-15	1,700	-	-	0-0	**10-15**	10-15	200	-	-	-	**10-15**
T Robinson Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	-	**10-15**
S Harris, Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	-	**10-15**
A Haynes, Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	-	**10-15**
G Collins-Punter, Associate Non-executive Director (until 31 Dec 2023)	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	-	**10-15**
G Sharma, Associate Non-executive Director (until 30 Apr 2023)	0-5	-	-	-	0-0	**0-5**	10-15	-	-	-	-	**10-15**
J Worrall, Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	-	**10-15**
A Moore, Non-executive Director (from 12.3.24)	0-5	-	-	-	0-0	**0-5**	-	-	-	-	-	-
D Moon, Non-executive Director (from 01.3.24)	0-5	-	-	-	0-0	**0-5**	-	-	-	-	-	-
I Browne, Associate Non-executive Director (from 01 Dec 2023)	0-5	-	-	-	0-0	**0-5**	-	-	-	-	-	-
A Garcea, Associate Non-executive Director (from 01 Dec 2023)	0-5	-	-	-	0-0	**0-5**	-	-	-	-	-	-
M Farmer, Associate Non-executive Director (from 01 Jan 2024)	0-5	-	-	-	0-0	**0-5**	-	-	-	-	-	-

Notes

1. J MacDonald held a position with Derbyshire ICS between 1st April 2023 and 30th June 2023, then Chair for University Hospitals Northampton (UHN) between 1st July 2023 and 31st March 2024 for which he was paid a remuneration of £60k and the remainder for which he has earned a remuneration of £67,708 which is paid by UHL.
2. R Mitchell was also CEO for the University Hospitals of Northampton (UHN) from 30th October 2023, he continued his role within UHL and was paid via UHL and recharged 25% Northampton Trust and 25% Kettering Trust.
3. D Moon (Non Executive Director), was paid in arrears in May for the salary relating to March 2024.
4. A Moore (Non Executive Director), is paid by UHN and is recharged to UHL for the salary.
5. In 2023/24 the Trust continue to pay the salary of M Wightman, who left the Board in 2021/22. This remuneration was in the range £45-£50k.

Name and title	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 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2024 £'000	Employer's contribution to stakeholder pension
A Furlong, Medical Director	0-0	30-32.5	65-70	190-195	1,442	131	1,743	24,472
A Carruthers, Chief Information Officer	0-0	25-27.5	35-40	90-95	501	145	714	16,691
R Cassidy, Director of Corporate and Legal Affairs	5-7.5	0-0	20-25	0-0	148	111	291	17,128
L Hooper, Chief Financial Officer	0-0	32.5-35	35-40	100-105	488	178	736	20,519
J Melbourne, Chief Operating Officer	7.5-10	70-72.5	45-50	120-125	409	491	955	14,196
R Mitchell, Chief Executive	0-0	42.5-45	50-55	140-145	733	199	1,037	31,095
L Abeyratne, Director for Health Equality and Inclusion (from 7 June 2022)	7.5-10	0-0	25-30	0-0	163	161	351	10,443
M Simpson, Director of Estates and Facilties (from 11 April 2022)	2.5-5	0-0	10-15	0-0	80	37	144	19,375
C Teeney, Director of People and Organisations (from 1 June 2022)	0-0	0-0	70-75	0-0	1,064	39	1,227	16,887
J Hogg, Chief Nurse (from 9 May 2022)	0-0	0-0	0-0	0-0	-	-	-	-
M Smith, Director of Communications and Engagement	0-2.5	0-0	10-15	0-0	73	33	131	16,763
S Barton, Deputy Chief Executive	0-0	40-42.5	45-50	120-125	726	203	1,023	20,929

Average number of employees (WTE basis) (subject to audit)

	Total	Permanent	Other	Total
	2023/24	2023/24	2023/24	2022/23
	No.	No.	No.	No.
Medical and dental	2,295	2,073	222	**2,183**
Administration and estates	3,140	2,955	185	**2,892**
Healthcare assistants and other support staff	3,169	3,093	76	**3,967**
Nursing, midwifery and health visiting staff	5,382	4,856	526	**4,484**
Nursing, midwifery and health visiting learners	3	3	0	**95**
Scientific, therapeutic and technical staff	1,795	1,693	102	**1,353**
Healthcare science staff	943	934	9	**499**
Total average numbers	**16,727**	**15,606**	**1,122**	**15,473**
Of which:				
Number of employees (WTE) engaged on capital projects	**52**	52		**59**

Exit Packages (subject to audit)

There was 1 compulsory redundancy and 12 other exit packages agreed in 2023/24.

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	No.	£000	No.	£000	No.	£000	No.	£000
Exit package cost band (including any special payment element)								
<£10,000			6	25	**6**	**25**	1	15
£10,000 - £25,000			5	93	**5**	**93**	1	2
£25,001 - £50,000			1	32	**1**	**32**		
£150,001 - £200,000	1	160			**1**	**160**		
Total	**1**	**160**	**12**	**150**	**13**	**310**	**2**	**17**

Exit packages: other (non-compulsory) departure payment		
	Payments agreed	**Total value of agreements**
	Accounts	**Accounts**
	No.	**£000**
Contractual payments in lieu of notice	10	133
Non-contractual payments requiring HMT approval (special severance payments)*	2	17
Total	**12**	**150**

Expenditure on consultancy (subject to audit)

We spent £1.3m on consultancy services in 2023/24 (£2.6m in 2022/23).

Fair Pay Disclosure (subject to audit)

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

The banded remuneration of the highest paid Director in the Trust in the financial year 2023/24 was £240,000-£245,000 (2022/23, £235,000 - £240,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

In 2023/24, 49 employees received remuneration in excess of the highest-paid director (21 employees in 2022/23). Remuneration across the Trust ranged from £10k to £627k (2022/23 £9.1k-£538k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. For the purposes of this disclosure the remuneration of each employee is stated on an annualised, full time equivalent basis. Between 2022/23 and 2023/24 there has been no significant movement in the ratio of the highest paid Director's pay to that of the workforce.

2023/24	**25th Percentile pay**	**Median pay**	**75th Percentile Pay**
Total remuneration (£)	27,603	36,327	49,063
Salary component of total remuneration (£)	24,336	22,383	37,303
Pay ratio information	8.8	6.7	4.9
2022/23			
Total remuneration (£)	25,814	35,207	46,801
Salary component of total remuneration (£)	25,782	35,207	46,743
Pay ratio information	9.2	6.7	5.1

		Percentage change in remuneration	
		Highest paid Director	All Other Employees
2023/24	Salary and allowance	3.34%	-4.67%
	Total pay	3.28%	-4.78%
2022/23	Salary and allowances	6.50%	8.10%
	Total pay	6.50%	8.20%

Off payroll payments

Reporting related to the Review of Tax Arrangements of Public Sector Appointees

The Trust is required by HMRC to make formal tax assessments of all workers directly engaged by the Trust, either through a personal service company (PSC) or through an agency, to ensure those individuals are paying the appropriate amount of tax and national insurance (known as IR35).

The Trust's tax policy ensures compliance with the Department of Health and HMRC guidelines. During 2023/24 all existing off-payroll engagements were subject to a risk-based assessment as to whether assurance needed to be sought that the individual was paying the right amount of tax. Where necessary, that assurance has been sought.

We do not have any cases where assurances have not been received or terminations have taken place as a result of assurances not being received.

HM Treasury requires public sector bodies to report arrangements where individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements, not being classed as employees). We are required to disclose:

- For all off-payroll engagements as of 31 March 2024, for more than £245 per day.
- For all new off-payroll engagements, for more than £245 per day.
- For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024.

The Trust has 57 relevant off-payroll engagements as of 31 March 2024, for more than £245 per day. All off-payroll engagements have been subject to a risk based assessment and assurance has been sought as to whether the individual is paying the right amount of tax.

For all off-payroll engagements as of 31 March 2024, for more than £245 per day.

	Number
Number of existing engagements as of 31 March 2024	19
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	10
for between 3 and 4 years at the time of reporting	2
over 4 years at the time of reporting	6

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2023 and 31 March 2024, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	18
Of which...	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	19
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024.

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year.	16

Richard Mitchell

Chief Executive

27 June 2024

Our Parliamentary Accountability and Audit Report:

Fees and Charges
Refer Note 5.2 in the Financial Statements.

Remote contingent liabilities
There are no known remote contingent liabilities in 2023/24.

Other contingent liabilities
The Trust reported no contingent liabilities of in 2023/24 in respect of outstanding legal claims.

Losses and special payments
Refer Note 33 in the Financial Statements

Gifts
The Trust has published 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.

Our Finance Report:

Overview of the 2023/24 Financial Position

Over the past year, UHL have made significant progress delivering key priorities for patients, as we continued to restore services following the end of the pandemic, against a background of industrial action, increased demand and pressures on budgets due to inflation. We have improved against almost every headline objective of 23/24 – we have either done what we set out to do or made meaningful progress towards it. This is all thanks to the commitment, adaptability and professionalism shown by staff across UHL.

There was a clear expectation that from 22/23 that there would be a transition towards a normal financial regime, which would see overall funding levels reduce from those experienced as a result of the Pandemic. As the Trust moved away from the Covid funding regime, managing Trust finances, including cash and achieving financial balance was clearly going to be challenged. Like many providers the Trust accumulated cash reserves during the Covid period, which have subsequently been impacted by the deficits of the last 2 years, although the Trust has not needed to access the DHSC cash revenue support facility through to the end of 23/24.

An Elective Recovery Fund (ERF) was established to support NHS healthcare systems to work collaboratively to restore elective services against the backdrop of unprecedented demands on the services following Covid. The ERF supports the cost of services working flexibly to take on the additional activity needed to reduce the backlog of patients requiring elective services such as outpatient appointments or surgeries. What that really means is that where UHL has found a way to deliver more

appointments and carry out more procedures than it normally would have, we have been paid more for the delivery of services.

Despite this, recovery of services and efforts to restore activity levels, address waiting lists and increase productivity has led to an increase in costs, particularly relating to pay. The financial plan for 23/24 forecast a £10m deficit. However, there were known risks at that time, which materialised within the financial position, such that the final outturn was a £52.8m deficit, representing a deviation from the original plan of £42.8m. The drivers of this adverse position included unfunded inflation, urgent and emergency care pressures, ERF spend above target, unfunded industrial action, re-banding of healthcare assistants and a reduction in planned income to cover the costs of nationally funded capital schemes.

The Trust remains committed to achieving sustained financial recovery and using our taxpayers money as optimally and productively as possible for the delivery of patient care. We all share the desire to deliver more for patients with the resources that we have. This requirement to be more productive and effectively do more with less year on year was reflected by the Trust delivering efficiencies of £64.2m in 23/24 against its target of £63m.

The Trust is required to meet certain financial duties, in order to provide assurance to the taxpayer on how public funds have been managed. Each NHS Trust is required to ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account. With the exceptions of breakeven financial duty and delivering its agreed in year adjusted financial performance target, the Trust achieved its statutory financial duties, including maintaining capital spending and cash within the limits set by DHSC, as set out in the table below.

The key headlines of 23/24 from a financial point of view were:

- a revenue deficit, after technical adjustments, of £52.8m, following a deficit of £12.5m in 22/23 and a surplus of £20.2m in 2021/22
- A record level of capital investment of £122.0m (£96.5m in 22/23 and £75.3m in 21/22).
- Delivery of a Cost Improvement of £64.2m (£35m in 22/23 and £17.1m in 21/22).
- Reconfiguration and modernisation programme enabling work continues at pace.
- Contraction in year end cash balance to £39.7m (from £103.3m at 31 March 22).
- Maintained high achievement against the Better Payments Practice Code for paying suppliers promptly of 94%.

A summary of how the reported deficit presented in the Accounts reconciles to the adjusted financial performance, against which the Trust is monitored is set out in the table below:

	Group	
Adjusted financial performance (control total basis):	**2023/24 £000**	**2022/23 £000**
Surplus / (deficit) for the period	(65,326)	(33,699)
Remove impact of consolidating NHS charitable fund	2,295	(2,427)
Remove net impairments not scoring to the Departmental expenditure limit	12,225	12,958
Remove I&E impact of capital grants and donations	(2,205)	243
Prior Period Adjustments		10,281
Gains on disposal of assets		
Remove net impact of inventories received from DHSC group bodies for COVID response	180	185
Adjusted financial performance surplus / (deficit)	**(52,831)**	**(12,459)**

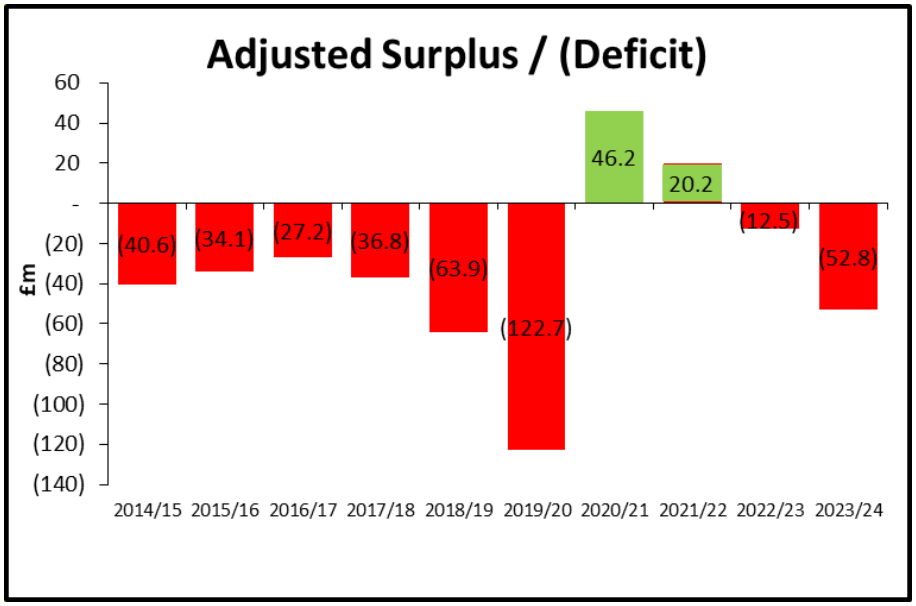
Although the Trust remains within the Recovery Support Programme, improved governance has been achieved through progressing a roadmap to sustainable financial governance and delivering its operational financial improvement plan. The roadmap mapped actions and outcomes to the Recovery Support Programme. The improvement in financial in 23/24 were set out in the Annual Governance Statement.

In the past 2½ years, The Trust has produced five years sets of Accounts (19/20, 20/21, 21/22, 22/23 and 23/24). These have all been adopted and published, with successive improvements in the audit opinion (following the historical financial misreporting that took place in 18/19 and 19/20) as follows:

- 19/20 – Disclaimer of opinion
- 20/21 – Adverse opinion
- 21/22 – Qualified opinion (with 11 qualifications)
- 22/23 – Qualified opinion (with 2 qualifications)
- 23/24 – Unqualified opinion

The Trust submitted its 23/24 accounts in accordance with the national timetable to ensure consolidation with the National NHS accounts.

