University Hospitals of Leicester
NHS Trust

Annual Report

2024/25

University Hospitals of Leicester NHS Trust

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Welcome from the Chair

It is my privilege to write this opening statement to the 2024/25 UHL Annual Report. I am approaching the completion of my first year as Chair of both University Hospitals of Leicester (UHL) and University Hospitals of Northamptonshire (UHN) – and what a year it has been.

In this foreword, I want to reflect on the progress we've made, acknowledge the challenges we continue to face and reaffirm my commitments for the year ahead.

The NHS, like many organisations, is undergoing a period of profound transformation — arguably one of the most significant in its history. At UHN / UHL, we face this challenge with both confidence and realism. Everyone reading this report will be well aware of the challenges facing the NHS and we, at UHN and UHL, are not immune from this. We remain determined to respond with resilience, innovation, and purpose.

Our Boards are committed to exercising greater financial control in a safe and responsible manner to secure a more sustainable operating environment. We are transforming our hospitals into digitally-led and data-driven organisations. This is a game-changing priority for our teams, and while the scale of the challenge is clear, so too is the opportunity. We are already seeing how new systems will deliver efficiencies and improved levels of care for our communities. Equally important is our ongoing effort to foster a strong and healthy organisational culture - where colleagues work in safe, positive and inclusive working environments. I was pleased and reassured to see improvements in our recent staff survey results indicating that we are making progress. However, we know there is more to do to ensure every member of our workforce share the same positive experiences.

The complexity of our operating environment demands deep collaboration, not only within our hospitals, but across the UHN/UHL group, and critically, with our system partners. That includes local authorities, general practice and our wider community-based stakeholders. We know that only by working together can we deliver truly integrated, high-quality care.

Leicester, Leicestershire and Rutland are among the most diverse regions in the country, both socially and ethnically. We have a responsibility to understand and meet the needs of all our patients, regardless of their background. I am proud of the work we have done, and continue to do, with our local communities to build trust, improve access, and shape services that are culturally responsive and inclusive.
We support the Government's commitment to focus on three strategic shifts, moving care from:

- hospital to community
- sickness to prevention
- analogue to digital

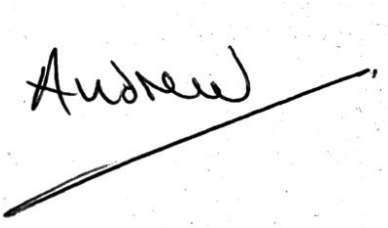
By actively pursuing these shifts our Boards believe we can make progress on cutting waiting times for care, tackling health inequalities and making the NHS sustainable for the long term.

Over the course of the year, I have been humbled by the dedication and compassion of our staff. Despite facing complex and often difficult circumstances, their unwavering

commitment to delivering the best possible care is inspiring. I have had the privilege of visiting many services and teams across the Trust, as well as engaging with key community groups and stakeholders.

I remain steadfast in my belief that we can, and must, continue to improve. We owe it to our patients, our staff, and our communities to keep striving for excellence in all that we do. I fully accept that there is always more to be done.

Thank you to everyone who plays a role in helping our Trusts deliver on our mission.



Andrew Moore
Trust Chair, UHL NHS Trust
25 June 2025

Welcome from the Chief Executive

2024/25 at University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire NHS Group has been a year of change. Andrew Moore, UHL Chair, joined in the summer and has built on the foundations delivered by John MacDonald, his predecessor. Laura Churchward, UHN CEO, joined in the autumn.

UHL UHN is the largest provider of healthcare in the NHS, and we have a key role to play in overall NHS delivery – this is an opportunity and a responsibility. Local, regional and national colleagues are watching us with increasing interest and support. Improvements at UHL UHN are not only important for the people who use our services, but they will have a material impact on the NHS.

UHL UHN is a group formed from three statutorily separate hospitals, Kettering General Hospitals Foundation Trust, Northampton General Hospitals NHS Trust and University Hospitals of Leicester NHS Trust. We have been working together for 20 months and all three Trusts are at different stages of their own change cycles. Patient care is improving but there is a huge amount to do to ensure all patients receive safe, timely, high-quality care. Progress has been made with planned care and emergency waiting times. Staff survey results are mixed with some areas reporting the highest engagement in their peer group, and some the lowest. Across the three Trusts, the experience for all colleagues is not at the level we want it to be. There is a strong relationship between being a better employer for all and providing safe care to all. UHL UHN has a large deficit, and we are committed in 2025/26 to take actions to safely reduce it. A key part of this is working more effectively across the group and delivering actions which consistently improve productivity and efficiency.

UHL UHN has three priorities in 2025/26:

- Transforming patient care
- Strengthening our culture
- Delivering our financial plan

And these priorities are underpinned by ten commitments:

1. **We will** deliver national access targets in planned care and transform pathways with system partners to safely reduce the number of people accessing urgent and emergency care (UEC) in our hospitals.
2. **We will** deliver our Quality priorities, which includes PSIRF and the perinatal safety programme.
3. **We will** take action on the 2024 staff survey feedback and deliver our People Plan prioritised actions for 2025, which includes action to tackle bullying, discrimination and harassment.
4. **We will** deliver major digital change, including the new EPR, aligning clinical systems across UHN and exploring automation of corporate systems.
5. **We will** go further in integrating clinical and corporate services across UHN, delivering seamless pathways and improving safety and outcomes for our patients.
6. **We will** further develop our collaborative model with UHL, improving productivity and creating joint plans for clinical and corporate services where appropriate.
7. **We will** accelerate work to integrate patient care, removing barriers between secondary, community and primary care services.
8. **We will** deliver our workforce plan as a key component of financial plan delivery.
9. **We will** increase our research and trial activities by 10%.
10. **We will** foster a learning culture, rolling out our 'Improving Together' continuous improvement methodology and giving teams the tools to improve care, experience, and productivity.

Whilst 2024/25 was a year of change, the pace of change in 2025/26 must increase for us to deliver our three priorities. The UHL UHN operating model will evolve and we also recognise the benefits of working more closely and effectively with general practice and community partners in Leicester, Leicestershire, Northamptonshire and Rutland.

I know we do not get everything right and colleagues are working under sustained pressure, but I am proud to work at UHL UHN. I would like to thank colleagues, patients, our communities and partner organisations for their support last year and this year.

Richard Mitchell
Chief Executive, UHL NHS Trust

25 June 2025

Overview: *About us*

Welcome to our 2024/25 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

Our strategy for 2023-2030: Leading in healthcare, trusted in communities, has 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

As part of delivering our wider Group Clinical Strategy this ambitious programme will reconfigure acute and maternity services for the people of Leicestershire, Leicester and Rutland health system (known hereafter as LLR). Both as part of the New Hospital Programme (NHP) and additional government capital funding opportunities a rolling programme of capital investment will see modern infrastructure development in a strategic and co-ordinated way.

New, state of the art buildings will be developed at both the Leicester Royal Infirmary (LRI) and the Glenfield Hospital (GH) sites as part of the NHP programme and is currently forecast to begin construction in 2030. Towards the end of the programme it 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 the NHP's standard hospital design (Hospital 2.0), 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 using modern methods of construction (MMC) and will meet central Net Zero Carbon targets, thereby reducing our backlog maintenance and improving the critical infrastructure.In addition, Education and Training centres will be created in the historic Victoria building, providing our medical students and staff with modern learning environments.

Enabling Works
To enable the construction of new buildings at both the LRI and Glenfield Hospital (GH) sites we will be carrying out enabling works which will clear the areas required. At the LRI, several old and costly to maintain buildings are due for clearance and demolition. This will involve a complex sequencing of moves of staff and clinical services into refurbished or new accommodation either on or off site. This work is due to commence in 2025/26. Work at the GH is not as developed as is not anticipated this will commence until 2026/27.

East Midlands Planned Care Centre
Over the past year, the East Midlands Planned Care Centre at the Leicester General Hospital has been developed in 2 phases the 1st having opened in May 2023 and the 2nd more recently becoming operational in December 2024. The final element in Phase 2 is the development of a large outpatient pharmacy which opens to the public imminently. All services within the building are open and functioning. EMPCC will treat over 100,000 patients per year in a transformed patient pathway, with some of the most advanced digital technology available at UHL.

Endoscopy
As part of the development of the planned care campus, the construction of a new £17m Endoscopy Unit at EMPCC on the site of the Leicester General Hospital site is in progress with a timescale that sees this brand new facility open in August 2025. The new Endoscopy Unit will increase capacity and reduce our waiting list. This facility will have 6 operational procedure rooms and all supporting facilities providing a state of the art environment for patients.

Year in review – news highlights

April to June 2024

Leicester Fertility Centre launches new website

Leicester Fertility Centre launched a new one-stop shop website in April. The user-friendly site presents the latest information and resources for patients, potential donors and healthcare professionals, and offers tailored fertility treatment, helping people across Leicester, Leicestershire and Rutland to have families. Since its establishment in 1989, the Centre has helped in the conception of more than 1,000 babies. The multidisciplinary team consists of more than 25 colleagues, including medical consultants, nurses, embryologists and administrators.

'One-stop' clinics put patients at heart

In May, UHL opened two new nurse-led clinics to increase our capacity to save lives by detecting inherited cardiac conditions (ICCs). With the help of the Joe Humphries Memorial Trust (JMHT), a local charity, we launched family screening and diagnostic genetic testing services. The service supports individuals with diagnosed ICCs and their family members, under the leadership of Consultant Cardiologist, Dr Harshil Dhutia.

Trusts appoint new Group Chair

The University Hospitals of Leicester NHS Trust (UHL) and the University Hospitals of Northamptonshire NHS Group (UHN) appointed Andrew Moore as our new Group Chair in June. Andrew, who was a Non-Executive Director (NED) at UHN since February 2023 and at UHL since February 2024, was appointed to the role of Group Chair following a competitive recruitment process to replace John MacDonald, who retired in July after a 35-year career in the NHS.

July to September 2024

UHL's first Health Equality Summit

On 9 July, UHL hosted our first summit for health equality, called 'Together We Can'. Healthcare professionals, community leaders, and advocates dedicated to reducing health inequalities came together to understand the local picture and take action in partnership. The event was the first of its kind for the Trust and the University of Leicester's Institute for Policy, shaped by community leaders and members of our new Health Equality Partnership. Summit highlights included a keynote speech by Professor Bola Owolabi, Director of the National Healthcare Inequalities Improvement Programme at NHS England, alongside a panel of community leaders sharing their views.

Shortlist success in the HSJ Awards

UHL was shortlisted for four prestigious Health Service Journal (HSJ) Awards; Integrated Care Initiative of the Year, Medicines, Pharmacy and Prescribing Initiative of the Year, Partnership of the Year, and Reducing Inequalities and Improving Outcomes for Children and Young People. The national awards celebrate healthcare excellence.

Groundbreaking ceremony for Hinckley's Community Diagnostic Centre

A groundbreaking ceremony took place on 16 July 2024, to celebrate an important milestone for Hinckley's new Community Diagnostic Centre (CDC). The ceremony at the existing site of the Hinckley and District Community Hospital, marked the start of construction work to build the £24.6 million facility, providing CT and MRI scans, endoscopy, X-ray and ultrasound facilities. CDC forms part of a wider programme of work to improve community health services in Hinckley.

Celebrating South Asian Heritage Month 2024: 'Free to Be Me'

We were proud to celebrate South Asian Heritage Month, recognising the diversity and contributions of our colleagues. From 18 July to 17 August, we honoured the rich cultures, histories, and contributions of South Asian communities in the UK. We focused on the stories of colleagues such as Stephy Harshal, originally from Kerala in India, on her fulfilling journey as a nurse and Pathway to Excellence facilitator. The theme, "Free to Be Me", encouraged colleagues to embrace and express their unique identities. Countries taking part include Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and the Maldives.

Stroke consultant wins £1.3 million research fellowship

In August, Dr Jatinder Minhas was awarded a Future Leaders Fellowship from UK Research and Innovation (UKRI). Dr Minhas is an Honorary Consultant Stroke Physician at UHL and a Clinical Associate Professor of Stroke Medicine at the University of Leicester, carrying out research funded by the National Institute for Health and Care Research (NIHR) Leicester Biomedical Research Centre. Jatinder carries out studies into the cardiovascular causes of strokes, and tests and develops medical tools to help prognosis and improve patient recovery. The UKRI Future Leaders Fellowship scheme will support Dr Minhas in his future work.

Hospital Hoppers named after local healthcare heroes

At an event in August, our fleet of four Hospital Hopper buses were named after UHL colleagues past and present to honour their outstanding contributions to patient care. The electric shuttle buses regularly connect the Glenfield Hospital, the Leicester Royal Infirmary and the Leicester General Hospital, seven days a week. Following a public competition, the names chosen were Dr Sanjiv Nichani, Professor Sally Singh, Professor Tony Gershlick, and Frances Deacon. The electric buses replaced a fleet of diesel vehicles, saving 210 tonnes of carbon emissions per year in the process.

New dialysis unit opens

On Monday 26 August, UHL opened the doors of our new dialysis unit to treat people with kidney disease. The Leicester South Dialysis Unit is located at Genesis Park in South Wigston and replaces the unit at the Leicester General Hospital. The new unit has 35 dialysis stations and has capacity to increase to 49 stations as demand rises. The unit also has consultation rooms, an isolation suite comprising nine rooms with ensuite facilities, and a home dialysis training suite.

Transforming Cancer Care: New partnership with Flatiron Health UK to advance cancer research

In September, UHL partnered with Flatiron Health UK to translate Leicester, Leicestershire and Rutland’s cancer patient records into high-quality data to expand

cancer research opportunities. The increased access to cancer data increases the potential to develop and improve cancer care for patients in the UK. This partnership is a major step forward in creating a unique and leading cancer database in the UK to unlock new opportunities to enhance cancer research and care.

Life-saving screening offered at health event

More than 100 local people benefited from potentially life-saving health screening and checks at a city centre health festival in September. The Health Festival was part of a drive to offer more health prevention in the community, helping to save lives and improve health and wellbeing. The checks included life-saving aortic aneurysm screening for men aged 65 or over who are most at risk of having the serious condition, which can be fatal if not diagnosed and treated early. Head and neck checks were also available as part of a push for earlier cancer diagnosis, and attendees could get their livers screened for common conditions and diseases as well as receiving health advice to improve their liver health.