Adjusted retained surplus/(deficit)



Income and Expenditure Summary

As the NHS emerged out of the pandemic during 22/23 and through 23/24, there was a clear expectation, nationally, that providers must transition towards business as usual. This saw overall funding levels reduces in real terms from those experienced during the Pandemic.

The financial and operational challenges the Trust faces in delivering sustainable finances is significant. Achieving sustainable finances and optimising the use of its resources for patients at the same time as improving productivity is one of the Trust's key strategic goals. However, the Trust remains in a recurrent deficit position.

The financial plan for 23/24 forecast of a £10m deficit. However, there were known risks at the time the plan was prepared that were considered likely to materialise (and did), such that the final outturn deteriorated to a £52.8m deficit which represented unfunded inflation, urgent and emergency pressures due to actual activity being greater than forecast by c5% and ERF income/spend above target. In addition there were emergence of further cost pressures that were unknown during the planning round, including unfunded Industrial Action of (£2m), the re-banding of healthcare assistants (£4m) and underfunding of depreciation associated with nationally funded capital scheme (£2.5m).

Total income from patient care activities increased by £95m (6.5%). The table below illustrates the income received in 2023/24 from different sectors, compared with previous years:

Income Received from Different Sectors	2016/17 Actual £000s	2017/18 Actual £000s	2018/19 Actual £000s	2019/20 Actual £000s	2020/21 Actual £000s	2021/22 Actual £000s	2022/23 Actual £000s	2023/24 Actual £000s
NHS England	258,067	288,791	305,886	350,224	380,632	395,912	472,791	503,843
Clinical Commissioning Groups/Integrated Commissioning Board	513,658	522,902	542,245	539,952	685,583	765,772	848,594	924,425
Department of Health and Social Care	-		10,625	18,494				
Non NHS Private Patients	2,864	2,872	2,821	2,798	1,641	2,740	3,353	4,147
Other income from Patient Care	5,993	5,766	2,894	34,491	1,515	2,131	2,702	4,628
Income from Patient Care Activities	**780,582**	**820,331**	**864,471**	**945,959**	**1,069,371**	**1,166,555**	**1,327,440**	**1,437,043**
Other operating income	143,687	127,958	129,845	144,616	212,142	68,632	69,527	52,026
Education training, and Research						84,956	93,548	97,661
Other Operating Income	**143,687**	**127,958**	**129,845**	**144,616**	**212,142**	**153,588**	**163,075**	**149,687**
Total Income	**924,269**	**948,289**	**994,316**	**1,090,575**	**1,281,513**	**1,320,143**	**1,490,515**	**1,586,730**

The Trust continues to largely operate to fixed or block funding envelopes, although since the 2023/25 national NHS payment system came into effect on 1 April 2023 elective healthcare commissioned between trusts and NHS commissioning bodies has been subject to an aligned payment and incentive (API) payment. Under these rules, trusts and commissioners agree a fixed (block) element, based on funding an agreed level of activity. However, the API variable element means Systems have access to additional funding for elective activity performed above the fixed agreed baseline level, funded through the Elective Recovery Fund (ERF). Although this partly addresses some of the elective funding pressure, appropriate funding for growing year on year urgent and emergency activity delivered continues to present a major financial challenge for the Trust.

Other operating income reduced by £13.4m, largely as a consequence of removal of reimbursement and top up funding given in 22/23 but longer available in 23/24 (£5.3m); a reduction in donations and grants (£3.4m), income received in respect of staff recharges (£3.2m), as well as other income charges (£5m); offset by an increase in education and research funding (£4m).

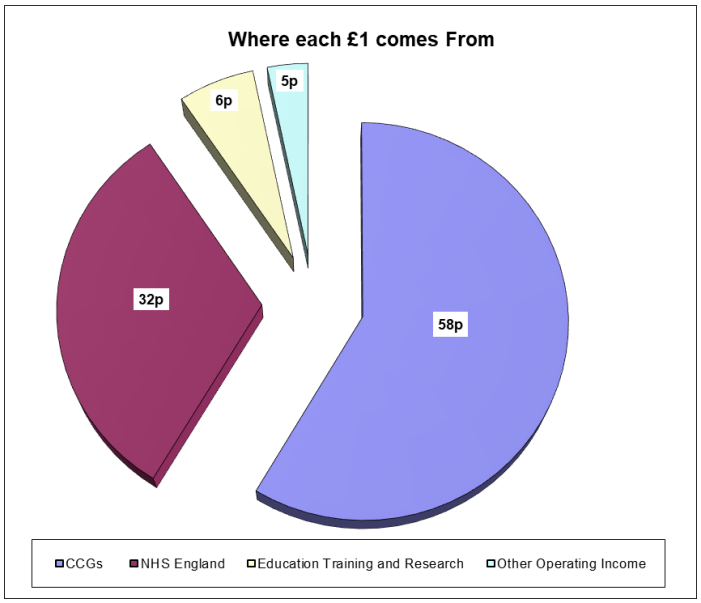
Employment costs accounted for 62% of our total operating costs (60% in 22/23) increasing by £109m during the year. This reflected an overall increase in the workforce (average WTE worked) of 1,249 (8%) to 16,722 (permanent and temporary) during 2023/2024, as the Trust recruited substantively to vacancies. There will be a sustained focus on reducing temporary pay costs moving into 2024/25. The Trust also has had to account for £36.6m of DOH funded pension costs in M12.

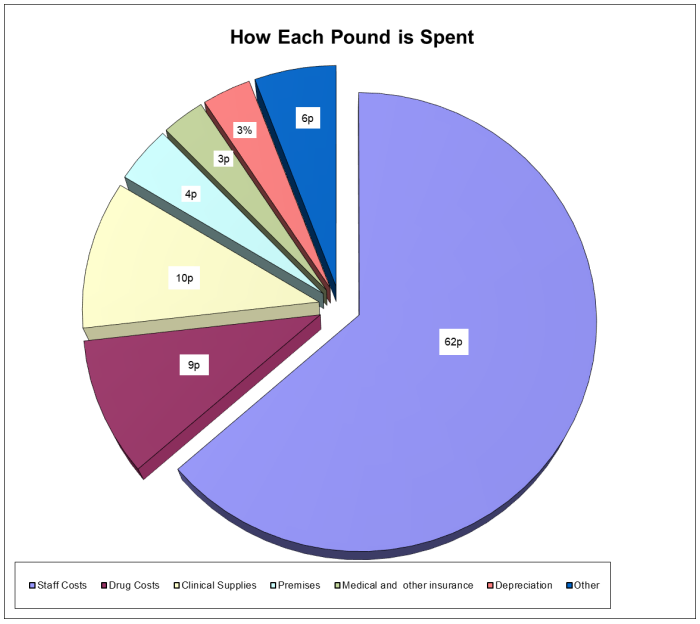
Depreciation and amortisation costs increased by £2.7m reflective of the significant capital investment in the last 3 years, much of which has been concentrated on investment in short life medical equipment and IT infrastructure. 23/24 was also the second year of the new leasing accounting standard (IFRS16), which saw new leases come onto the Trust's balance sheet with depreciation impact (as oppose to accounting for leases as non pay operating rentals under the previous accounting standard).

	2016/17 Actual £000s	2017/18 Actual £000s	2018/19 Actual £000s	2019/20 Actual £000s	2020/21 Actual £000s	2021/22 Actual £000s	2022/23 Actual £000s	2023/24 Actual £000s
Staffing	575,895	597,876	629,537	698,996	745,371	777,761	897,482	1,006,581
Drugs	102,168	105,789	102,124	107,139	124,239	127,949	144,487	152,807
Clinical Supplies and Services	103,653	109,211	117,635	124,593	128,314	142,808	167,500	166,509
Depreciation and Amortisation	26,407	27,663	32,176	34,991	37,030	39,499	51,730	54,581
Clinical Negligence	23,724	27,398	30,664	31,927	34,744	38,204	38,824	48,002
Premises	33,308	33,753	43,469	54,976	48,019	52,572	58,928	64,507
Research and Development	22,932	34,376	35,763	36,124	35,254	38,680	42,610	48,002
Other Operating costs	78,216	49,535	61,262	107,866	59,020	62,098	103,220	91,294
Total Expenditure	**888,087**	**936,066**	**1,052,630**	**1,088,746**	**1,211,991**	**1,279,571**	**1,504,781**	**1,632,283**

In delivering its year end position, the Trust generated financial cost savings/additional income of £64.2m, through its efficiency programme. The Trust seeks to identify and remove non value adding practices, procedures or delays which impede the patient experience. Financial savings are a by-product of introducing improvements in the patient care pathway.

The two charts below give some further information on where our income comes from and how we use it to deliver our full range of services to patients.



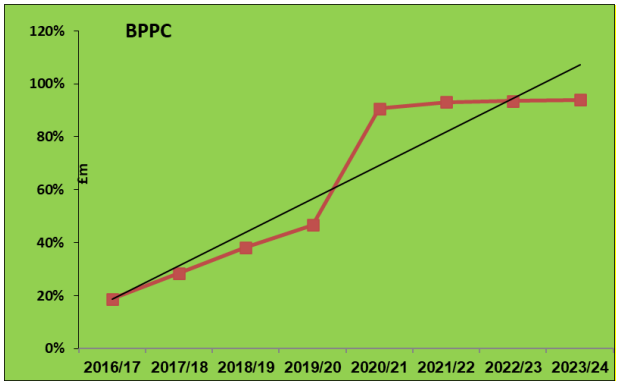


Better Payments Practice Code (BPPC)

The Trust manages creditor payments in line with NHS terms and conditions, paying to 30 day terms in most cases, unless we are contractually obligated to pay earlier. This is measured by our BPPC performance, which was maintained at 94% of valid supplier invoices being paid within 30 days or their due date (if later).
Work continues to transform the purchase to pay workstream, strengthening the financial controls and standardising system processes and improving efficiency of the

transaction process through greater automation, integrated working between procurement and Finance colleagues and less manual intervention. This has included full 100% coverage of a *No PO No Pay Policy*, ensuring that expenditure cannot be committed without a valid and manager approved purchase order. Work has now begun to embed in these changes in the way we do things.

The table below shows the improvement over the past few years. In challenging economic times, it is particularly important to support our suppliers and local businesses by ensuring prompt payments are made to them. The BPPC remains an important performance metric, which is monitored at national level.



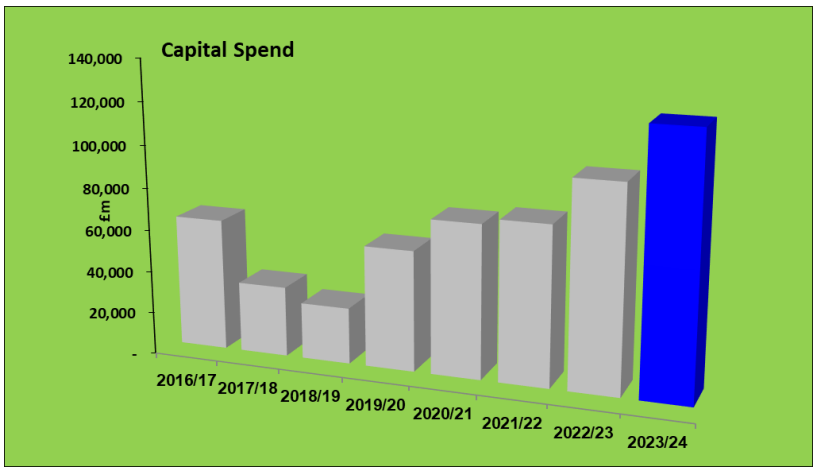
Capital Investment

In 23/24, the Trust delivered a major capital investment programme of £122m. This level of expenditure on our estate, medical equipment and IT is a record for the Trust. The tables and graph below show how we have been able to build our level of capital expenditure in the last eight years. In 23/24, there was significant investment in medical equipment, IT modernisation and digitisation, as well as continued investment in the Trust's estate and reconfiguration programme, to ensure healthcare services to our patients is provided in a modern and safe surroundings. This investment will help UHL to continue to make important progress on the things that matter most for our patients: improving waiting times and safety in urgent and emergency care, further reducing the longest waits for tests and treatment for cancer and elective care, making it easier for people to access primary care.

Specifically, the following significant investments took place in support of delivering strategic and operational priorities:

- Continued development of the East Midlands Planned Care Centre (£21m), which will open in 2023/24.
- Increased urgent and emergency care capacity (£24m), including modular ward development.
- Continued deployment of electronic patient record (EPR) (£7m), fundamental for the collection, processing and availability of patient data for research and training and in terms of visibility of records across patient pathways, patient safety, efficiency, and financial savings.
- IT end user computing devices and refresh (£11m) to ensure that staff have modern IT equipment available to them to allow them to do their roles to the best of their abilities.

- Other investment in IT infrastructure and digitisation (£6m).
- New and replacement linear accelerators (£7m) in support of access to and reducing waits for cancer diagnosis.
- Investment in other front line medical equipment (£22m) including equipping the new Endoscopy unit and Hinckley Community Diagnostics Centre which will both open in 24/25, imaging kit and 2 surgical robots to give medical staff access to modern equipment in delivering services to patients.
- Enabling work to commence the New Hospitals Programme (£2m), which will see the Trust invest over £600m in modernising its building infrastructure over the next 5 years.
- A range of Estates schemes (£19m) including enabling works of medical equipment installation, commencement of theatre decant programme, nurse training facility, statutory and CQC compliance and backlog schemes, lighting modernisation, expansion of the Pharmacy Subsidiary accommodation and other projects to support the smooth running of the hospital.



Financial Outlook

System Working

This creation of Integrated care boards (ICBs) in 22/23 has brought a much greater focus on health system working and collaboration across local health economies for the benefit of patients. Local healthcare systems, comprised of ICBs and providers will continue to be the key unit for financial planning purposes. As set out in the ICB and NHS finance business rules, all ICBs and systems have a breakeven requirement as well as a duty to seek to comply with the system resource limits.

Within Leicestershire, Leicester and Rutland (LLR) Integrated Care System, there has already been much work on Leicester wide sustainability and transformation plan, ensuring that planning and service delivery is aligned. The Trust continues to develop its medium-term financial strategy to inform the development of the annual financial plan for the Trust. The Trust actively engages with its System partners and NHS England and other partners to develop and agree detailed financial and operational plans. The Leicester, Leicestershire and Rutland (LLR) ICB and the Trust are working together to plan and deliver a triangulated financial plan that shows an improved net system financial position for 24/25, recognising that for 24/25, the Trust and System will remain in deficit.

For 24/25, the contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will continue to be to pay unit prices for activity delivered. NHS England will cover additional costs where systems exceed agreed activity levels. Urgent and emergency pathways remain on a block funding arrangement and as a consequence the Trust will continue to face rising operational and financial pressures. System working on this challenge will be the key area of focus, as without it, UHL will not achieve a financially sustainable position.

Priorities, Funding and Operating Environment
The financial challenge for 24/25 and the next few years is extremely difficult, balancing the optimism of striving to treat more patients and be more productive with the reality of limited and constrained financial envelope. Funding has been increased by 1% to reflect additional pressures since the original 24/25 allocations were published in January 2023. In the Spring 24 Budget, the Chancellor announced £2.45 billion of extra funding for the NHS for 24/25, but this only covers the recurrent cost of the pay deal and maintains real NHS flat funding for 24/25 to this end.