New robotic bronchoscopy service launched at the Glenfield Hospital

In September, UHL announced the launch of the UK's first joint respiratory and thoracic NHS robotic bronchoscopy services outside of London. Based at the Glenfield Hospital, the technology enhances early diagnosis and treatment of lung cancer, which remains one of the leading causes of cancer-related deaths in the UK. Lung cancer has a poor survival rate due to the frequency of late diagnosis, when treatment options become more limited and less effective.

October to December 2024

Black History Month 2024: Reclaiming narratives

Black History Month 2024, which took place in October, focused on reclaiming narratives. The theme embraced taking control of stories, celebrating heritage, and ensuring voices are heard. We celebrated the stories of colleagues such as Rolicia Spence-Cumberbatch, from Saint Vincent and the Grenadines. She reflected on her career journey and how Black History Month was not only a time to reflect on the past, but also an opportunity to celebrate the present and envision the future.

UHL Recognition Awards

The winners of the 2024 UHL Recognition Awards were announced on the evening of Friday 4 October at the Athena in Leicester. The annual event showcased the individuals and teams at UHL who make a real difference in the lives of our patients, colleagues, and communities. The 2024 winners included colleagues from across our clinical management groups and corporate directorates, in both clinical and non-clinical roles, demonstrating the breadth of talent in the organisation. Winners included midwife,

Emma Robinson, who won the award for Patient Choice after being nominated by a new mum for saving the life of her newborn baby, Maya-Jay. Emma's decisiveness helped identify that Maya-Jay needed emergency treatment for what was later confirmed to be sepsis.

Group Director of Research and Innovation appointed

Professor Nigel Brunskill was appointed as Group Director of Research and Innovation at the University Hospitals of Leicester NHS Trust (UHL) and the University Hospitals of Northamptonshire NHS Group (UHN) in October. Nigel is a clinical academic nephrologist with extensive senior leadership experience in managing clinical research delivery across NHS and academic sectors. He has a strong track record of expanding research opportunities and attracting external research infrastructure funding. Nigel is also the Director of the Leicestershire Academic Health Partners and the Director of Research and Innovation at UHL.

New app supports chronic pancreatitis patients

Our Hepato-Pancreato-Biliary (HPB) service launched an app in October, designed to provide essential support and information for people living with chronic pancreatitis. This life-changing illness can lead to severe symptoms including pain, nutritional issues, and diabetes, often requiring long-term management and care. The free app, 'My Chronic Pancreatitis', offers a wide range of resources to help patients understand and manage their condition. It includes information on managing symptoms, accessing further support, and a series of podcasts featuring expert advice. Users can hear from consultant HPB surgeons, dietitians, pain specialists, clinical psychologists, and diabetes specialist nurses, all of whom offer valuable insights into the condition.

Research on pandemic health inequalities wins prestigious award

The 2024 Corrine Camilleri-Ferrante Prize from NHS England was awarded to Dr Daniel Pan at the Annual Faculty of Educators' Development Symposium on 16 October, for research he conducted into health inequalities. The research was undertaken in collaboration with colleagues at the University of Manchester and the World Health Organisation (WHO), and this was published in EClinicalMedicine. It builds on Dr Pan's existing research with Professor Manish Pareek, Consultant in Infectious Diseases at UHL and Clinical Professor in Infectious Diseases at the University of Leicester, which demonstrated that ethnic minority groups were disproportionately affected by COVID-19, accounting for the large number of hospitalisations and deaths. Dr Pan's work addressed these inequalities in exposure to infection specifically, so that ethnic minority groups should be less affected in future pandemics.

Professor Garcea featured in HSJ's top 50 most influential Black, Asian and minority ethnic people in health

Associate Non-Executive Director, Professor Aruna Garcea, was named one of the 50 most influential Black, Asian and minority ethnic people in health by the Health Service Journal (HSJ) in October. Aruna, who was appointed to the Trust Board in December 2023, is also a GP in Leicester. With extensive experience in primary care, Aruna also holds roles as Chair of the NHS Confederation Primary Care Network and medical advisor to a local GP federation. Previously, Aruna was also Clinical Director of the Leicester City and University Primary Care Network. Additionally, Aruna holds the role

of Women's Health Lead for the Leicester, Leicestershire and Rutland Integrated Care Board and is a visiting Professor at the Lincoln University School of Pharmacy.

Leicester Hospitals Charity awarded 'charity of the year'

Leicester Hospitals Charity (LHC) celebrated two wins at the VAL (Voluntary Action Leicester) Awards 2024.The awards took place on Friday 18 October at the historic Grand Hotel in Leicester, recognising the extraordinary efforts of local organisations and individuals who have made a significant difference to the lives of people across Leicester, Leicestershire and Rutland. Leicester Hospitals Charity, which supports patients, carers, and NHS staff won the 'City Charity of the year' and 'Charity of the year' awards.

New Chemotherapy Suite opens at the Leicester Royal Infirmary

Cancer care for the patients of Leicester, Leicestershire and Rutland was transformed by the opening of a new chemotherapy suite on Monday 21 October, thanks to generous donations to the Leicester Hospitals Charity Chemotherapy Suite Appeal. The refurbished chemotherapy suite features modern amenities, new treatment equipment and six additional chairs to help to provide 4,000 more chemotherapy treatments every year. The appeal raised more than £700,000 thanks to generous donations from the local community. The appeal was led by Leicester Hospitals Charity with the support of GEMS Charity.

Testing for HIV, Hepatitis B and C rolls out in Emergency Department

In November, our Emergency Department (ED) launched a new screening programme, with the aim of testing more than 100,000 people a year for HIV, Hepatitis B and Hepatitis C. From Monday 25 November, every patient aged 18 years and over who is already having blood samples taken for testing will have an additional sample taken to screen for the three blood borne viruses, unless they opt out. The blood borne virus testing will lead to earlier diagnosis and treatment for patients who may be unaware that they have one of the viruses.

UHL secures funding boost for commercial research

In December, UHL secured funding as part of a £100 million national investment to give more people the opportunity to take part in health research. Based at the Leicester General Hospital, the National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centre (CRDC) will act as a regional hub for pioneering clinical trials. The CRDC will support a network of researchers in hospitals and GP practices across Leicestershire and Northamptonshire, delivering trials for a range of health conditions.

500th baby with jaundice treated at home

In December, UHL celebrated treating 500 babies with jaundice at home. The neonatal homecare team treats babies with light therapy at home rather than in hospital, meaning families can be home sooner, freeing up hospital beds for other poorly infants. Jaundice, the yellow colour seen on the skin of many newborn babies, is caused by a build-up of bilirubin in the blood. Phototherapy, also known as light therapy, is a treatment using a special type of light which makes it easier for newborn babies to break down and remove the bilirubin from their system. Baby Ivy, who was born at the Leicester Royal Infirmary, was home in time for Christmas thanks to the service, which was launched in January 2023.

The East Midlands Planned Care Centre welcomes first patients

UHL's new East Midlands Planned Care Centre (EMPCC) officially opened its doors on Monday 9 December, a major milestone in creating additional elective capacity at UHL. The £48 million EMPCC at the Leicester General Hospital will provide an extra 100,000 appointments every year for outpatient consultations and low-complexity treatments, including day case surgery. The centre is dedicated to planned care only, reducing the risk of cancellations or delays for patients during surges in demand for urgent and emergency care. Services include ear, nose and throat, general surgery, gynaecology, ophthalmology, and urology.