Many of the ambitions for 24/25 reflect the reality of the multi-year process of recovering from the impact of the pandemic and improving services for patients. Given the current context, many of them will be stretching. Despite the challenges we face we share the desire to deliver more for patients with the resources that we have. A relentless focus on improvement, reducing delays and unnecessary processes will be critical to delivering on the priorities of patients and balancing system finances for the LLR health system.

The 24/25 priorities and operational planning guidance focusses on the recovery of our core services through continuous improvement in access, quality, and productivity, whilst transforming the way we deliver care and create stronger foundations for delivery in the future. UHL has already made significant progress towards eradicating two year waits for elective care and delivering urgent cancer checks. This was achieved alongside continuing to recover to the build-up of health needs during the pandemic and capacity constraints in social care and increased costs due to inflation. In 24/25, the key requirements for acute providers within health systems will be to maintain the increase in core urgent and elective capacity established in 23/24, complete agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients.

The overall financial framework remains consistent, including the commissioning payment approach used to support elective recovery. Consistent with these priorities, specifically, in the coming year, UHL will:

- Continue to focus on recovering our core service delivery and productivity.
- Reduce temporary staffing spend and removing off-framework agency use and improving the adoption of and compliance with best value frameworks and contracts
- Reduce the delay for patients who are still in hospital beyond their discharge ready date (which also significantly impacts on our daily bed capacity to provide a hospital bed to those patients who require one). We must also implement more productive and flexible working practices to make the most of the growth in workforce across UHL in recent years.

In addition, all system previous years' overspends are subject to repayment. To allow systems time to stabilise their spending, it was confirmed that repayments will not start until the second year following the year in which the overspends first arose. For 24/25, repayments relating to 22/23 will be captured in the integrated care system (ICS) financial planning template through a 'repayment of prior year deficit' adjustment. Overspends will be repaid over a minimum 3-year period.

Delivering the financial plan and long-term financial sustainability will be a significant challenge, given the Trust continues to forecast a deficit through to 26/27 which will requires significant financial improvement to address.

The LLR Integrated Care System (ICS) were required to submit an Operational Plan comprising of activity, performance, workforce and finance commitments for the 2024/25 financial year. The table below provides an overview of the UHL Trust Board approved submission.

Activity	**Performance**
Elective Growth will be experienced across the key Inpatient (4%) and Outpatient (2%) points of delivery. With 100% of the inpatient growth resulting from the opening of new capacity. Current CMG analysis suggests unmitigated continued growth Emergency admissions of 4%. It is important to note this is activity funded on block contract and this growth forecast will not be affordable, system wide transformation is required to reduce this demand on UHL services. UHL will therefore be planning for 0% growth across UEC Attendances and Admissions.	University Hospitals of Leicester is planning to meet key Elective and Cancer standards, including: • 62-day Cancer backlog position. • Cancer Faster Diagnosis Standard. • Zero patients waiting more than 78 & 65 weeks. However, UEC standards will be challenging to meet (if current trends continue). • UHL A&E Four Hour target performance will peak at 62.8%, this enables LLR system d elivery of the 4-hour target (once urgent treatment centre performance is included). • Ambulance hand over delay target.
Workforce	**Finance**
University Hospitals of Leicester workforce would reduce by 222 colleagues (with growth of 442 colleagues offset by reductions in temporary spend -663 WTE).	University Hospitals of Leicester would finish the year with a deficit of 64.8m (following delivery of CIP in the region of £92.0m).

For 2023/24, the LLR system deficit is forecast to reach £80m at the end of March 2024 (UHL comprising £64.8m of this position). This UHL forecast deficit assumes delivery of a £92m CIP programme. Given the level of ambition within the existing CIP programme and financial risk, LLR is unable to improve the position. NHSE have implemented a new financial regime that introduces the penalty of a system capital reduction for those systems forecasting a financial deficit (£5.8 million for LLR, of which £4.9m has been deducted from UHL's capital plan).

Financial sustainability over the next three years is dependent upon all 24/25 CIP improvements ideally being delivered recurrently. In 23/24 UHL delivered approximately £25m of recurrent CIP out of £64.8m. A challenge of this scale requires significant Executive level ownership, focus and oversight.

Delivery of the 24/25 financial plan is realistically possible if the Trust can generate a productivity improvements and minimize 'unwarranted' pay and non-pay costs. Over the next 3 years, a 30% improvement is required.

There are 3 overarching goals for financial sustainability:

- It is vital to mitigate this risk by minimising, and indeed eliminating, all unwarranted cost pressures. This will necessitate enhanced grip and control across all three drivers: pay, non-pay and income.

- Fix and deliver the fundamentals this will provide a firm foundation for the significant improvements, transformation and innovation needed; whilst ensuring we continue to deliver on existing workstreams and programmes of work. Examples include, ensuring we understand our data, being paid correctly for the work we do and maximising non-pay efficiencies.

- Improve by 10%: This is the scale of productivity improvement needed in 24/25 and indeed annually for the next three years. This improvement will broadly be required to be delivered across all key Trust performance indicators and strategic initiatives.

Controlling Temporary Staffing
Consistent with NHS England instruction and against a context of significant investment in the permanent workforce, it is essential that UHL continues to control and reduce its temporary expenditure, including complying with System agency expenditure limits. The agency spending of each ICB and its partner NHS trusts is not allowed to exceed the System agency expenditure limit set by NHS England in each financial year. Agency expenditure limits for 24/25 have been set using broadly the same approach as in 23/24. The overall intention is to reduce aggregate agency spending for all Trusts to 3.2% as a proportion of the total NHS pay bill.

All Systems are expected to reduce their agency spending by at least 5%, but those systems spending above 3.2% of total pay will be set limits that would reduce spending by more than 5%. Systems with the highest excess spending are therefore required to make the biggest reductions. NHS England reserves the right to set lower limits where systems return a deficit plan, and an additional 10% reduction may be required from those systems in these circumstances. System performance against the agency expenditure limits is monitored on a full-year basis.

UHL must therefore continue to take action to reduce expenditure on NHS agency staff, encourage workers back into substantive and bank roles, and achieve compliance with agency controls. This includes ending the use of off-framework providers and improving compliance with NHS agency price caps. A national temporary staffing dashboard and toolkits on the better use of substantive and bank staff have been produced to support this.

Capital
Core ICB capital allocations for the year period 22/23 to 24/25 had already been published and remain the foundation of capital planning for future years. For UHL, this translates into a opening capital programme for 24/25 of c£99m (including the £4.9m deduction for planning to achieve a balanced financial position), which in addition to investment in the core areas, includes further investment of in the Planned Care Centre,

a new Endoscopy facility and in urgent and emergency care and additional bed capacity. All these initiatives will help to improve patient flow through the Trust and support the Trust in restoring activity to ensure our patients receive the high quality care they need within appropriate timeframes and setting. The £3.4 billon national investment of capital in data and technology, from 25/26 onwards announced in the Spring Budget, will allow us to roll out technology and digital services to improve access, waiting times and outcomes.

Despite this, capital funding remains severely constrained, with difficult decisions being taken each year, in the context of a 3 year prioiritised capital plan, on what can and cannot be funded in any given year, including rationing funding to the most critical and regulatory back log and replacement maintenance and equipment breakdown requirements, with very limited opportunities to invest in new developments.

Cash
NHS England expects providers to continue to have sufficient cash resource to meet working capital requirements without the need for further cash support. This will support prompt payment for goods and services received (refer BPPC). In instances where providers may need help, revenue cash support is available via the issue of public dividend capital (PDC). However, efficient transacting with systems should ensure that requirements are kept to a minimum. Alternatively, within a system where a provider has a revenue or working capital cash need, DHSC can facilitate cash transfers between providers within that System. The Trust will require revenue support in 24/25 consistent with the deficit plan submitted.

Summary
The Trust will work closely with its LLR System partners to continue to provide safe and high quality healthcare to its resident population, within the constrained capital and revenue resources it has available to it in 24/25, recognising in particular that it must improve productivity, achieve an unprecedented efficiency target and deliver services with an affordable workforce, including minimising the use of agency staffing. Despite these financial operational challenges, through strong local health community partnership working, supported by new ways of working, it is possible to achieve a sustainable financial position for the System in the medium term.

Going Concern
The Accounts are presented for both the ‘Trust’ and ‘Group’, including the consideration of the Trust’s private Pharmacy Company subsidiary and the UHL Charity. The Accounts have been prepared on a ‘going concern’ basis. The definition of going concern in the public sector focuses on the expected continued provision of services by the public sector rather than a specific organisational form. This means that even when a body is going to cease to exist, it does not affect its going concern status. The FReM (financial reporting manual) guidance is that the financial statements are prepared on a going concern basis unless there are plans for, or no realistic alternative other than the dissolution of the Trust without the transfer of its services to another entity within the public sector.

The Board of Directors has carefully considered the principle ‘going concern’ and the Directors have concluded that, having made appropriate enquiries, the Trust has adequate financial resources and there are no material uncertainties related to the financial position of the Trust and Group that would compromise the continued delivery

of the operational services of the Trust. As directed by the DHSC Group Accounting Manual 2023/24 the Directors have therefore prepared the financial statements on this basis as they consider that the services currently provided by the Trust will continue to be provided in the future.

Financial Statements

Accounting Policies

The Annual Accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) and accounting policies. Their preparation has been guided by the 2023/24 Group Accounting Manual issued by the Department of Health and Social Care. They represent a “true and fair view” of our activity in 2023/24, are materially accurate and contain no known misstatements or errors of such magnitude that they would mislead the reader with regard to the financial standing of the Trust. We are required to disclose related undertakings as required by the section 409 of the Companies Act 2006. Trust Group Holdings (TGH) Hospital Pharmacy Services Nottingham (HPSN) Limited is a wholly owned subsidiary of The University of Leicester Hospitals NHS Trust. The Accounts are presented for both the “Group” and “Trust”, in accordance with the Group accounting standards (IFRS 10).

External Auditors

We employed the services of KPMG as the external auditor for the Trust. The auditors perform their work in accordance with the Audit Commission’s Code of Practice. The Code of Audit Practice define the scope, nature and extent of local audit work. The main areas of work included the audit of financial statements and review of our arrangements for value for money in the use of resources.

KPMG charged audit-related fees of £300k (excluding VAT) for The Trust and £20k (excluding VAT) for TGH. We did not receive any non-audit services from KPMG in 2023/24.

Fraud Awareness

We comply with the National Counter Fraud Initiative and the Trust has an accredited local counter fraud specialist.

Foreword to Accounts

The Accounts for the year ended 31 March 2024 have been prepared by the University Hospitals of Leicester NHS Trust under section 98(2) of the NHS Act 1977 (as amended by section 24(2) schedule 2 of the NHS and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statements of responsibility in respect of the accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the Directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The Directors confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board

Richard Mitchell
Chief Executive
27 June 2024

Lorraine Hooper
Chief Financial Officer
27 June 2024

Independent auditors report

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of University Hospitals of Leicester NHS Trust ("the Trust") for the year ended 31 March 2024 which comprise the Group and Trust Statement of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2024 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State for Health and Social Care with the consent of HM Treasury on 23 June 2022 as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and Trust's services or dissolve the Group and the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Directors' assessment that there is not

a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve statutory break-even duties and/or control totals delegated to the Group by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to non-pay and non-depreciation expenditure recognition, particularly in relation to the completeness of manual year-end accruals in response to the possible pressure to report that the planned financial position has been met.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals posted to cash or revenue with an unexpected account pairing and those posted as part of the year end close procedures that reduced the level of expenditure recorded, in order to critically assess whether there was an appropriate basis for posting the journal.
- Inspecting a sample of invoices of expenditure, in the period around 31 March 2024, to determine whether expenditure has been recognised in the appropriate

accounting period.

- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.

***Identifying and responding to risks of material misstatement related to compliance with* laws and regulations**

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Directors and other management (as required by auditing standards), and discussed with the Directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Group is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

As further outlined in the *Report on Other Legal and Regulatory Matters* section of our report, we made a referral under section 30 of the Local Audit and Accountability Act 2014 to the Secretary of State on 20 May 2024 as the Trust continues to be in breach of its 'breakeven duty' set out at paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection , anti- bribery, employment, food and drug administration, contract and anti-money laundering legislation, recognising the regulated nature of the Group's and Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non- compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material

misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non- compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023/24. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2023/24.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on Page 79, the Directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 79 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with

ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have identified the following significant weaknesses:

Significant Weakness – Medium Term Finance Planning (Financial Sustainability)

We draw attention to the Review of Effectiveness in the Annual Governance Statement on page 74 which states that, whilst the Trust has taken actions in respect of a significant weakness identified in relation to Medium Term Finance Planning and the recommendations made in relation to this, further work is required by the Trust in order to address this issue. We first reported this significant weakness in our audit report for the year ended 31 March 2022.

Significant Weakness – Cost Improvement Programme Planning (Financial Sustainability)

The final financial plan for the Trust for 2024/25 includes a £64.8 million deficit for the year to 31 March 2025. This plan is reliant on the delivery of an ambitious Cost Improvement Programme (CIP) of £91.6 million, which is greater than the CIP delivered in the current year. The Trust is at risk of not meeting the CIP plan, given the historic delivery performance on CIP, and the need for further work in order to fully develop the CIP schemes for 2024/25.

Recommendation

We recommend that the Trust build on the current arrangements in place to identify recurrent CIP schemes and to monitor progress of the delivery of such schemes at the corporate directorate level in order to support delivery of the 2024/25 CIP plan.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 79, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(2A) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

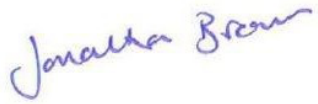
We made a Section 30 referral to the Secretary of State on 20 May 2024 as the Trust continues to be in breach of its 'breakeven duty' set out at paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of University Hospitals of Leicester NHS Trust for the year ended 31 March 2024 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.