Leicester Royal Infirmary outpatient pharmacy set to improve patient experience

A new outpatient pharmacy at the Leicester Royal Infirmary opened in December to improve patient experience and reduce waiting times. The new TrustMed pharmacy, which is in the main car park, replaced the previous outpatient pharmacy unit directly next door. The pharmacy has a more comfortable waiting area for patients, improved accessibility, enhanced privacy for patient confidentiality, a better layout for pharmacists, and more space. It also has a bigger drug storage area and 19 dispensing computers to shorten waiting times for patients.

UHL launches SafeZone App to protect colleagues

In December, we became the first acute trust in the country to start using a safety app to keep colleagues safe. The SafeZone App went live across the Leicester Royal Infirmary, the Leicester General Hospital and the Glenfield Hospital sites, including surrounding car parks. Colleagues can download the app, share their location, and alert security teams about any safety-related incidents, including violence or aggression, at the touch of a button. We also became the first NHS organisation to join the SafeZone Alliance, working with the nearby University of Leicester to deploy the app across both of their sites.

Three colleagues recognised in New Year Honours List 2025

At the end of the year, UHL celebrated the outstanding achievement of three colleagues recognised in the New Year Honours List 2025. Non-Executive Director, Professor Ivan Browne, was awarded an Officer of the Order of the British Empire (OBE) for his services to public health; Laparoscopic and Liver Surgeon, Professor David Lloyd, was appointed a Member of the Order of the British Empire (MBE) for his services to surgery; and Royal Voluntary Service (RVS) volunteer, Betty Cobley, was awarded a Medal of the Order of the British Empire (BEM) for her charitable services.

January to March 2025

Campaign launched to tackle abuse towards staff

In January, UHL launched a new campaign to tackle physical and verbal abuse towards colleagues working on our premises, with figures showing there are around 100 recorded incidents of aggression every month, including physical assault and verbal abuse. The 'Kindness campaign' features images of real healthcare workers talking about their recent experiences at the hospitals, with straplines such as 'we are proud to care for you' and 'please don't abuse our staff'.

Trust achieves re-accreditation as NHS Veteran Aware

In February, we were proud to be re-accredited as a Veteran Aware Trust, a commitment to providing the best healthcare and support to veterans, their families, and the Armed Forces Community. Assessors reviewed the Trust's work against eight standards, which included building strong relationships with the armed forces community, supporting armed forces colleagues, and identifying and caring for patients who have served in the armed forces.

Trust Group joins European network for responsible use of AI in healthcare

UHL and the University Hospitals of Northamptonshire NHS Trust (UHN) Group became the first in England to join European TRAIN – the Trustworthy and Responsible AI Network for healthcare leaders on the continent. Membership of the consortium reflects the leading-edge work by UHL and UHN group to test and embed Artificial Intelligence (AI) solutions for the benefit of patients, communities and colleagues.

Through collaboration, TRAIN members will improve the quality, safety, and trustworthiness of AI in health. They will do this by sharing best practices, and by facilitating the development of a federated AI outcomes registry for organisations to share amongst themselves, thereby ensuring data privacy is maintained.

Trust details plan to prevent illnesses and diseases

In February, UHL launched its annual Prevention Report, which detailed how we will move from sickness to prevention. The Prevention Report shows UHL's commitment to prioritising proactive care to reduce the risk of illness, injury, or disease before they happen or worsen. UHL marked the launch of the 2025 report at the first of a series of community health events at the African Caribbean Centre in Leicester, where members of the public could take up free liver screening, head and neck cancer checks, learn the basics of CPR, and gather health advice from more than 20 stalls.

New endoscopy unit takes shape at the Leicester General Hospital

A brand-new unit that will expand endoscopy services for patients in Leicester, Leicestershire and Rutland is taking shape at the Leicester General Hospital. Construction of the new £18 million site, which will feature six procedure rooms, as well as 20 pods for patients before and after their procedures, started in 2024. The new standalone, two-storey unit will provide around 17,000 endoscopy appointments every year. With the structural frame of the building now in place and the roof complete, a 'topping out' ceremony for the unit took place on Thursday 27 February.

Hundreds of trees planted at the Leicester General Hospital to create more green spaces.

As part of our commitment to the NHS Forest network, hundreds of trees were planted at the Leicester General Hospital to improve the environment and create positive spaces . The initiative is part of a wider commitment to enhance biodiversity, promote wellbeing, and create green spaces that benefit patients, their families, and staff members. A community tree planting day was held on Friday 7 March as part of our commitment to the NHS Forest network, with support from partners Hastings Direct and Stepnell.

Celebrating 50 Years of Kidney Transplants in Leicester

This year, we celebrated the 50th anniversary of the first successful kidney transplant in Leicester. To mark the occasion, renal colleagues hosted a celebration event in the Secret Garden at the Glenfield Hospital on 14 March. The event was a chance for colleagues, patients, and their families to come together and reflect on how far kidney transplantation has come in the last five decades. The event featured talks from healthcare professionals, including Professor Sir Peter Bell, who carried out the historic transplant in 1975.

Section 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	2024/25	2023/24	2022/23	Trend
A&E (UHL) – Total Time in A&E (4hr Wait)	75%	60.3%	57.1%	54.6%	↑
A&E (UHL+ LLR UCC) – Total Time in A&E (4hr Wait)	75%	75.0%	72.5%	68.9%	↑
12 Hour Trolley Waits In A&E	0	9,668	13,379	11,916	↑
MRSA (All)	0	3	5	4	↑
Clostridium Difficile	92	211	165	134	↓
% Of All Adults Who Have Had VTE Risk Assessment On Admission To Hospital	95%	98.2%	96.9%	97.8%	↑
Never Events	0	5	4	8	↓
SHMI Mortality	<=100	99	102	104	↑
Urgent Operations Cancelled Twice	0	No Data	18	10	

Please note that 2024/25 data is up to the end of February

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

UEC has been challenged during 2024/25 although we have seen improvements and continue to work with partners across Leicester, Leicestershire and Ruland to improve pathways of care.

In 2024/25 we have:

- Expanded our Same Day Emergency Care pathways and seen an increase of 10% from 2023/24
- Developed Virtual Ward capacity in a number of specialities including Paediatrics.
- Opened a new ward at Glenfield Hospital
- Expanded specialist input into the Emergency Department at the Leicester Royal Infirmary
- Improved our discharge processes to get people home, or to the right place for their onward care, discharging c. 20,000 more patients than in 23/24.
- Reduced Length of Stay for our Emergency patients from 4.04 days to 3.73 days resulting in patients being able to go home quicker.
- Improved our 4-hour access performance from 72.7% in 23/24 to 75.2% in March 2025

During 2024/25 we were challenged with ambulance handover times affecting our ability to take patients from ambulances and into our emergency department Our ambulance performance across the year showed a deterioration of 7 minutes from an average of 40mins to 47minutes to handover. Our 12-hour performance was 12.03% in March 24 compared to 10.61% in March 2025.

This demonstrates the need to further improve our UEC performance. Our demand increased by 14,375 attendances to our Emergency Department, and we admitted 11,822 more patients to our hospitals compared with 2024/25. 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 2025/26 we will:

- Further develop of Same Day Emergency Care services with the new Frailty SDEC
- Develop our direct access pathways for our GP and Ambulance colleagues.
- Work with partners to ensure care plans are in place for those who use our

services on a high frequency basis.
- Open additional capacity in the community.
- Develop our medical daycase services enabling more patients to be treated as a daycase.
- Work with partners to further improve our discharge pathways.
- 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
- Transform the existing pathways for admission from ED into Medicine, Cardiology and Respiratory.
- Increased Nurse Delegated Discharge

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

Planned Care

Our performance

For 2024/25 there is a lot to be proud of in terms of progress across all aspects of Elective Care, Cancer Care and Diagnostics. Against a backdrop of industrial action in the early months of the financial year and on-going emergency and cancer pressure, our performance metrics continued to deliver well.

In May 2024, UHL were stepped down from all national tiering. This positive move was in response to a significant reduction in long waits and confidence in the leadership and delivery of improvements over the preceding months. In June 2024 the criteria for entering tiering changed and UHL were entered back for cancer only.

Elective

Our focus on reducing our waiting list this year has led to achievements including:

- The elimination of 104-week waiters through this year.
- Largely achieving the elimination of 78-week waiters this year, with exceptions only in particularly complex cases or to accommodate patient choice. In March 2025 our final reported 78-week waiter position was 5
- March 2025 our reported 65-week waiter position was 132.
- Setting ourselves the challenging ambition of having no patients waiting over a year for their treatment. Whilst we have not managed to deliver zero 52-week waiters yet, we are pleased that we have continued to significantly reduce this number, ending the year with 1,976. This represents under 2% of the total waiting list.
- Our total waiting list has stabilised over the year (April 2024 - March 2025), despite in year fluctuations and increases it now stands at 107,620.

We are very proud of these achievements; however, we accept that people are still waiting for longer than we would like on our waiting lists. As we move into 2025/26, we will continue to focus on reducing waiting times as one of the key expectations in the

NHS Elective Reform Plan, which aims for a return to the national 18 week wait standard by March 2029.

What we did in 2024/25

The key tenets of the operational plan for planned care in 2024/25 fell into five key themes; improving productivity (making our processes as efficient as possible), increasing capacity (ensuring we have the right services and facilities in place), outpatient transformation, process fundamentals and partnership (building strong links with our partners).

Our areas of focus included:

- Increasing day case activity and use of procedures rooms
- Improving theatre booking and scheduling
- Reducing non-attendance rates for appointments
- Increasing the use of our community capacity
- Opening of Phase 2 of the East Midlands Planned Care Centre
- Cementing our relationship with University Hospitals of Northampton to make best use of our capacity
- The roll out of best practice elective training

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 maintained digital innovation working in partnership with Accurx to expand the number of services using two-way patient messaging; 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. We have also piloted several initiatives to reduce follow up activity via digital questionnaires and triage forms.

Plans for 2025/26

For 2025/26, our focus remains on building on the foundations we have set over the last 3 years to continue to deliver improvement.

By March 2026 we aim to improve by 5 percentage points the number of patients waiting less than 18 weeks for treatment and for a first appointment. Whilst we aim to have zero patients waiting over 52 weeks, as a minimum our plan should see this number of patients move to less than 1% of the total waiting list.

All of our planned care plans (including cancer and diagnostics) for 2025/26 are underpinned by digital, and estate enabling schemes and are built around three key pillars:

- Improving **Productivity and Efficiency**, ensuring value for the patient as well as money.
- Building strong **Partnerships and Equity,** moving care from the acute to community.
- **Prevention and Early Diagnosis,** moving treatment to prevention.

More specifically our elective aims are to:

- Standardise Outpatients and Pre-operative processes

- Reduce “Did Not Attends” to below 5% by March 26
- Improve Daycase and theatre session utilisation rates to 85% by March 26
- Improve our elective surgical admissions length of stay to the upper quartile nationally
- Move to single waiting lists across UHL sites and review delivery of services by location.
- Focus on reducing waits for diagnostic tests – new Hinckley CDC capacity operational in May 25 with increased GP direct access.
- Complete a full musculoskeletal pathway review with a specific focus on back pain, community physiotherapy and rheumatology by January 26.
- Review the model of Advice and Guidance (A&G) by the end of May 25.

The implementation of the new Patient Administration System (PAS) in June 25 will support our teams to manage patient pathways more efficiently and reduce duplication. Additionally, from a digital perspective in 2025/26 we are exploring the use of artificial intelligence (AI) enhanced digital dictation in clinic and automated patient booking. From 1st April 25 patients can use the NHS App to manage appointments.

Cancer 2024/25

Progress has continued throughout 2024/25 reducing waiting times for patients and increasing the numbers we are able to diagnose within 28 days of referral.
Access to cancer diagnosis has improved with more than 77% of patients being diagnosed within 28 days of urgent suspected cancer referrals. This has meant that we have also seen a 9% increase in the number of confirmed cancers diagnosed earlier when compared to last year.

Caner waiting times have continued to reduce this year. At the beginning of the year 415 patients had waited beyond 62 days, this has fallen to 281 by the end of the year, a 32% reduction. Patients over 104 days has also reduced by 55% with 70 patients waiting more than this at the end of March. Notable progress has been made in Colorectal, Urology, Upper Gastrointestinal and Lung.

In March 2025 60.3% of patients with a confirmed diagnosis of cancer were treated within 62 days.

31-day performance remains of concern. In March 2025 79.8% patients received treatment within 31 days of a decision to treat. To support improvements, the radiotherapy linac replacement programme completed in 2024/25 and a 5th linac became functional at the end of the year. This will, over the next 12 months improve waits for patients and particularly for patients with prostate and breast cancer receiving hormone therapy prior to radiotherapy.

For 2025/26 improving the numbers of patients treated within 62 and 31 days with a confirmed diagnosed of cancer remains a priority.

What we did in 2024/25

- With support from our partners, including East Midlands Cancer Alliance we continued to invest in our cancer services for the population of Leicester, Leicestershire and Rutland. This has included support for additional activity in

urology, breast and skin pathways, increased the number of cancer nurse specialists available and improved cancer tracking.

- As part of increasing personalised care, a thousand more patients were added to the database, ensuring timely access to re-attend our services should the need arise.
- The cancer outcomes and services dataset (COSD) compliance improved across all three areas: staging, performance status and CNS indicator codes. This provides data nationally to inform patient outcomes and advancements in cancer treatment as well as the support available to patients at diagnosis.
- We worked in collaboration with the University Hospitals of Northamptonshire and East Midlands Acute Providers Network to support Oncology, Radiotherapy and Head and Neck Pathways, sharing resource where possible.
- Received mutual aid support from United Lincolnshire Hospitals, University Hospitals North Midlands, and Northampton General Hospital, offering an alterative location to receive breast or prostate radiotherapy.
- Commenced a change for suitable prostate patients to be offered high dose, reduced fractionations in line with advancements in clinical guidance.

Plans for 2025/26 include:

- Introducing a joint skin and plastics clinic in the first quarter of 2025/26 to improve experience and reduce multiple appointments.
- Introduce effective scheduling for oncology treatments to minimise on the day waiting times for patients.
- Continue to focus on waiting list management to ensure the earliest date is offered to patients.
- In April 2025 UHL will distribute and process FIT tests which will reduce the time patients and GPs will wait to receive results.
- Develop the project plan for the Lung Cancer Screening programme by March 2026 – the aim of the programme is to improve earlier identification of patients and improve outcomes.
- Extend the liver surveillance programme to identify signs and symptoms of liver cancer earlier.