Jonathan Brown
for and on behalf of KPMG LLP
Chartered Accountants
One Snowhill Snowhill Queensway
Birmingham
B4 6GH

27 June 2024

Appendix A

Annual Accounts 2023/24

Consolidated Statement of Comprehensive Income

		Group	
		2023/24	2022/23
	Note	£000	£000
Operating income from patient care activities	3	1,437,043	1,327,440
Other operating income	4	149,687	163,075
Operating expenses	7, 9	(1,632,283)	(1,504,781)
Operating surplus/(deficit) from continuing operations		**(45,553)**	**(14,266)**
Finance income	11	4,233	2,048
Finance expenses	12	(2,980)	(1,834)
PDC dividends payable		(20,455)	(18,982)
Net finance costs		**(19,202)**	**(18,768)**
Other gains / (losses)	13	(486)	(624)
Corporation tax expense		(85)	(41)
Surplus / (deficit) for the year		**(65,326)**	**(33,699)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(12,537)	-
Revaluations	18	25,698	19,434
Other recognised gains and losses		-	-
Gain / (loss) arising from on transfers by modified absorption		-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	20	393	(396)
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	13	-	-
Foreign exchange gains / (losses) recognised directly in OCI		-	-
Total comprehensive income / (expense) for the period		**(51,772)**	**(14,661)**
Surplus/ (deficit) for the period attributable to:			
University Hospitals of Leicester NHS Trust		(65,326)	(33,699)
TOTAL		**(65,326)**	**(33,699)**
Total comprehensive income/ (expense) for the period attributable to:			
University Hospitals of Leicester NHS Trust		(51,772)	(14,661)
TOTAL		**(51,772)**	**(14,661)**

Statements of Financial Position

		Group		Trust	
		31 March 2024	31 March 2023	31 March 2024	31 March 2023
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	15	29,130	15,507	29,130	15,507
Property, plant and equipment	16	718,930	667,682	718,919	667,668
Right of use assets	19	51,744	51,703	51,744	51,703
Other investments / financial assets	20	5,347	4,964	4,000	4,000
Receivables	23	3,019	3,099	3,019	3,099
Total non-current assets		**808,170**	**742,955**	**806,812**	**741,977**
Current assets					
Inventories	22	27,797	22,663	25,880	20,650
Receivables	23	39,406	62,928	38,623	61,737
Cash and cash equivalents	24	42,391	107,980	37,347	101,080
Total current assets		**109,594**	**193,571**	**101,850**	**183,467**
Current liabilities					
Trade and other payables	25	(165,728)	(187,250)	(165,206)	(186,070)
Borrowings	27	(9,434)	(12,231)	(9,435)	(14,146)
Provisions	28	(12,087)	(12,958)	(12,041)	(12,900)
Other liabilities	26	(4,812)	(4,196)	(4,813)	(4,196)
Total current liabilities		**(192,061)**	**(216,635)**	**(191,495)**	**(217,312)**
Total assets less current liabilities		**725,703**	**719,891**	**717,168**	**708,132**
Non-current liabilities					
Trade and other payables	25	-	-	-	
Borrowings	27	(34,373)	(29,514)	(34,372)	(27,596)
Provisions	28	(3,595)	(4,032)	(3,596)	(4,032)
Other liabilities	26	-	-	-	
Total non-current liabilities		**(37,968)**	**(33,546)**	**(37,968)**	**(31,628)**
Total assets employed		**687,735**	**686,345**	**679,199**	**676,504**
Financed by					
Public dividend capital		850,303	797,141	850,303	797,141
Revaluation reserve		217,730	202,796	217,730	201,349
Income and expenditure reserve		(388,118)	(323,314)	(388,833)	(321,986)
Charitable fund reserves	21	7,820	9,722	-	
Total taxpayers' equity		**687,735**	**686,345**	**679,199**	**676,504**

The notes form part of these accounts.

Name **Richard Mitchell**
Position **Chief Executive**
Date **27 June 2024**

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**797,141**	**202,796**	**(323,314)**	**9,722**	**686,345**
Surplus/(deficit) for the year	-	-	(65,808)	482	**(65,326)**
Impairments	-	(12,537)	-	-	**(12,537)**
Revaluations	-	25,698	-	-	**25,698**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	393	**393**
Public dividend capital received	53,162	-	-	-	**53,162**
Other reserve movements	-	1,773	1,004	(2,777)	**-**
Taxpayers' and others' equity at 31 March 2024	**850,303**	**217,730**	**(388,118)**	**7,820**	**687,735**

Consolidated Statement of Changes in Equity for the year ended 31 March 2023

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**760,831**	**188,573**	**(292,399)**	**7,691**	**664,696**
Surplus/(deficit) for the year	-	-	(37,187)	3,488	**(33,699)**
Other transfers between reserves	-	(5,211)	5,211	-	**-**
Revaluations	-	19,434	-	-	**19,434**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	(396)	**(396)**
Public dividend capital received	36,310	-	-	-	**36,310**
Other reserve movements	-	-	1,061	(1,061)	**-**
Taxpayers' and others' equity at 31 March 2023	**797,141**	**202,796**	**(323,314)**	**9,722**	**686,345**

Information on reserves

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

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

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

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 20.

Statements of Cash Flows

	Note	Group 2023/24 £000	Group 2022/23 £000	Trust 2023/24 £000	Trust 2022/23 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(45,553)	(14,266)	(43,420)	(15,243)
Non-cash income and expense:					
Depreciation and amortisation	7.1	54,581	51,730	54,578	51,726
Net impairments	8	12,225	12,958	12,225	11,511
Income recognised in respect of capital donations	4	(834)	-	(3,611)	(1,061)
(Increase) / decrease in receivables and other assets		23,522	(29,314)	22,975	(29,454)
(Increase) / decrease in inventories		(5,134)	(1,537)	(5,230)	(1,120)
Increase / (decrease) in payables and other liabilities		(26,102)	39,515	(25,431)	38,777
Increase / (decrease) in provisions		(1,349)	4,087	(1,254)	4,067
Movements in charitable fund working capital		264	(133)		-
Tax (paid) / received		(84)	(25)		-
Other movements in operating cash flows		1	2		(10)
Net cash flows from / (used in) operating activities		**11,537**	**63,017**	**10,832**	**59,193**
Cash flows from investing activities					
Interest received		4,017	1,886	4,017	1,886
Purchase of intangible assets		(8,861)	(4,776)	(8,861)	(4,776)
Sales of intangible assets		-	-	-	
Purchase of PPE and investment property		(90,657)	(66,024)	(90,657)	(66,024)
Sales of PPE and investment property		2,460	-	2,460	
Receipt of cash donations to purchase assets		822	-	3,599	1,061
Net cash flows from charitable fund investing activities		216	162		
Net cash flows from / (used in) investing activities		**(92,003)**	**(68,752)**	**(89,442)**	**(67,853)**
Cash flows from financing activities					
Public dividend capital received		53,162	36,310	53,162	36,310
Capital element of lease liability repayments		(14,195)	(16,866)	(14,195)	(15,307)
Other interest		(6)	(128)	(6)	(128)
Interest paid on lease liability repayments		(2,933)	(204)	(2,933)	(1,763)
PDC dividend (paid) / refunded		(21,151)	(17,814)	(21,151)	(17,814)
Net cash flows from / (used in) financing activities		**14,877**	**1,298**	**14,877**	**1,298**
Increase / (decrease) in cash and cash equivalents		**(65,589)**	**(4,437)**	**(63,733)**	**(7,362)**
Cash and cash equivalents at 1 April - brought forward		**107,980**	**112,417**	**101,080**	**108,442**
Prior period adjustments			-		
Cash and cash equivalents at 1 April - restated		**107,980**	**112,417**	**101,080**	**108,442**
Cash and cash equivalents transferred under absorption accounting		-	-		
Unrealised gains / (losses) on foreign exchange		-	-		
Cash and cash equivalents at 31 March	24	**42,391**	**107,980**	**37,347**	**101,080**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust reported a surplus of £52.8m in 2023/24, but did not seek any additional cash support from NHS Improvement (NHSI) in the year. Cash support will be required for24/25 and the Trust will follow the NHSI process to apply for revenue support. The Trust agreed contracts with local commissioners for 2023/24 and services are being commissioned in the same manner in the future as in prior years and there are no discontinued operations. Also there were no transfers of services or significantly amendment to the structure of the organisation in the year and there are no decision for such at this time. The Board of Directors also has a reasonable expectation that the Trust and group will have access to adequate resources in the form of support from the Department of Health and Social Care (NHS Act 2006 s42a) to continue to deliver the full range of mandatory services for the foreseeable future. The Directors have concluded that assessing the Trust and group as a going concern remains appropriate. Although these factors represent a material uncertainty that may cast significant doubt about the Trust's and group's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust and group will have adequate resources to continue in operational existence for the foreseeable future. As directed by the DHSC Group Accounting Manual 2023/24 the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

Note 1.3 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.

We consider going concern to be a critical judgement and this is discussed in section 1.2.

Valuation of the Trust's estate

The Trust engaged its valuers, Gerald Eve LLP, to revalue its estate as at the 31st March 2024. This revaluation applied a Modern Equivalent Asset (MEA) valuation methodology, which took into account the Trust's long term reconfiguration strategy. The Trust provided the valuers with the latest iteration of the Estates Strategy to inform the MEA valuation.

Note 1.4 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:

Income

The main income streams with the main areas of estimation uncertainty are covered in this section.

Timing of income recognition

There is some uncertainty around income recognition particularly in relation to work in progress and maternity pathway income at the year end, where some estimation is made as to the value of these totals. As agreement with NHS counterparties is necessary within the agreement of balances exercise for these balances we do not consider this is a significant risk.

Allowance for credit losses

We apply IFRS9 to our receivable balances at the year end. This requires us to establish an allowance for credit losses based upon our assessment of the likely recoverability of the outstanding debt in future. Whilst we use our experience, external advice and best estimation techniques to determine the likely recoverability, there is some uncertainty inherent in such an estimate.

Deferred income

Whilst we release income in the period to which it relates, at the time of the deferral there may be some uncertainty over the timing of future expenditure, particularly in research and development where projects may span several accounting periods.

Expenditure

The main areas of estimation uncertainty in relation to expenditure are covered in this section.

Accrued expenditure

The majority of our accrued expenditure relates to invoices received which have not yet been posted to our revenue position. Other estimated expenditure accruals are made where we have incurred expenditure during an accounting period but are yet to receive an invoice. There is a degree of uncertainty in relation to these accruals until the invoice is received.

Valuation of assets

The value of our land and buildings is based on a Modern Equivalent Asset valuation which uses an estimate of the future likely configuration of our estate. Within the Trust's five year estates strategy the reconfigured estate is assumed to have a smaller GIA area than the Trust's current three sites. There is some inherent uncertainty in this estimate as our reconfiguration plans may be further developed over the next five years.

Depreciation

Whilst we aim to give informed useful economic lives to our assets there is a degree of uncertainty in relation to the level of usage of the assets and the level of wear and tear which may reduce the life of the asset below the initial life allocated. Also, due to constraints around the availability of capital we may keep assets in use longer than originally planned. We assess the useful economic lives of our assets on an annual basis.

Note 1.5 Consolidation

The Trust is the corporate Trustee to Leicester Hospitals Charity NHS charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund’s statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity’s assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Trust Group Holdings Ltd

The Trust currently consolidates one subsidiary - Trust Group Holdings Limited (the Company). The Company is registered in the UK, company number 10388315, with a share capital comprising one share of £1 owned by the Trust. The company commenced trading on the 1 April 2017 as an Outpatient Dispensary service for the Trust. The service is provided across the three UHL sites, operating in normal business hours. A significant proportion of the company's revenue is inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements. The amounts consolidated are drawn from the published financial statements of TGH for 2023/24. TGH's accounting policies are aligned with those of the Trust.

Note 1.6 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. 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) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices 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.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

In 2023/24 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15.

(1) As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.7 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Approach to unrecoverable debt

The Trust recognises a loss allowance at an amount equal to lifetime expected credit losses (ECLs) under IFRS9's simplified approach – as mandated by HM Treasury. This applies to non-NHS Trade receivables; other long-term trade receivables; contract assets; and lease receivables.

We also adjust specific categories of debt (such as education, local authorities and overseas visitors) based on the likely level of irrecoverability as determined by the accounts receivable manager and team, taking into account historic levels of write offs and advice from solicitors and debt collection agencies. We increase the loss allowance for riskier debt categories such as overseas visitors.

Note 1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

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

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

Note 1.9 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 1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful 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 (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use. The Trust has revalued its assets with an effective date of revaluation of 31st March 2024.

The Trust's freehold and leasehold property values were updated by an external valuer, Gerald Eve LLP, a regulated firm of chartered surveyors. The valuation was prepared in accordance with the requirements of the RICS Professional Standards, the International Valuation Standards and IFRS.

The valuation has been prepared in accordance with the Government Financial Reporting Manual (FReM) to comply with IFRS, specifically with regard to IAS 16 'Property, Plant and Equipment' and IAS 40 'Investment Properties'.

The valuer's opinion of Fair Value was primarily derived using the Depreciated Replacement Cost approach to value the service potential, on a Modern Equivalent Asset (MEA) basis. The MEA valuation was based on the Trust's estates strategy, which outlines a five year major reconfiguration for the Trust's estate, and which effectively defines the Modern Equivalent Asset for the valuation.

The Trust's estates strategy is consistent with its clinical strategy and both strategies are intrinsically linked as we must reconfigure our estate in order to deliver our clinical strategy. We provided our estates strategy to our valuers, Gerald Eve LLP, to enable them to provide a more accurate MEA valuation based on our actual plans and future Trust configuration.

The Key Factors Impacting on the Land and Property Valuation

The valuation involves estimation techniques and in arriving at their opinion of the useful economic life and value of a building, the Trust's property valuation takes into account the following aspects:

· **Obsolescence**

- Physical Obsolescence - the age, condition and the probable costs of future maintenance.
- Functional Obsolescence – the suitability of the properties for their present use and the prospect of continuance or use for an alternative purpose. Another potential cause of functional obsolescence is legislative change, for example, statutory and regulatory compliance, including compliance with sustainability and energy legislation.

- Economic obsolescence – the extent of any loss in value resulting from external economic factors.

· **Environmental Factors -** Where the existing use has been considered in relation to the present and future characteristics of the surrounding area, local and national planning policies and restrictions likely to be imposed by the planning authority on the continuation of the use.

· **Change of Use -** Any identified present of future change of use of a building.

· **Indexation**

In arriving at the replacement build cost rates used in the DRC valuations, the Valuer relies on BCIS and other published costs data supplemented where available by knowledge of recent build costs incurred by UHL of constructing general and specialised healthcare accommodation. The indices are shown in the table below:

Site	2023/24	2022/23	National Factor	Local Factor	Combined Factor
TPI	390	379	1.029		
LRI/LGH/Glenfield	102	102		1.000	1.029
Lincoln	99	98		1.010	1.040
Loughborough	101	101		1.000	1.029

· **Floor Areas**

The Trust uses a database/repository for its estate data, including plans and floor areas. The system is updated on an ongoing basis to reflect new build and disposals and updates reflecting remeasurement to improve data quality. A snapshot of the system is taken at year end and provided to the Valuer to be used for the purposes of the valuation. The agreed approach with the Trust has been to calculate a baseline position to reflect the actual floorspace the Trust occupies. In addition the Trust has reviewed its asset list and has confirmed which buildings would be disposed of and what additional accommodation would need to be constructed, as part of the Estate Strategy rationalisation. This will result in a concentration of services at the LRI and Glenfield Hospital with only a residual presence at the LGH site.

Site	Baseline GIA	New Build GIA	Disposals GIA	2024 Estate MEA
LRI	170,594	27,398	(7,838)	190,155
LGH	91,679	N/A	(75,491)	16,188
GFH	78,531	26,733	N/A	105,264
Total	**340,804**	**54,131**	**(83,328)**	**311,607**

· **Land Values**

In assessing the land value, the Valuers had regard to the advice given in the DRC Guidance Note where the use, such as that of the Trusts' specialised Properties, is so specialised that it is impossible to categorise it in general market terms. Under these circumstances the Valuer has determined what other uses a buyer of an alternative site for the specialised use would have to compete in the market. The Valuer's assessment of land value for all the Trust's sites reflects their view as to the costs associated with acquiring light industrial/ employment or residential development land in the general locality of the actual sites.

To guide the land values adopted in the valuation, the valuer considered recent land sales of NHS sites, whilst also taking account of the size of the MEA hospital sites. There have been limited new land transactions over the last year in the locality, so the Valuer therefore has to consider the wider trends in land values at a national level, market sentiment and the impact of the factors identified above on residual land value. The assessment has been necessarily judgement led and has concluded that it would be appropriate to make a c10% reduction in land values generally adopted within DRC valuations as against positions taken at March 2024. This reflected a widely reported *softening* of the industrial and commercial land value market, which until last year had been performing quite strongly.

· **Sensitivity of Assumptions**

A sensitivity analysis of these assumptions allows the Trust to understand the impact on materiality, given the estimation uncertainty implicit in the valuation. The table below setting out at a high level the sensitivity of the valuation of the main hospital sites to movements in each of these key assumptions, using a 5% tolerance. 31 March 2024 balances have been used as the baseline to derive these values, as the valuation indices were applied to these balances in arriving at the 31 March 2023 valuation.

Assumption	Baseline Adjustment Factor	Assumption value (£m)	Sensitivity (+ 5%) (£m)	Sensitivity (- 5%) (£m)
Build Cost Index	1.029	14.747	25.426	(25.426)
Obsolescence Factor	(1.040)	(20.931)	(28.047)	28.047
Land value / acre	(1.100)	(4.814)	(2.407)	2.407

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of 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

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.

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.

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

Donated and grant funded assets

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

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

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	8	90
Dwellings	8	51
Plant & machinery	7	20
Transport equipment	8	15
Information technology	4	11
Furniture & fittings	8	31

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

Note 1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust 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 where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	2	10
Internally generated information technology	2	10

Note 1.12 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. Physical stock counts are performed as close to 31 March as possible and the exact timing takes into account the disruption to clinical areas. For example, theatre stock is counted at weekends close to 31 March when the theatres are not in operation.

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

We estimate the value of materials management and pharmacy ward stocks as these are areas not physically counted. We use a proportion of the maximum stock levels in these areas to estimate the stock held at year end.

Inventories held by the Trust Subsidiary - TGH Pharmacy
The Trust's Healthcare at Home services are provided by its subsidiary, TGH Ltd, and the stock in relation to this service is held by TGH Ltd until delivered to patients at home. Inventories are stated at the lower of cost and net realisable value. Cost includes all costs incurred in bringing each product to its present location and condition, on a first-in, first-out basis.

Note 1.13 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 1.14 Financial assets and financial liabilities

Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Impairment of financial assets

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

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

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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

Derecognition

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

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

Note 1.15 Leases

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

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

The Trust as a lessee

Recognition and initial 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.

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 includes 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 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

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 or other systematic basis. 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 considered to be 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 a 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.

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16.

Note 1.16 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 2024:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
	Exceeding 40 years	4.40%	3.00%

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 2023:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: minus 1.70%).

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 28.3 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.17 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 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 29, 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 1.18 Public dividend capital

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

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax

The Trust has no corporation tax liability itself however the Trust's subsidiary is liable to pay corporation tax and this is recognised in the group accounts.

Note 1.21 Climate change levy

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

Note 1.22 Foreign exchange

The functional and presentational currency of the Trust is sterling.
A transaction (foreign payment) which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.
Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.23 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.24 Losses and special payments

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

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

Note 1.25 Gifts

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

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

There are no standards relevant to the Trust awaiting adoption.

Note 2 Operating Segments

The Trust operates in one segment, which is the provision of healthcare.
The Trust subsidiary TGH operates a pharmacy service for the Trust and Leicester Hospitals Charity raises and disburses funds for the benefit of the Trust. Neither subsidiary is material to the operations of the Trust.

Note 3 Operating income from patient care activities (Group)

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)	2023/24 £000	2022/23 £000
Income from commissioners under API contracts - variable element*	285,511	
Income from commissioners under API contracts - fixed element*	955,135	1,117,809
High cost drugs income from commissioners	150,697	113,785
Private patient income	4,147	3,353
Elective recovery fund		29,631
National pay award central funding***	706	27,571
Additional pension contribution central funding*	36,622	32,589
Other clinical income	4,225	2,702
Total income from activities	**1,437,043**	**1,327,440**

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

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

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

***In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2023/24 £000	2022/23 £000
NHS England	503,843	472,791
Clinical commissioning groups		202,713
Integrated care boards	924,425	645,881
Department of Health and Social Care	-	-
Other NHS providers	-	-
NHS other	-	-
Local authorities	-	-
Non-NHS: private patients	4,147	3,353
Non-NHS: overseas patients (chargeable to patient)	2,903	1,382
Injury cost recovery scheme	1,322	1,320
Non NHS: other	403	-
Total income from activities	**1,437,043**	**1,327,440**
Of which:		
Related to continuing operations	1,437,043	1,327,440
Related to discontinued operations	-	-

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

	2023/24	2022/23
	£000	£000
Income recognised this year	2,903	1,382
Cash payments received in-year	817	339
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	1,462	-

Note 4 Other operating income (Group)

	2023/24			2022/23		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	47,736	-	**47,736**	43,086	-	**43,086**
Education and training	55,555	-	**55,555**	50,462	-	**50,462**
Non-patient care services to other bodies	11,176		**11,176**	9,742		**9,742**
Reimbursement and top up funding				5,392		**5,392**
Income in respect of employee benefits accounted on a gross basis	8,302		**8,302**	9,464		**9,464**
Receipt of capital grants and donations and peppercorn leases		834	**834**		-	**-**
Charitable and other contributions to expenditure		566	**566**		2,355	**2,355**
Support from the Department of Health and Social Care for mergers		-	**-**		-	**-**
Revenue from finance leases		-	**-**		-	**-**
Revenue from operating leases		413	**413**		275	**275**
Amortisation of PFI deferred income / credits		-	**-**		-	**-**
Charitable fund incoming resources		2,008	**2,008**		5,351	**5,351**
Other income	23,097	-	**23,097**	36,948	-	**36,948**
Total other operating income	**145,866**	**3,821**	**149,687**	**155,094**	**7,981**	**163,075**
Of which:						
Related to continuing operations			149,687			163,075

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

No revenue was recognised in the reporting period that was included in within contract liabilities at the previous period end (2022/23 - £Nil).

Note 5.2 Transaction price allocated to remaining performance obligations

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

Note 5.3 Fees and charges (Group)

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.

	2023/24	2022/23
	£000	£000
Income	4,263	3,010
Full cost	(3,079)	(1,562)
Surplus / (deficit)	**1,184**	**1,448**

Note 6 Operating leases - University Hospitals of Leicester NHS Trust as lessor

This note discloses income generated in operating lease agreements where No trust selected is the lessor.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

Note 6.1 Operating leases income (Group)

	2023/24	2022/23
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	413	275
Variable lease receipts / contingent rents	-	-
Total in-year operating lease income	**413**	**275**

Note 6.2 Future lease receipts (Group)

	31 March 2024	31 March 2023
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	279	198
- later than one year and not later than two years	-	-
- later than two years and not later than three years	-	-
- later than three years and not later than four years	-	-
- later than four years and not later than five years	-	-
- later than five years	-	-
Total	**279**	**198**

Note 7.1 Operating expenses (Group)

	2023/24	2022/23
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,878	3,438
Purchase of healthcare from non-NHS and non-DHSC bodies	20,704	14,309
Purchase of social care	-	-
Staff and executive directors costs	1,006,325	897,213
Remuneration of non-executive directors	257	269
Supplies and services - clinical (excluding drugs costs)	166,488	167,500
Supplies and services - general	17,592	14,997
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	152,807	144,487
Inventories written down	7	-
Consultancy costs	1,267	2,613
Establishment	8,439	7,801
Premises	64,556	58,928
Transport (including patient travel)	9,039	7,104
Depreciation on property, plant and equipment	49,468	46,339
Amortisation on intangible assets	5,113	5,391
Net impairments	12,225	12,958
Movement in credit loss allowance: contract receivables / contract assets	282	1,697
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	(4,164)	3,390
Change in provisions discount rate(s)	(117)	(526)
Fees payable to the external auditor		
audit services- statutory audit	335	334
other auditor remuneration (external auditor only)	-	-
Internal audit costs	134	112
Clinical negligence	42,488	38,824
Legal fees	711	740
Insurance	751	709
Research and development	48,031	42,610
Education and training	3,713	3,002
Expenditure on short term leases	7,761	1,679
Expenditure on low value leases	-	-
Variable lease payments not included in the liability	-	-
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	-	-
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	-	-
Car parking & security	334	4,658
Hospitality	-	1
Losses, ex gratia & special payments	35	56
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other NHS charitable fund resources expended	1,727	2,011
Other	13,097	22,137
Total	**1,632,283**	**1,504,781**
Of which:		
Related to continuing operations	1,632,283	1,504,781
Related to discontinued operations	-	-

Note 7.2 Other auditor remuneration (Group)

The Trust has not paid any remuneration to the auditor in respect of non-audit services (2022-23 - £Nil).

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2022/23: £1 million).

Note 8 Impairment of assets (Group)

	2023/24	2022/23
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	5,883	12,958
Impairments of charitable fund assets	-	-
Impairments/Write off	6,342	-
Total net impairments charged to operating surplus / deficit	**12,225**	**12,958**
Impairments charged to the revaluation reserve	12,537	-
Total net impairments	**24,762**	**12,958**

An impairment is a permanent reduction in the value of a Trust's asset. It may be a fixed asset or an intangible asset. There are 2 causes of the £24.7m impairment taken through a combination of the Trust's I&E Account (£12.2m) and the revaluation reserve (£12.5m).

The asset verification exercise undertaken in 23/24 on non land and building assets identified £7.6m of assets as at 31 March 2023 that needed to be de-recognised as they no longer existed or were no longer in use or had been duplicated within the accounting record. As the Trust Board do not consider the effect on the prior period financial statements to be material, this has been corrected in the current period by recognition of an expense of £6.3m in "other" line within impairment of assets. The remaining £1.3m is included within depreciation and amortisation for the year ended 31 March 2024.

In addition the annual property valuation undertaken by our independent valuers identified a further £18.4m reduction in the net book value of land and buildings that needed to be adjusted, so these assets can be recorded in the accounting statements at fair value. The 2 main drivers behind these reductions are the assessed annual market price movement in the value of commercial land and property and a valuation by our Valuers of new capital costs works undertaken to our buildings, both new and refurbishment work in 23/24, which can lead to a building having a value lower than the capitalised costs incurred in construction, when the work is completed and valued. It should be noted that an upward movements in the value of assets that had previously been impaired arising from the annual property valuation, would result in the reversal of a previous years' impairment. The £18.4m is therefore a net impairment, which includes such an upward revaluation. In addition £25.7m was identifed as an upward revaluation on property assets that were taken through the revaluation reserve , meaning that the overall impact of the property valuation in 23/24 was an overall net gain of £7.3m (£25.7m less £18.4m).

Note 9 Employee benefits (Group)

	2023/24 Total £000	2022/23 Total £000
Salaries and wages	786,887	711,147
Social security costs	85,144	68,006
Apprenticeship levy	3,966	3,274
Employer's contributions to NHS pensions	120,775	107,116
Pension cost - other	100	126
Temporary staff (including agency)	33,192	28,370
NHS charitable funds staff	-	-
Total gross staff costs	**1,030,064**	**918,039**
Recoveries in respect of seconded staff	-	-
Total staff costs	**1,030,064**	**918,039**
Of which		
Costs capitalised as part of assets	3,564	3,124

Note 9.1 Retirements due to ill-health (Group)

During 2023/24 there were 7 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £1,746k (£21k in 2022/23).

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 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%).

The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020.

Note 11 Finance income (Group)

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

	2023/24	2022/23
	£000	£000
Interest on bank accounts	4,017	1,886
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
NHS charitable fund investment income	216	162
Other finance income	-	-
Total finance income	**4,233**	**2,048**

Note 12.1 Finance expenditure (Group)

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

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on lease obligations	2,933	1,860
Interest on late payment of commercial debt	6	126
Total interest expense	**2,939**	**1,986**
Unwinding of discount on provisions	41	(152)
Other finance costs	-	-
Total finance costs	**2,980**	**1,834**

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

	2023/24	2022/23
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	1
Amounts included within interest payable arising from claims made under this legislation	6	126
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses) (Group)

	2023/24	2022/23
	£000	£000
Gains on disposal of assets	1,171	-
Losses on disposal of assets	(1,657)	(624)
Gains / losses on disposal of charitable fund assets	-	-
Total gains / (losses) on disposal of assets	**(486)**	**(624)**

Note 15.1 Intangible assets - 2023/24

Group	Software licences	Internally generated information technology	Intangible assets under construction	Charitable fund intangible assets	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**41,379**	**12**	**-**	**-**	**41,391**
Transfers by absorption	-	-	-	-	**-**
Additions	3,191	-	5,679	-	**8,870**
Impairments	(2,689)	-	-	-	**(2,689)**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	15,267	-	-	-	**15,267**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2024	**57,148**	**12**	**5,679**	**-**	**62,839**
Amortisation at 1 April 2023 - brought forward	**25,884**	**-**	**-**	**-**	**25,884**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	5,113	-	-	-	**5,113**
Impairments	(630)	-	-	-	**(630)**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	3,342	-	-	-	**3,342**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Amortisation at 31 March 2024	**33,709**	**-**	**-**	**-**	**33,709**
Net book value at 31 March 2024	**23,439**	**12**	**5,679**	**-**	**29,130**
Net book value at 1 April 2023	**15,495**	**12**	**-**	**-**	**15,507**

Note 15.2 Intangible assets - 2022/23

Group	Software licences	Internally generated information technology	Intangible assets under construction	Charitable fund intangible assets	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	**36,624**	**-**	**-**	**-**	**36,624**
Prior period adjustments	-	-	-	-	**-**

Valuation / gross cost at 1 April 2022 - restated	**36,624**	**-**	**-**	**-**	**36,624**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	**-**
Transfers by absorption	-	-	-	-	**-**
Additions	4,764	12	-	-	**4,776**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	(9)	-	-	-	**(9)**
Valuation / gross cost at 31 March 2023	**41,379**	**12**	**-**	**-**	**41,391**
Amortisation at 1 April 2022 - as previously stated	**20,502**	**-**	**-**	**-**	**20,502**
Prior period adjustments	-	-	-	-	**-**
Amortisation at 1 April 2022 - restated	**20,502**	**-**	**-**	**-**	**20,502**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	**-**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	5,391	-	-	-	**5,391**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	(9)	-	-	-	**(9)**
Amortisation at 31 March 2023	**25,884**	**-**	**-**	**-**	**25,884**
Net book value at 31 March 2023	**15,495**	**12**	**-**	**-**	**15,507**
Net book value at 1 April 2022	**16,122**	**-**	**-**	**-**	**16,122**

Notes

A transfer has been recognised in the year ended 31 March 2024 from property, plant and equipment to intangibles of £11.925m (£15.267m Gross Cost less £3.342m accumulated depreciation) for the Group and the Trust in relation to assets that should have previously been presented as intangibles. These assets had been depreciated/amortised appropriately, so the reclassification has no impact on the income and expenditure for the year. As the Board do not consider the effect on the prior period financial statements to be material, this has been corrected in the current period.