From a digital perspective we want to increase our efficiency by improving the way our patient administration system interfaces with our cancer system and introduce paperless remote planning for Radiotherapy.

Diagnostics

UHL has seen a continued reduction in the number of patients waiting over 6 weeks for a diagnostic test.

The overall waiting list did grow by 7% since April 2024 to just under 28,000, however the number of patients waiting over 13 week waits by March 2025 has reduced by 61% from 2,395 to 923. Patients waiting more than 6 weeks also reduced by 34% to 4,281. Notable progress has been in Endoscopy, Computerised Tomography (CT) and Non Obstetric Ultrasound (NOUS)

There has been specific capacity challenges in some areas, including MRI and sleep

services, however additional activity has been sourced to support waits in the last quarter of 2024/25 which will continue into 2025/26.

A reduction in diagnostic waiting times has continued despite increases in demand from urgent and emergency, cancer and referral to treatment (RTT) pathways. Improving productivity has and will continue to be a key driver to maximise capacity for patients waiting tests.

Nationally the expectation in 2024/25 was for organisations to ensure 95% of patients waited less than six weeks for a diagnostic test, UHL's figure was 75% in April 2024 improving to 84.7% for March 2025. There is more to do to continue to reduce these waits utilising resources and new community diagnostic hubs to deliver the standard of 95% by March 2026.

What we did in 2024/25

- Delivered 14,782 additional tests compared to last year
- Significantly reduced the number of patients waiting for an Endoscopy tests by 90% over 13 weeks and 82% of patients waiting over 6 weeks.
- CT have reduced over 13 weeks by 76% since the start of the year
- NOUS reduced six week waits by 93%.
- Progressed the £24million capital investment for the Hinckley Community Diagnostic Centre – due to open in May 2025.
- A new Endoscopy unit is being built with patients accessing the unit from August 2025 which will see increased capacity and reduced waiting times.
- Initial progress to track and improve productivity of resources across elective MRI, CT and Endoscopy.

Plans for 2025/26 include:

In May 2025 we will open the Hinckley Community Diagnostic Centre and in August 2025 the Endoscopy Unit at the Leicester General Hospital. Both of these significant investments will increase capacity and the number of tests directly accessible via GPs.

Along with plans to improve productivity, the key aim is to continue to see a reduction in overall waiting list and achieve a target of 95% patients receiving a diagnostic test within 6 weeks of referral by March 26.

We want to:

- Reduce our reliance on short-term capacity solutions by achieving best practice benchmarks for the number of scans per machine per hour.
- Reduce Did Not Attends (DNA) for MRI and CT tests to less than 3%.
- Develop a Leicestershire, Leicester and Rutland Strategy for Diagnostics by July 25

Across all of our Planned Care plans we will:

- 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
- Continue to grow our strong elective partnerships built across UHL and University Hospitals Northamptonshire.

Quality

Improving Quality

UHL's goal is safe, outstanding, individualised care, free from hospital-acquired harm. This drives our continuous approach to quality improvement, and we're proud of our staff's resilience and achievements in reducing falls, pressure ulcers, and catheter-associated urinary tract infections, with an on-going focus on these areas.

Our **Tissue Viability Team** has continued to build on the foundations of last year's ambitious plans. 24/25 saw the introduction of a new system of review and patient prioritisation, moving away from an online diary to a Patient Activity Dashboard, measuring and reporting on agreed Key Performance Indicators. Our Tissue Viability Team have embedded advanced skills into their day-to-day practice, ensuring that patients receive earlier intervention for more complex wound management, which in turn supports better patient outcomes. The team will continue its improvement approach throughout 2025/26, focusing on advancing technology, wound care techniques, and collaboration to further reduce Hospital Acquired Pressure Ulcers and enhance wound care support.

Inpatient falls continue to remain below the national average and our Falls Team continually strive to reduce falls incidents. The team continues to deliver an annual programme of training focusing on lying and standing blood pressures, safe recovery of patients and immediate management of patients post fall. A network of Falls Link Staff across the Trust meets quarterly, focusing on recognition of falls risks and early intervention of preventative measures. Falls sensor devices will be introduced in clinical areas to reduce the risk of falls for our most vulnerable patients. The team is also collaborating on a research project to understand in the impact of falls technology on inpatient falls.

Our **Continence Team** continue to deliver a wide portfolio of quality improvement initiatives, including the launch of Urinary Device daily assessments and care plans on Nervecentre. The team have secured funding for a ground-breaking piece of research exploring the use of female external catheters, as an alternative to traditional indwelling catheters. This piece of work supports the work stream to identify patient risk factors and further reduce Catheter Associated Urinary Tract Infections. The team continues to promote the 'Taste the Difference Challenge' linking with Trusts nationally sharing their experiences of decaffeinated drinks for patients in reducing the impact of incontinence. Throughout 2025/26 the continence team will continue promote optimal management and alternatives for indwelling catheters to reduce infection risks and support improved continence outcomes for patients.

In 2024 we began designing an assessment and accreditation tool, adopting a modernised approach to include the use of digital data and technology. The assessment and accreditation process was developed based upon a successful model created and implemented at University College London Hospitals NHS Foundation Trust.

Through collaboration with key stakeholders, we launched the **Leicester Excellence Accreditation Framework (LEAF)** a multi-disciplinary, data-driven approach to ward accreditation, replacing the previous Assessment & Accreditation model. LEAF aims to foster a culture of accountability, enhance patient care, and promote colleagues' well-being through a team-based approach, developed in collaboration with Future Nurse. This framework emphasises continuous improvement, supported by digital data analysis, and is structured around five core pillars: Quality and Safety, Efficiency, Patient Experience, Colleague Experience, and Improvement.

The LEAF accreditation process comprises two key components: the LEAF dashboard, providing real-time insights into ward performance across key metrics, and a 12-month Quality Improvement Initiative presentation showcasing the team's achievements in driving measurable improvements. As teams embark on their journey towards excellence, the LEAF accreditation process identifies significant milestones. This framework provides key benefits, including data-driven insights, standardised care, colleague engagement, continuous improvement, and recognition and reward.
A pilot programme, initiated in March 2024, involved five wards across diverse Clinical Management Groups (CMGs), selected to represent a range of experiences with previous accreditation processes. The pilot focused on evaluating the LEAF system's efficacy in improving the delivery of safe, efficient, and patient-centred care. Key activities included defining the characteristics of a 'good ward' and determining how these characteristics could be measured by data. The pilot phase yielded positive results, particularly in enhanced teamwork and colleague engagement. Feedback indicated that LEAF cultivated a sense of ownership, leading to increased motivation. All participating wards have since successfully completed their first Quality Improvement (QI) projects, focusing on patient care, and achieved competency in QI fundamentals.

Building on the pilot's success, LEAF is being implemented in a phased approach. Phase 1, commenced in November 2024, focusing on adult inpatient wards. To accelerate trust-wide implementation, Phase 1 is being fast-tracked for completion by August 2025. Phase 2, encompassing specialist clinical areas such as Emergency Departments, Critical Care, Paediatrics, Maternity, and Outpatients, is scheduled to begin in September 2025.