Impairment/write-offs of £2.059m (Gross cost £2.689m less accumulated depreciation of £630k) is included within the impairment note (note 8) and the impairment line on operating expenses (Note 7.1) for both the Group and Trust positions related to intangible assets that have been written off/impaired in the current year as a result of the asset verification exercise undertaken by management. These write-offs relate to assets that are no longer in use within the Trust and Group.

Note 16.1 Property, plant and equipment - 2023/24

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 - brought forward	**55,420**	**495,176**	**6,310**	**31,636**	**131,321**	**338**	**57,561**	**3,596**	**781,358**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	9,564	62	58,622	16,437	-	11,233	459	**96,377**
Impairments/Write offs	(2,477)	(20,230)	(54)	-	(1,861)	-	(3,977)	-	**(28,599)**
Reversals of impairments	-	5,894	2	-	-	-	-	-	**5,896**
Revaluations	13	25,370	315	-	-	-	-	-	**25,698**
Reclassifications	-	22,142	-	(26,205)	4,086	-	(15,357)	67	**(15,267)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(9,207)	-	-	-	**(9,207)**
Valuation/gross cost at 31 March 2024	**52,956**	**537,916**	**6,635**	**64,053**	**140,776**	**338**	**49,460**	**4,122**	**856,256**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**-**	**-**	**-**	**79,181**	**183**	**32,075**	**2,237**	**113,676**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	19,300	431	-	8,901	6	4,538	74	**33,250**
Impairments/Write offs	-	1,556	-	-	(351)	-	(1,205)	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	812	-	(4,154)	-	**(3,342)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(6,258)	-	-	-	**(6,258)**
Accumulated depreciation at 31 March 2024	**-**	**20,856**	**431**	**-**	**82,285**	**189**	**31,254**	**2,311**	**137,326**
Net book value at 31 March 2024	**52,956**	**517,060**	**6,204**	**64,053**	**58,491**	**149**	**18,206**	**1,811**	**718,930**
Net book value at 1 April 2023	**55,420**	**495,176**	**6,310**	**31,636**	**52,140**	**155**	**25,486**	**1,359**	**667,682**

Note:

The derecognition/disposal of assets £2,949k primarily relates to the transfer of Linear Accelerator from the Trust to the MES provider , which therefore no longer appears in the PPE note but apprears in the Right of Use disclosure

Note 16.2 Property, plant and equipment - 2022/23

Group	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 2022 - as previously stated	**60,128**	**467,471**	**5,555**	**39,912**	**170,624**	**338**	**55,537**	**2,693**	**802,258**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2022 - restated	**60,128**	**467,471**	**5,555**	**39,912**	**170,624**	**338**	**55,537**	**2,693**	**802,258**
IFRS 16 implementation - reclassification to right of use assets	-	(3,675)	-	-	(59,693)	-	(10,863)	-	**(74,231)**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	8,245	-	39,672	9,738	-	9,541	907	**68,103**
Impairments	(3,207)	(16,910)	-	-	-	-	-	-	**(20,117)**
Reversals of impairments	-	7,159	-	-	-	-	-	-	**7,159**
Revaluations	(1,501)	3,077	624	-	-	-	-	-	**2,200**
Reclassifications	-	29,809	131	(47,948)	12,640	-	5,368	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,988)	-	(2,022)	(4)	**(4,014)**
Valuation/gross cost at 31 March 2023	**55,420**	**495,176**	**6,310**	**31,636**	**131,321**	**338**	**57,561**	**3,596**	**781,358**
Accumulated depreciation at 1 April 2022 - as previously stated	**-**	**649**	**-**	**-**	**113,470**	**177**	**30,769**	**2,137**	**147,202**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2022 - restated	**-**	**649**	**-**	**-**	**113,470**	**177**	**30,769**	**2,137**	**147,202**
IFRS 16 implementation - reclassification to right of use assets	-	(760)	-	-	(39,246)	-	(5,904)	-	**(45,910)**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	16,994	351	-	6,845	6	8,710	104	**33,010**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(16,883)	(351)	-	-	-	-	-	**(17,234)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,888)	-	(1,500)	(4)	**(3,392)**
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**79,181**	**183**	**32,075**	**2,237**	**113,676**
Net book value at 31 March 2023	**55,420**	**495,176**	**6,310**	**31,636**	**52,140**	**155**	**25,486**	**1,359**	**667,682**
Net book value at 1 April 2022	**60,128**	**466,822**	**5,555**	**39,912**	**57,154**	**161**	**24,768**	**556**	**655,056**

Notes

A transfer has been recognised in the year ended 31 March 2024 from property, plant and equipment to intangibles of £11.925m (£15.267m Gross Cost less £3.342m accumulated depreciation) for the Group and the Trust in relation to assets that should have previously been presented as intangibles. These assets had been depreciated/amortised appropriately, so the reclassification has no impact on the income and expenditure for the year. As the Board do not consider the effect on the prior period financial statements to be material, this has been corrected in the current period.

The Trust has finalised its exercise to track and locate its plant & equipment assets during the year, responding to the weaknesses highlighting in previous periods. It was a detailed exercise and has involved a large amount of staff from across the Trust as well as support from external specialists to log, verify and tag over 16,000 of individual plant & equipment assets across the Trust. The existence of these assets will now be reviewed and will be confirmed by individual departments on an annual basis, as business as usual. A total impairment/write-off of £4.282m (Gross cost of £5.838m less accumulated depreciation of £1.556m) is included within the impairment note (Note 8) and the impairment line on operating expenses (Note 7.1) for the Group and Trust related to plant and machinery and information technology assets that have been written off in the current year as a result of this asset verification exercise undertaken by management in the current period. These write-offs/disposals relate to assets that no longer exist within the Trust or Group. As the Trust Board do not consider the effect on the prior period financial statements to be material, this has been corrected in the current period.

Note 16.3 Property, plant and equipment financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	52,956	516,867	6,204	64,034	55,136	149	18,180	1,799	-	**715,325**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	193	-	19	3,355	-	26	12	-	**3,605**
NBV total at 31 March 2024	**52,956**	**517,060**	**6,204**	**64,053**	**58,491**	**149**	**18,206**	**1,811**	**-**	**718,930**

Note 16.4 Property, plant and equipment financing - 31 March 2023

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	55,420	494,978	6,310	31,636	48,109	155	25,486	1,326	-	**663,420**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	198	-	-	4,031	-	-	33	-	**4,262**
NBV total at 31 March 2023	**55,420**	**495,176**	**6,310**	**31,636**	**52,140**	**155**	**25,486**	**1,359**	**-**	**667,682**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease										**-**
Not subject to an operating lease										**-**
NBV total at 31 March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Note 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	500	-	-	-	-	-	-		**500**
Not subject to an operating lease	55,420	494,676	6,310	31,636	52,140	155	25,486	1,359		**667,182**
NBV total at 31 March 2023	**55,420**	**495,176**	**6,310**	**31,636**	**52,140**	**155**	**25,486**	**1,359**	**-**	**667,682**

Note 17 Donations of property, plant and equipment

	Group and Trust	
	2023/24	2022/23
	£000	£000
Assets purchased with donations from the Trust's charitable fund	2,768	1,061
Assets received from DHSC relating to Covid treatment	-	-
Other	804	-
	3,572	**1,061**

Note 18 Revaluations of property, plant and equipment

The Trust's land and buildings are held at valuation. Details are disclosed in note 1 and explained in Note 8.

Note 19 Leases - University Hospitals of Leicester NHS Trust as a lessee

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

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

Payment for the fair value of the services received

The annual unitary payment is applied to meet the annual finance cost and to repay the lease liabilities over the contract term.

Interest costs charged to revenue

An annual finance cost is calculated by applying the implicit interest rate in the leases to the opening lease liabilities for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

Property plant and equipment assets recognised on the balance sheet

The finance lease assets are recognised as property, plant and equipment. The asset values, life and depreciation for the scheme are provided to the Trust by the Lessors.

Depreciation on the property, plant and equipment is charged to revenue.

Liability

Lease liabilities are recognised at the same time as the assets are recognised. The liabilities are measured initially at the same amount as the fair value of the assets and are subsequently measured as finance lease liabilities in accordance with IAS 17 Leases.

Asset replacement

Any assets, or asset components provided by the lessor during the contract are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the lessor and are measured initially at their fair value.

Assets contributed by the Trust to the operator for use in the scheme (MES only).

Assets contributed for use in the scheme are recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Note 19.1 Right of use assets - 2023/24

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**21,865**	**74,762**	**58**	**14,257**	**110,942**	**8,431**
Transfers by absorption	-	-	-	-	**-**	-
Additions	1,488	9,398	-	3,660	**14,546**	-
Remeasurements of the lease liability	1,229	979	-	-	**2,208**	-
Movements in provisions for restoration / removal costs	-	-	-	-	**-**	-
Impairments	-	-	-	-	**-**	-
Reversal of impairments	-	-	-	-	**-**	-
Revaluations	-	-	-	-	**-**	-
Reclassifications	1	-	-	-	**1**	1
Disposals / derecognition	-	(495)	-	-	**(495)**	-
Valuation/gross cost at 31 March 2024	**24,583**	**84,644**	**58**	**17,917**	**127,202**	**8,432**
Accumulated depreciation at 1 April 2023 - brought forward	**3,551**	**47,634**	**40**	**8,014**	**59,239**	**1,229**
Transfers by absorption	-	-	-	-	**-**	-
Provided during the year	4,460	8,776	18	2,964	**16,218**	1,114
Impairments	-	-	-	-	**-**	-
Reversal of impairments	-	-	-	-	**-**	-
Revaluations	-	-	-	-	**-**	-
Reclassifications	1	-	-	-	**1**	(97)
Disposals / derecognition	-	-	-	-	**-**	-
Accumulated depreciation at 31 March 2024	**8,012**	**56,410**	**58**	**10,978**	**75,458**	**2,246**
Net book value at 31 March 2024	**16,571**	**28,234**	**-**	**6,939**	**51,744**	**6,186**
Net book value at 1 April 2023	**18,314**	**27,128**	**18**	**6,243**	**51,703**	**7,202**

Net book value of right of use assets leased from other NHS providers	2,640
Net book value of right of use assets leased from other DHSC group bodies	3,546

Note 19.2 Right of use assets - 2022/23

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**-**	**-**	**-**	**-**	**-**	**-**
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	3,675	59,269	-	11,287	**74,231**	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	10,738	2,278	58	-	**13,074**	8,431
Transfers by absorption	-	-	-	-	**-**	-
Additions	3,494	9,243	-	2,970	**15,707**	-
Remeasurements of the lease liability	3,958	3,972	-	-	**7,930**	-
Movements in provisions for restoration / removal costs	-	-	-	-	**-**	-
Impairments	-	-	-	-	**-**	-
Reversal of impairments	-	-	-	-	**-**	-
Revaluations	-	-	-	-	**-**	-
Reclassifications	-	-	-	-	**-**	-
Disposals / derecognition	-	-	-	-	**-**	-
Valuation/gross cost at 31 March 2023	**21,865**	**74,762**	**58**	**14,257**	**110,942**	**8,431**
Accumulated depreciation at 1 April 2022 - brought forward	**-**	**-**	**-**	**-**	**-**	**-**
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	760	39,574	-	5,576	**45,910**	-
IFRS 16 implementation - adjustments for existing subleases	-	-	-	-	**-**	-
Transfers by absorption	-	-	-	-	**-**	-
Provided during the year	2,791	8,060	40	2,438	**13,329**	1,229
Impairments	-	-	-	-	**-**	-
Reversal of impairments	-	-	-	-	**-**	-
Revaluations	-	-	-	-	**-**	-
Reclassifications	-	-	-	-	**-**	-
Disposals / derecognition	-	-	-	-	**-**	-
Accumulated depreciation at 31 March 2023	**3,551**	**47,634**	**40**	**8,014**	**59,239**	**1,229**
Net book value at 31 March 2023	**18,314**	**27,128**	**18**	**6,243**	**51,703**	**7,202**
Net book value at 1 April 2022	**-**	**-**	**-**	**-**	**-**	**-**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	7,202

Note 19.3 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 27.1.

	Group & Trust	
	2023/24	2022/23
	£000	£000
Carrying value at 1 April	**41,745**	**20,243**
Prior period adjustments		1
Carrying value at 1 April - restated	**41,745**	**20,244**
IFRS 16 implementation - adjustments for existing operating leases		13,074
Transfers by absorption	-	-
Lease additions	14,546	15,707
Lease liability remeasurements	2,208	7,930
Interest charge arising in year	2,933	1,860
Early terminations	(497)	-
Lease payments (cash outflows)	(17,128)	(17,070)
Other changes	-	-
Carrying value at 31 March	**43,807**	**41,745**

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

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

Note 19.4 Maturity analysis of future lease payments at 31 March 2024

	Group & Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	9,434	-
- later than one year and not later than five years;	32,676	3,533
- later than five years.	1,697	-
Total gross future lease payments	**43,807**	**3,533**
Finance charges allocated to future periods	-	-
Net lease liabilities at 31 March 2024	**43,807**	**3,533**
Of which:		
Leased from other NHS providers		-
Leased from other DHSC group bodies		3,533

Note 19.5 Maturity analysis of future lease payments at 31 March 2023

	Group & Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2023	**31 March 2023**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	12,799	1,000
- later than one year and not later than five years;	25,813	5,386
- later than five years.	8,238	1,128
Total gross future lease payments	**46,850**	**7,514**
Finance charges allocated to future periods	(5,105)	(246)
Net finance lease liabilities at 31 March 2023	**41,745**	**7,268**
Of which:		
Leased from other NHS providers		-
Leased from other DHSC group bodies		7,268

Note 20 Other investments / financial assets (non-current)

	Group & Trust	
	2023/24	**2022/23**
	£000	**£000**
Carrying value at 1 April - brought forward	**4,964**	**5,362**
Prior period adjustments		-
Carrying value at 1 April - restated	**4,964**	**5,362**
At start of period for new FTs	-	-
Transfers by absorption	-	-
Acquisitions in year	891	959
Movement in fair value through income and expenditure	-	-
Movement in fair value through OCI	393	(396)
Net impairments	-	-
Transfers to / from assets held for sale	-	-
Amortisation at the effective interest rate	-	-
Current portion of loans receivable transferred to current financial assets	-	-
Disposals	(901)	(961)
Carrying value at 31 March	**5,347**	**4,964**

Note 21 Analysis of charitable fund reserves

	31 March 2024 £000	31 March 2023 £000
Unrestricted funds:		
Revaluation reserve	5,749	6,043
Restricted funds:		
Other restricted income funds	2,071	3,679
	7,820	**9,722**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 22 Inventories

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Drugs	9,231	8,081	7,314	6,068
Work In progress	-	-		
Consumables	18,258	14,154	18,258	14,154
Energy	308	428	308	428
Other	-	-		
Charitable fund inventory	-	-		
Total inventories	**27,797**	**22,663**	**25,880**	**20,650**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £866k (2022/23: £2,540k). Write-down of inventories recognised as expenses for the year were £7k (2022/23: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £566k of items purchased by DHSC (2022/23: £2,355k).

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

Note 23.1 Receivables

	Group		Trust	
	31 March 2024	31 March 2023	31 March 2024	31 March 2023
	£000	£000	£000	£000
Current				
Contract receivables	32,693	58,116	32,691	58,116
Allowance for impaired contract receivables / assets	(4,623)	(4,370)	(4,623)	(4,370)
Prepayments (non-PFI)	6,535	4,693	6,519	4,676
PDC dividend receivable	87	-	87	-
VAT receivable	3,788	2,899	3,142	2,246
Corporation and other taxes receivable	28	24	28	
Other receivables	741	1,242	779	1,045
NHS charitable funds receivables	157	324		-
Total current receivables	**39,406**	**62,928**	**38,623**	**61,713**
Non-current				
Contract receivables	2,155	1,891	2,155	1,891
Allowance for impaired contract receivables / assets	(481)	(452)	(481)	(452)
Other receivables	1,345	1,660	1,345	1,660
Total non-current receivables	**3,019**	**3,099**	**3,019**	**3,099**
Of which receivable from NHS and DHSC group bodies:				
Current	20,637	43,922	20,637	43,922
Non-current	1,345	1,660	1,345	1,345

Note 23.2 Allowances for credit losses - 2023/24

	Group & Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2023 - brought forward	**4,822**	**-**
Transfers by absorption	-	-
New allowances arising	2,637	-
Changes in existing allowances	-	-
Reversals of allowances	(2,355)	-
Utilisation of allowances (write offs)	-	-
Changes arising following modification of contractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2024	**5,104**	**-**

Note 23.3 Allowances for credit losses - 2022/23

	Group	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2022 - as previously stated	**3,125**	**-**
New allowances arising	1,697	-
Allowances as at 31 Mar 2023	**4,822**	**-**

Note 24.1 Cash and cash equivalents movements

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

	Group		Trust	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
At 1 April	**(4,437)**	**112,417**	**(7,362)**	**108,442**
Net change in year	(65,589)	(4,437)	(63,733)	(7,362)
At 31 March	**(65,589)**	**(4,437)**	**(63,733)**	**(7,362)**
Broken down into:				
Cash at commercial banks and in hand	5,081	6,948	37	48
Cash with the Government Banking Service	37,310	101,032	37,310	101,032
Total cash and cash equivalents as in SoFP	**42,391**	**107,980**	**37,347**	**101,080**
Bank overdrafts (GBS and commercial banks)	-	-	.	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**42,391**	**107,980**	**37,347**	**101,080**

Note 25.1 Trade and other payables

	Group		Trust	
	31 March 2024	31 March 2023	31 March 2024	31 March 2023
	£000	£000	£000	£000
Current				
Trade payables	47,171	44,297	48,035	59,805
Capital payables	16,590	10,882	16,590	10,882
Accruals	66,697	101,823	65,689	85,387
Receipts in advance and payments on account	-	-		
PFI lifecycle replacement received in advance	-	-		
Social security costs	10,602	9,229	10,577	9,216
VAT payables	-	-		
Other taxes payable	11,198	8,908	11,188	8,895
PDC dividend payable	-	609		609
Pension contributions payable	12,125	10,471	12,125	10,471
Other payables	1,106	888	1,002	805
NHS charitable funds: trade and other payables	240	143		
Total current trade and other payables	**165,728**	**187,250**	**165,206**	**186,070**
Of which payables from NHS and DHSC group bodies:				
Current	5,530	9,105	9757	9105
Non-current	-	-		

Note 25.2 Early retirements in NHS payables above

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

Group and Trust	31 March 2024	31 March 2024	31 March 2023	31 March 2023
	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 26 Other liabilities

	Group & Trust	
	31 March 2024	31 March 2023
	£000	£000
Current		
Deferred income: contract liabilities	4,812	4,196
Total other current liabilities	**4,812**	**4,196**

Note 27.1 Borrowings

	Group & Trust	
	31 March 2024	31 March 2023
	£000	£000
Current		
Lease liabilities	9,434	12,231
Total current borrowings	**9,434**	**12,231**
Non-current		
Lease liabilities	34,373	29,514
Total non-current borrowings	**34,373**	**29,514**

Note 27.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2023/24	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2023	**41,745**	**41,745**
Cash movements:		
Financing cash flows - payments and receipts of principal	(14,195)	**(14,195)**
Financing cash flows - payments of interest	(2,933)	**(2,933)**
Non-cash movements:		
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023		**-**
Transfers by absorption	-	**-**
Additions	14,546	**14,546**
Lease liability remeasurements	2,208	**2,208**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	**-**
Application of effective interest rate	2,933	**2,933**
Change in effective interest rate	-	**-**
Changes in fair value	-	**-**
Early terminations	(497)	**(497)**
Other changes	-	**-**
Carrying value at 31 March 2024	**43,807**	**43,807**

Group - 2022/23	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2022	**20,243**	**20,243**
Prior period adjustment	1	**1**
Carrying value at 1 April 2022 - restated	**20,244**	**20,244**
Cash movements:		
Financing cash flows - payments and receipts of principal	(16,866)	**(16,866)**
Financing cash flows - payments of interest	(204)	**(204)**
Non-cash movements:		
IFRS 16 implementation - adjustments for existing operating leases / subleases	13,074	**13,074**
Transfers by absorption	-	**-**
Additions	15,707	**15,707**
Lease liability remeasurements	7,930	**7,930**
Application of effective interest rate	1,860	**1,860**
Change in effective interest rate	-	**-**
Changes in fair value	-	**-**
Early terminations	-	**-**
Other changes	-	**-**
Carrying value at 31 March 2023	**41,745**	**41,745**

Note 28.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Other	Total
	£000	£000	£000	£000
At 1 April 2023	**1,723**	**918**	**14,349**	**16,990**
Transfers by absorption	-	-	-	**-**
Change in the discount rate	(58)	(59)	(296)	**(413)**
Arising during the year	219	92	7,210	**7,521**
Utilised during the year	(274)	(68)	(3,466)	**(3,808)**
Reclassified to liabilities held in disposal groups	-	-	-	**-**
Reversed unused	(1)	-	(4,737)	**(4,738)**
Unwinding of discount	26	15	89	**130**
Movement in charitable fund provisions	-	-	-	**-**
At 31 March 2024	**1,635**	**898**	**13,149**	**15,682**
Expected timing of cash flows:				
- not later than one year;	217	66	11,804	**12,087**
- later than one year and not later than five years;	977	249	117	**1,343**
- later than five years.	441	583	1,228	**2,252**
Total	**1,635**	**898**	**13,149**	**15,682**

Note 28.2 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Pensions: injury benefits	Other	Total
	£000	£000	£000	£000
At 1 April 2023	**1,723**	**918**	**14,291**	**16,932**
Transfers by absorption	**-**	**-**	**-**	**-**
Change in the discount rate	**(58)**	**(59)**	**(296)**	**(413)**
Arising during the year	**219**	**92**	**7,210**	**7,521**
Utilised during the year	**(274)**	**(68)**	**(3,466)**	**(3,808)**
Reclassified to liabilities held in disposal groups	**-**	**-**	**-**	**-**
Reversed unused	**(1)**	**-**	**(4,724)**	**(4,725)**
Unwinding of discount	**26**	**15**	**89**	**130**
At 31 March 2024	**1,635**	**898**	**13,104**	**15,637**
Expected timing of cash flows:				
- not later than one year;	217	66	11,759	**12,042**
- later than one year and not later than five years;	977	249	117	**1,343**
- later than five years.	441	583	1,228	**2,252**
Total	**1,635**	**898**	**13,104**	**15,637**

Note 28.3 Clinical negligence liabilities

At 31 March 2024, £275,039k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals of Leicester NHS Trust (31 March 2023: £307,297k).

Note 29 Contingent assets and liabilities

	Group & Trust	
	31 March 2024	31 March 2023
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	-	71
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**-**	**71**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**71**
Net value of contingent assets	**-**	**-**

Note 30 Contractual capital commitments

	Group & Trust	
	31 March 2024	31 March 2023
	£000	£000
Property, plant and equipment	16,235	15,692
Intangible assets	426	-
Total	**16,661**	**15,692**

Note 31 Other financial commitments

The Group and Trust have no other financial commitments.

Note 32 Financial assets and liabilities

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Note 32.1 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2024	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	29,743	-	-	**29,743**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	39,764	-	-	**39,764**
Consolidated NHS Charitable fund financial assets	2,784	-	5,347	**8,131**
Total at 31 March 2024	**72,291**	**-**	**5,347**	**77,638**

Carrying values of financial assets as at 31 March 2023	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	56,427	-	-	**56,427**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	103,345	-	-	**103,345**
Consolidated NHS Charitable fund financial assets	4,959	-	4,964	**9,923**
Total at 31 March 2023	**164,731**	**-**	**4,964**	**169,695**

Note 32.2 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2024	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	30,522			**30,522**
Other investments / financial assets	4,000			**4,000**
Cash and cash equivalents	37,346			**37,346**
Total at 31 March 2024	**71,868**	**-**	**-**	**71,868**

Carrying values of financial assets as at 31 March 2023	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	56,230			**56,230**
Other investments / financial assets	4,000			**4,000**
Cash and cash equivalents	101,080			**101,080**
Total at 31 March 2023	**161,310**	**-**	**-**	**161,310**

Note 32.3 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under leases	43,807	-	**43,807**
Obligations under PFI, LIFT and other service concessions	-	-	**-**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	120,842	-	**120,842**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Consolidated NHS charitable fund financial liabilities	240	-	**240**
Total at 31 March 2024	**164,889**	**-**	**164,889**

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Obligations under leases	41,745	-	**41,745**
Trade and other payables excluding non financial liabilities	152,306	-	**152,306**
Consolidated NHS charitable fund financial liabilities	143	-	**143**
Total at 31 March 2023	**194,194**	**-**	**194,194**

Note 32.4 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care			**-**
Obligations under leases	43,807		**43,807**
Obligations under PFI, LIFT and other service concessions			**-**
Other borrowings			**-**
Trade and other payables excluding non financial liabilities	125,924		**125,924**
Other financial liabilities			**-**
Provisions under contract			**-**
Total at 31 March 2024	**169,731**	**-**	**169,731**

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Obligations under leases	41,745		**41,745**
Trade and other payables excluding non financial liabilities	151,348		**151,348**
Total at 31 March 2023	**193,093**	**-**	**193,093**

Note 32.5 Fair values of financial assets and liabilities

The book value of financial liabilities is a reasonable approximation of fair value.

Note 32.6 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.

	Group		Trust	
	31 March 2024	31 March 2023	31 March 2024	31 March 2023
	£000	£000	£000	£000
In one year or less	130,516	165,248	134,300	165,798
In more than one year but not more than five years	32,676	25,813	32,676	28,315
In more than five years	1,697	8,238	1,697	8,154
Total	**164,889**	**199,299**	**168,673**	**202,267**

Note 33 Losses and special payments

	2023/24		2022/23	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	-	-	-	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	835	1,698	-	-
Stores losses and damage to property	-	-	-	-
Total losses	**835**	**1,698**	**-**	**-**
Special payments				
Compensation under court order or legally binding arbitration award	1	35	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	95	198	130	307
Special severance payments	2	17	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**98**	**250**	**130**	**307**
Total losses and special payments	**933**	**1,948**	**130**	**307**
Compensation payments received				

Note 34 Gifts

The Group and Trust made no gifts in 2023/24 (2022/23 - none)

Note 35 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the University Hospitals of Leicester NHS Trust. The Leicester Hospitals Charity is a related party of all members of the Trust Board, as the Trust Board is the Charity's corporate trustee.

MATERIAL DEPARTMENT OF HEALTH AND SOCIAL CARE ENTITIES

The Department of Health and Social Care is regarded as a related party. During the year University Hospitals of Leicester NHS Trust has had a significant number of material transactions with the DHSC and with entities for which the DHSC is regarded as Parent Department. These included:
Cambridge University Hospitals NHS Foundation Trust
North West Anglia NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
University Hospitals of Derby and Burton NHS Foundation Trust
Leicestershire Partnership NHS Trust
Northampton General Hospital NHS Trust
Nottingham University Hospitals NHS Trust
United Lincolnshire Hospitals NHS Trust
NHS Cambridgeshire and Peterborough ICB
NHS Coventry and Warwickshire ICB
NHS Derby and Derbyshire ICB
NHS Leicester, Leicestershire and Rutland ICB
NHS Lincolnshire ICB
NHS Northamptonshire ICB
NHS Nottingham and Nottinghamshire ICB
National Institute for Health and Care Excellence
NHS Business Services Authority (incl ESR transactions and student bursaries)
NHS Resolution
Supply Chain Coordination Limited
NHS Property Services
Community Health Partnerships

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the following organisations:
HM Revenue and Customs - Other Taxes and Duties
HM Revenue and Customs - VAT
Leicester City Council
NHS Blood and Transplant
NHS Pension Scheme

The Trust also had significant transactions with Leicester University, mainly concerning medical research.