Quality assurance visits are an integral component of LEAF, complementing the LEAF dashboard. These unannounced visits, conducted by the LEAF Nursing Team, play a crucial role in ensuring clinical areas consistently meet the high standards of care expected at UHL. These visits identify areas of excellence and areas for improvement, contributing to safe, timely, and personalised patient care, and fostering a culture of continuous learning and development. Clinical areas typically undergo twice-yearly unannounced visits, with more frequent visits scheduled for additional support as needed. Each visit assesses ten key standards using the MEG digital platform, including medicines management, infection control, nutrition & hydration, person-centred care, and leadership.

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 Care 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 colleague groups bringing corporate priorities together. The **Pathway to Excellence ®** Team have been instrumental in engaging with colleagues across all sites and from different professional backgrounds during 2024/25 supporting the continuation of our Pathway journey. Our greatest achievement in 2024/25 was being awarded with Pathway to Excellence ® designation at the Glenfield Hospital site. This esteemed accreditation underscores UHL's dedication to Nursing, Midwifery, and AHP excellence, driving benefits such as improved staff retention, enhanced training and development opportunities, and alignment with the UHL Strategic Workforce Plan 2022-27 and the Nursing, Midwifery & AHP priorities. It reflects our commitment to cultivating a culture of excellence that seeks to make UHL a great place to give and receive care. It is our ambition to attain designation for the Leicester General Hospital in 2025/26 and we are currently preparing the evidence for this site.

The team continue to lead a campaign of promotion and engagement with all 6 of the standards demonstrating how the implementation is having an impact across the Trust.

Shared Decision Making (SDM) - with a dedicated multi-professional focus, SDM has helped shape colleague empowerment across the Trust, promoting the voice of our direct care colleagues to enable change to be made at ward/ clinical area level. It has provided council members with professional development and career progression opportunities. Most importantly it is a platform to improve colleague engagement in wider Trust strategies and initiatives, proving to be an effective conduit for board to ward communication. There are now more than 90 Shared Decision-making Councils across the Trust.

Leadership - promoting leadership opportunities for colleagues at all levels has supported empowerment in making decisions and driving change at direct care delivery level. The demand for leadership courses has greatly increased and forums between

the Trust's leadership team and direct care colleagues has been strengthened. The implementation of the pathway stars forum has proved beneficial to support colleagues to become ambassadors for pathway, lead on initiatives in their areas and to be part of a Trust-wide network.

Safety - The team have collaborated with clinical teams who support the safety agenda to ensure that the messages to colleagues are joined up. Advocating the safety standard has been instrumental in encompassing safety initiatives and deciphering new frameworks to direct care colleagues. Joint working with CMG and corporate colleagues to deliver safety messages has proved effective in engaging teams in discussions about how to prevent harm, minimise unnecessary risk and improve care/services.

Quality -The team have supported colleagues to plan and initiate quality initiatives to support patient care. They have undertaken quality improvement training to help support the Trusts' continuous improvement journey. Working with clinical interdisciplinary colleagues has shaped the delivery and inclusive approach to LEAF. This has sequentially encouraged a team working approach to problem solving and improvement.

Wellbeing - The team have supported several well-being initiatives for colleagues and have implemented the BEE award in 2024/25 to be inclusive of all colleagues, along with the ongoing DAISY programme which achieved its ambition of more than 24 DAISY honourees for the year. Through promotion of SDM and pathway stars there has been an increase in health and well-being ambassadors across the organisation, which influences shaping the future H&WB priorities for the Trust.

Professional Development - working cohesively with education teams across the Trust has enabled colleagues to readily access opportunities for development. Colleagues report feeling valued and invested in and more equipped to influence evidence-based care and to have an active role in quality improvement and audit. In addition, supporting a few colleagues to attend the international conference (Oct '24) emphasised the importance of collaborative learning, offering UHL representatives a unique opportunity to gain a broader perspective on global healthcare challenges and solutions.

Creating a positive practice environment inspires direct care colleagues and has a significant 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.

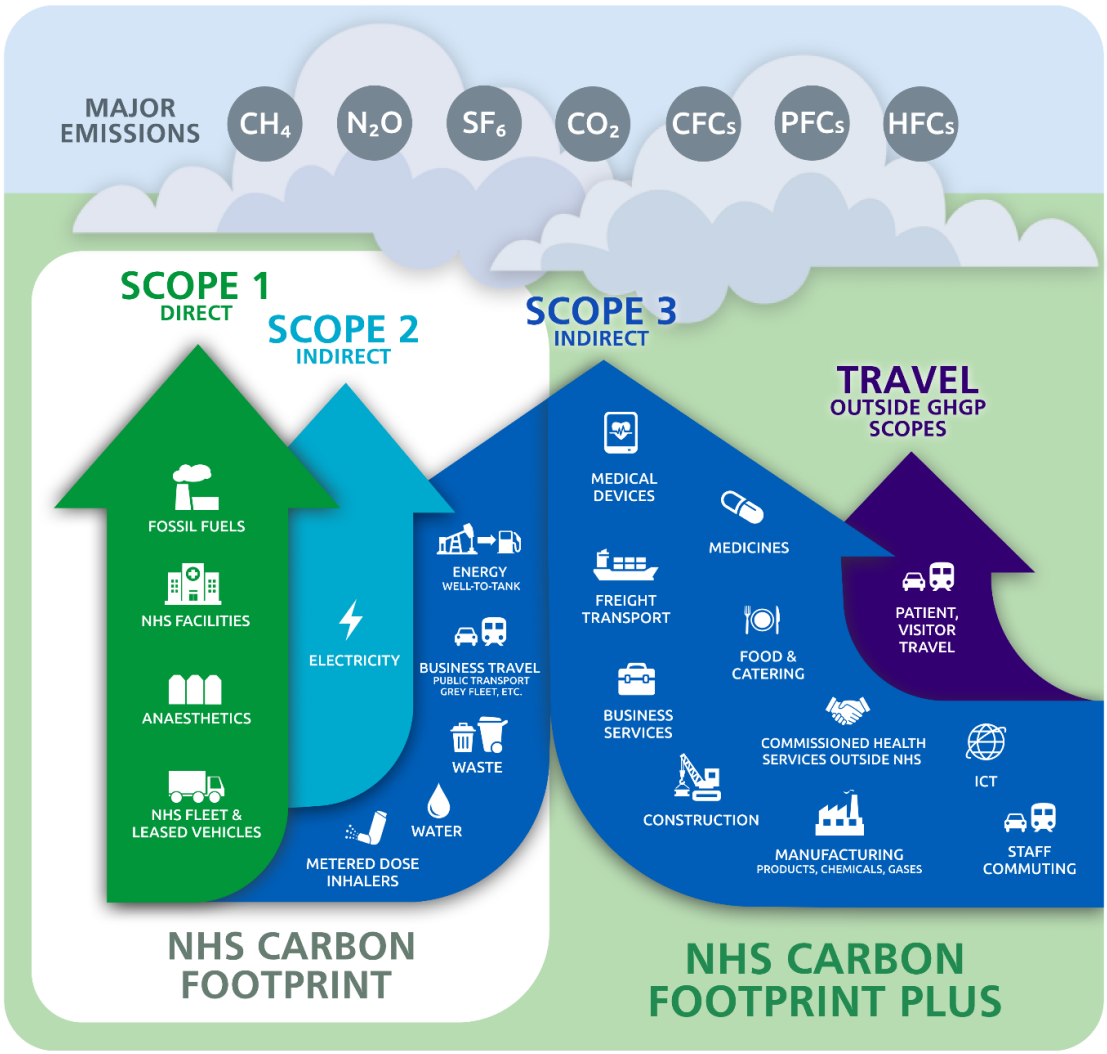
There are numerous methods of measuring the impact of excellence which we are constantly building on. We have recently taken part in a regional research study, which has investigated the tangible outcomes that promoting pillars of excellence can be attributed to. This has supported our previous hypotheses and assumptions around the effects of initiating the Pathway to Excellence® programme. It also helps understand our position further in terms of future delivery of the programme and measuring its success.