Note 1 Better Payment Practice code

Non-NHS Payables	2023/24 Number	2023/24 £000	2022/23 Number	2022/23 £000
Total non-NHS trade invoices paid in the year	190,534	934,748	170,393	800,530
Total non-NHS trade invoices paid within target	179,597	880,562	160,023	748,718
Percentage of non-NHS trade invoices paid within target	94.3%	94.2%	93.9%	93.5%
NHS Payables				
Total NHS trade invoices paid in the year	3,433	90,622	3,811	110,398
Total NHS trade invoices paid within target	2,864	79,216	2,799	93,482
Percentage of NHS trade invoices paid within target	83.4%	87.4%	73.4%	84.7%

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 2 External financing

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

	2023/24 £000	2022/23 £000
Cash flow financing	102,682	26,059
Leases taken out in year		
Other capital receipts		
External financing requirement	**102,682**	**26,059**
External financing limit (EFL)	102,548	26,059
Under / (over) spend against EFL	**(134)**	**-**

Note 3 Capital Resource Limit

	2023/24 £000	2022/23 £000
Gross capital expenditure	122,001	96,516
Less: Disposals	(3,444)	(622)
Less: Donated, granted and peppercorn leased capital additions	(3,611)	(1,061)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	-
Charge against Capital Resource Limit	**114,946**	**94,833**
Capital Resource Limit	115,080	94,938
Under / (over) spend against CRL	**134**	**105**

Note 4 Breakeven duty financial performance

	2023/24 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(52,831)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
Add back incremental impact of IFRS 16 on PFI revenue costs in 2023/24	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**(52,831)**

Note 5 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		51	1,013	88	91	(39,655)	(40,648)	(34,051)
Breakeven duty cumulative position	3,910	3,961	4,974	5,062	5,153	(34,502)	(75,150)	(109,201)
Operating income		697,692	696,257	719,154	758,665	770,393	834,376	866,036
Cumulative breakeven position as a percentage of operating income		0.6%	0.7%	0.7%	0.7%	(4.5%)	(9.0%)	(12.6%)

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(27,152)	(34,455)	(44,879)	(111,368)	9,715	3,778	(12,459)	(52,831)
Breakeven duty cumulative position	(136,353)	(170,808)	(215,687)	(327,055)	(317,340)	(313,562)	(326,021)	(378,852)
Operating income	924,269	960,790	992,246	1,086,969	1,284,222	1,318,977	1,486,225	1,587,499
Cumulative breakeven position as a percentage of operating income	(14.8%)	(17.8%)	(21.7%)	(30.1%)	(24.7%)	(23.8%)	(21.9%)	(23.9%)

Staff costs

	Group			
			2023/24	2022/23
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	786,887	-	**786,887**	711,147
Social security costs	85,144	-	**85,144**	68,006
Apprenticeship levy	3,966	-	**3,966**	3,274
Employer's contributions to NHS pension scheme	120,775	-	**120,775**	107,116
Pension cost - other	100	-	**100**	126
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	33,192	**33,192**	28,370
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**996,872**	**33,192**	**1,030,064**	**918,039**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**996,872**	**33,192**	**1,030,064**	**918,039**
Of which				
Costs capitalised as part of assets	3,564	-	**3,564**	3,124

Average number of employees (WTE basis)

	Group			
			2023/24	2022/23
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	2,073	222	**2,295**	2,183
Ambulance staff	-	-	**-**	-
Administration and estates	2,953	187	**3,140**	2,892
Healthcare assistants and other support staff	3,093	76	**3,169**	3,967
Nursing, midwifery and health visiting staff	4,856	526	**5,382**	4,484
Nursing, midwifery and health visiting learners	3	-	**3**	95
Scientific, therapeutic and technical staff	1,693	102	**1,795**	1,353
Healthcare science staff	934	9	**943**	499
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**15,605**	**1,122**	**16,727**	**15,473**
Of which:				
Number of employees (WTE) engaged on capital projects	52	-	**52**	59

Reporting of compensation schemes - exit packages 2023/24

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	6	**6**
£10,000 - £25,000	-	5	**5**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**12**	**13**
Total cost (£)	£160,000	£149,840	**£309,840**

Reporting of compensation schemes - exit packages 2022/23

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**1**	**2**
Total resource cost (£)	£160,000	£38,000	**£198,000**

Exit packages: other (non-compulsory) departure payments

	2023/24		2022/23	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	10	133	-	-
Exit payments following Employment Tribunals or court orders	-	-	1	38
Non-contractual payments requiring HMT approval	2	17	-	-
Total	**12**	**150**	**1**	**38**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Appendix B

Code of Governance compliance assessment 2023/24

* indicates where the provision requires a supporting explanation in a Trust's Annual Report, even in the case that the Trust is compliant with the provision. The Code of Governance guidance states that where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
Section A	**Board leadership and purpose**			
A2.1*	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.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • Our Sustainability Report • Working with Partners • AGS
A2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
A2.3*	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.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • Staff Report
A2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	Y	N/A	
A2.5	In line with principle 1.3 above (principle 1.3 = *"The board of directors should give particular attention to the Trust's role in reducing health inequalities in access, experience and outcomes."*), the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.	Y	N/A	
A2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
	context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.			
A2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners.	Y	N/A	
A2.8*	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.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • Working with Partners
A2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	Y	N/A	
A2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
	and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).			
A2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Y (in the event that this happens)	N/A	
Section B	**Division of responsibilities**			
B2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Y	N/A	
B2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	Y	N/A	
B2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Y	N/A	
B2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
B2.6*	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that 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, material 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 (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval). - is an appointed representative of the trust's university medical or dental school.	Y	The Dean of the University of Leicester Medical School is also a UHL Non-Executive Director	Covered in the following sections of the 2023/24 Annual Report: • Accountability Report (corporate governance section – recorded in the declaration of interests table)
B2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	Y	N/A	
B2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees.	Y	N/A	
B2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
B2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.	Y	N/A	
B2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	Y	N/A	
B2.13*	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • Accountability Report (corporate governance report)
B2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
B2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Y	N/A	
B2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Y	N/A	
B2.17	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.	Y	N/A	
Section C	**Composition, succession and evaluation - Provisions for NHS Trust Board appointments**			
C3.1	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
	chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.			
	Board appointments: provisions applicable to both NHS Foundation Trusts and NHS Trusts			
C4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Y	N/A	
C4.2*	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	N	Information is on the Trust's external website https://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/trust-board-senior-directors/	Link to the Trust's external website page containing this information is in the Annual Report 2023/24, in the Accountability Report section (Directors'/ Members' report).
C4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
	chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.			
C4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	Y	N/A	
C4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	Y	N/A	
C4.7*	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 or governors.	Y	N/A	Deloitte review referred to in the Trust's Annual Report for 2021/22. An external Well Led assessment is being scheduled for 2024/25
C4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Y	N/A	
	Development, information and support			
C5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	Part	A more structured and comprehensive NED induction programme is in development	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
C5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	Y		
C5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust	Part	The Trust's 'policy for policies' has been updated to clarify the arrangements for disseminating and publicising new and updated Trust policies and procedures	
C5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	Part	A more structured and comprehensive NED induction programme is in development	
C5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Y (NEDs)	N/A	
C5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
C5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	Y	N/A	
C5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	Y	N/A	
C5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Y	N/A	
C5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
C5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Y	N/A	
C5.13	Committees should be provided with sufficient resources to undertake their duties.	Y	N/A	
C5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	Y	N/A	
	Insurance cover			
5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers.	Y	N/A	
Section D	**Audit, risk and internal control**			
D2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
D2.2	The main roles and responsibilities of the audit committee should include: - monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them - providing advice (where requested by the board of directors) on whether 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 position and performance, business model and strategy - reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself - monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether ther-e is a need for one and making a recommendation to the board of directors - reviewing and monitoring the external auditor's independence and objectivity - reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements - reporting to the board of directors on how it has discharged its responsibilities.	Y	N/A	
D2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
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 - an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • AGS
D2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor.	Y	N/A	
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.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • Statement of Directors' Responsibilities in Respect of the Accounts
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.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • AGS
D2.8*	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.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • AGS

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
D2.9*	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 a going concern are expected to be rare.	Y	N/A	Covered in the following sections of the 2023/24 Annual Report: • Our Finance Report • Statement of Directors' Responsibilities in Respect of the Accounts
Section E	**Remuneration**			
E2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. - Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. - Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. - Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
E2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Y	N/A	
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.	Y (in the event that happens)	N/A	Would be covered in the Remuneration Report section of the Annual Report 2023/24 if this has occurred
E2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	Y	N/A	
E2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	Y	N/A	
E2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	Y	N/A	
E2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including	Y	N/A	

Provision	Description	Comply	Explain any deviation	2023/24 Annual Report location (where required)
	pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.			

Glossary of terms

Acute Care is specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

Acuity The measurement of the intensity of care required for a patient delivered by a registered nurse. There are six categories ranging from minimal care to intensive care.

Admission the point at which a person begins an episode of care, e.g. arriving at an inpatient ward.

Ambulatory care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

A&E (Accident & Emergency) see Emergency Department.

Board Assurance Framework (BAF) is a key mechanism which Trust Boards should be using to reinforce strategic focus and better management of risk.

Cannulation intravenous cannulation involves putting a “tube” into a patient’s vein so that infusions can be inserted directly into the patient’s bloodstream.

Care Plan a plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy.

Care Quality Commission the organisation that make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

Carbapenem resistant organisms are a group of germs which can live harmlessly inside the bowel and, except for their resistance to antibiotics, are identical to our normal gut bacteria. Carrying them in the bowel is not a direct risk to patients. They are only a danger if they cause infections.

CCG (Clinical Commissioning Group) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

CIP (Cost Improvement Programme) a Cost Improvement Programme (CIP) is the identification of schemes to increase efficiency/ or reduce expenditure. CIPs can include both recurrent (year on year) and non- recurrent (one-off) savings. A CIP is not simply a scheme that saves money. The most successful CIPs are often those based on long-term plans to transform clinical and non-clinical services that not only result in a permanent cost savings, but also improve patient care, satisfaction and safety.
Clinical Governance is a framework that ensures that NHS organisations monitor and improve the quality of services provided and that they are accountable for the care they provide.

Clinical Management Groups (CMG) we have seven Clinical Management Groups: CHUGGS (Cancer, Haematology, Urology, Gastroenterology and General Surgery); CSI (Clinical Support and Imaging); ESM (Emergency and Specialist Medicine); ITAPS (Critical Care, Theatres, Anaesthesia, Pain and Sleep); MSS (Musculoskeletal and Specialist Surgery); RRCV (Renal, Respiratory and Cardiovascular); W&C (Women’s and Children’s).

Clinical Negligence Scheme for Trust (CNST) is a scheme for assessing a Trust's arrangements to minimise clinical risk for service users and staff. Trusts need to pay 'insurance'

which can offset the costs of legal claims against the Trust. Achieving CNST Levels (1, 2 or 3) shows the Trust's success in minimising clinical risk and reduces the premium that the Trust must pay.

Clinician is a person who provides direct care to a patient such as a doctor, nurse, therapist, pharmacist, psychologist etc.)

Commissioner is responsible for getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc.

Commissioning is the process of identifying a community's social and/or health care needs and finding services to meet them.

Community Care aims to provide health and social care services in the community to enable people live as independently as possible in their own homes or in other accommodation in the community.

Co-morbidity is the presence of two or more disorders at the same time. For example, a person with depression may also have diabetes.

CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. This means that a proportion of our income depends on achieving quality improvement and innovation goals, agreed between the Trust and its commissioners. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients, a principle fully supported at all levels of the hospital.

Diagnosis is identifying an illness or problem by its symptoms and signs.

Discharge is the point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan (see Care plan).

Emergency Admission when a patient admitted to hospital at short notice because of clinical need or because alternative care is not available.

Emergency Department is a hospital department that assesses and treats people with serious and life- threatening injuries and those in need of emergency treatment. Also sometimes called A&E (Accident & Emergency).

Friends and Family Test (FFT) launched in April 2013, the FFT question asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

General Medical Council: The General Medical Council (GMC) works to protect patient safety and support medical education and practice across the UK. They do this by working with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems.

General Practitioner (GP) is a family doctor, usually patient's first point of contact with the health service.

GIRFT (Getting it Right First Time): Getting It Right First Time is a national programme

designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing.

Health Care Assistants (can also be referred to as Health Care Support Workers) are non-qualified nursing staff who carry out assigned tasks involving direct care in support of a registered/qualified nurse. There are two grades of Health Care Assistants, A and B grade. A grades would expect to be more closely supervised, while B grades may regularly work without supervision for all or most of their shift, or lead on A grade.

Human Resources is a department found in most organisations that works to recruit staff, assist in their development (e.g. providing training) and ensure that staff work in good conditions.

Information Management and Technology (IM&T) refers to the use of information held by the Trust, in particular computerised information and the department that manages those services.

Intermediate Care Services are services that promote independence, prevent hospital admission and/or enable early discharge. Intermediate care typically provides community-based alternatives to traditional hospital care.

Model Hospital: The Model Hospital is a free digital tool from NHS Improvement available to all NHS provider trusts. It supports the NHS to provide the best patient care in the most efficient way. It allows trusts to compare their productivity and identify opportunities to improve.

Mortality means death rate. In the NHS it is used when referring to the expected death rate for conditions or procedures.

Multidisciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.

NICE is the National Institute for Health and Clinical Excellence, an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Non-Executive Director is a member of the Trust Board. They act a two way representative. They bring the experiences, views and wishes of the community and patients to the Trust Board. They also represent the interests of the NHS organisation to the Community.

NHS England leads the NHS in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

NHS Improvement is responsible for overseeing foundation trusts and NHS provider trusts, as well as independent providers that provide NHS-funded care. They offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, they help the NHS to meet its short-term challenges and secure its future.

Nursing and Midwifery Council: The Nursing and Midwifery Council, NMC, make sure nurses, midwives and nursing associate have the skills they need to care for people safely, with integrity, expertise, respect and compassion, from the moment they step into their first job.

Out of Hours (OOH) is the provision of GP services when your local surgery is closed, usually during the night, at weekends and Bank Holidays.

Palliative care is an area of healthcare that focuses on relieving and preventing the suffering of patients.

Peri-natal mortality is the number of stillbirths and deaths in the first week of life per 1,000 live births, after 24 weeks gestation.

Primary Care is the care will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

QIPP (Quality Innovation Productivity and Prevention) In July 2010, the White Paper 'Equity and excellence: Liberating the NHS' set out the government's vision for the future of the NHS. The White Paper outlined the government's commitment to ensuring that QIPP supports the NHS to make efficiency savings, which can be reinvested back into the service to continually improve quality of care.

Risk assessment identifies aspects of a service which could lead to injury to a patient or staff member and/or to financial loss for an individual or Trust.

Royal College of Nursing: The Royal College of Nursing is the world's largest nursing union and professional body.

Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).

Serious Untoward Incidents (SUI) is to describe a serious incident or event which led, or may have led, to the harm of patients or staff. Members of staff who were not involved in the incident investigate these and the lessons learned from each incident are used to improve care in the future.

SHMI (Summary Hospital-level Mortality Indicator) The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Stakeholders are a range of people and organisations that are affected by or have an interest in, the services offered by an organisation.

Tertiary Care is when a hospital consultant decides that more specialist care is needed. Mental Health Services are included in this (see also Secondary care).

TTO (To-take-out) are medicines supplied by the hospital pharmacy for patients to take with them when they are discharged (see discharge) from hospital.

Triage a system which sorts medical cases in order of urgency to determine how quickly patients receive treatment.

Urgent Care Centre is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent care centres

primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency department visit.

Urgent care centres are distinguished from similar ambulatory healthcare centres such as emergency departments and walk in centres by their scope of conditions treated and available facilities on-site.

Walk-in-Centre (WiC) is a medical centre offering free and fast access to health-care advice and treatment. Centres provide advice and treatment for minor injuries and illnesses and guidance on how to use NHS services.

Whistle-blowing is the act of informing a relevant person in an organisation of instances or services in which patients are at risk.

If you would like this information in another language or format such as EasyRead or Braille, please telephone **0116 250 2959** or email **equality@uhl-tr.nhs.uk**

اگر آپ کو یہ معلومات کسی اور زبان میں درکار ہیں، تو براہِ کرم مندرجہ ذیل نمبر پر ٹیلی فون کریں۔

ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਨੰਬਰ 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

إذا كنت ترغب في الحصول على هذه المعلومات بلغةٍ أُخرى، الرجاء الاتصال على رقم الهاتف الذي يظهر في الأسفل

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જો તમને અન્ય ભાષામાં આ માહિતી જોઈતી હોય, તો નીચે આપેલ નંબર પર કૃપા કરી ટેલિફોન કરો.

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All information is accurate at time of publishing (August 2024).