Sustainability

At University Hospitals of Leicester (UHL), sustainability continues to be an essential component of our operational strategy, aiming for comprehensive alignment with NHS England's ambitious Net Zero goals. Our robust Green Plan (2022-2025) provides a structured pathway to embedding sustainability in every aspect of our healthcare delivery.

The Trust has reinforced its commitment to sustainability by systematically embedding sustainability practices within its governance structure, operations, and strategic decision-making processes. Our comprehensive approach ensures continued progress toward achieving net zero emissions and enhancing environmental responsibility across all Trust activities.

UHL implemented the Trust's Green Plan in January 2022, outlining its commitment to environmental sustainability and alignment with NHS England's Net Zero objectives. The Green Plan set ambitious goals of achieving net-zero carbon emissions for Scope 1 and 2 by 2040 and Scope 3 by 2045. The primary focus areas included reducing carbon emissions, single-use plastics, and air pollution while fostering a greener and healthier environment for patients, staff, and visitors.



To enhance governance and accountability, the Trust established the Sustainability Working Group in October 2024. This group monitors, tracks, and reports progress regularly, ensuring sustainability objectives align closely with NHS England's requirements. Clear roles and responsibilities are defined within each subgroup, and a structured schedule for reporting and review includes monthly check-ins, quarterly updates to the Trust Leadership Team, biannual updates to Our Future Hospital Transformation Committee, annual reporting to the Audit Committee, and Trust Board.

In 2024/25, UHL strengthened its governance framework to support sustainability initiatives. The establishment of the Sustainability Working Group marked a significant milestone, providing oversight, accountability, and guidance across all sustainability actions. This group ensures regular reporting of sustainability updates to the Trust Board quarterly, facilitating ongoing monitoring and ensuring integration of climate risks into the Corporate Risk Register.

This structured, integrated approach ensures that sustainability at UHL remains robust, forward-thinking, and responsive to the evolving environmental, regulatory, and healthcare landscape.

Despite notable progress, UHL identified challenges that need addressing, including gaps in communication, resource constraints, funding shortages, and clear ownership

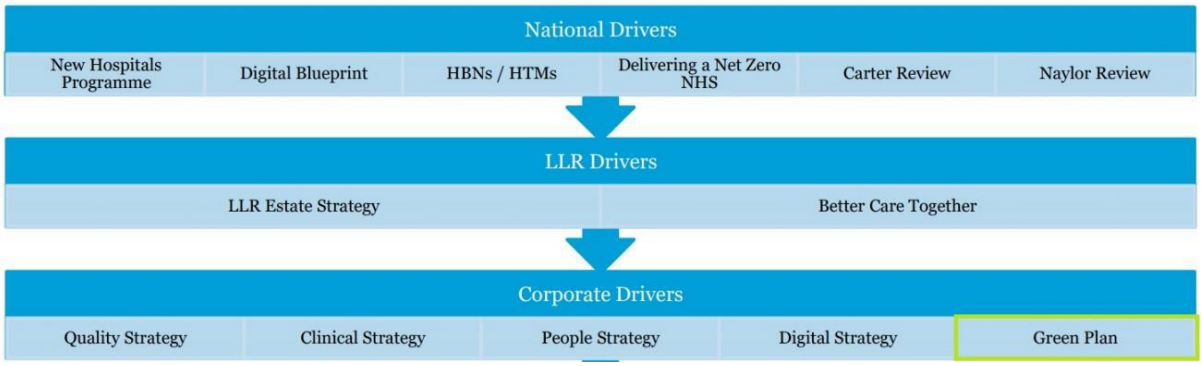
of sustainability actions across departments. Strategic actions to overcome these include enhanced stakeholder engagement, increased internal and external communication efforts, and securing dedicated funding for green initiatives using an "Invest to Save" approach.

Preparations are now underway for the Refreshed Green Plan (2025-2028), which will build on existing successes and address outstanding challenges. It emphasises stakeholder involvement, clearly defined SMART targets, compliance with legal obligations, and transparent progress tracking and reporting. The new plan includes a broadened scope with additional focus areas such as the UHL Sustainability Plan, Our Future Hospitals, and the Green Team.

UHL Green Plan

Since its implementation in January 2022, the Green Plan has been a guide for UHL's commitment to environmental responsibility and NHS England's Net Zero objectives, aiming to reduce carbon emissions, air pollution, and single-use plastics. With the existing plan concluding in 2025, the Sustainability Working Group has been actively monitoring and updating progress to ensure a smooth transition into the Refreshed Green Plan. The release of the NHS England Refresh Green Plan Guidelines on 4th February 2025 has set a deadline of 31st July 2025 for approval and publication of the Refreshed Green Plan, reinforcing the Trust's need to prioritise sustainability efforts. Additionally, in 2025, the failure to prioritise Green Plan actions will be formally added to the Trust's risk register, highlighting the importance of continued focus and accountability in delivering on sustainability commitments.

The Green Plan is aligned with the Trust's Quality, Clinical, People, and Digital Strategies, operating within the framework of the Trust's overarching corporate priorities and strategic drivers.



Current Green Plan (2022-2025)

Implemented in January 2022, UHL's Green Plan sets clear targets to achieve net-zero carbon emissions for Scope 1 and 2 by 2040 and Scope 3 by 2045. The plan strategically focuses on reducing carbon emissions, single-use plastics, and air pollution, enhancing the sustainability of patient care and staff environments.

Structured into several dedicated sub-groups, the Green Plan targets specific sustainability areas:

1. **Workforce and System Leadership:** Empowering NHS staff and leaders to champion sustainability initiatives.
2. **Sustainable Models of Care:** Redesigning care pathways to minimise environmental impact.
3. **Digital Transformation**: Leveraging digital technologies to reduce carbon emissions.
4. **Travel and Transport:** Promoting sustainable travel options for staff and patients.
5. **Estates and Facilities:** Enhancing the sustainability of NHS buildings and facilities.
6. **Medicines:** Reducing the environmental footprint of pharmaceuticals.
7. **Supply Chain and Procurement:** Ensuring sustainable practices in procurement processes.
8. **Food and Nutrition:** Providing sustainable and healthy food options.
9. **Adaptation:** Preparing for the impacts of climate change on healthcare delivery.
10. **UHL Carbon Footprint:** Baseline carbon footprint of UHL.

In 2024, two additional areas were introduced to enhance sustainability efforts:

1. **UHL Sustainability Plan**
2. **Green Team**

43 Green Plan actions have been completed, with a further 15 in progress and 21 yet to be started.

Key Achievements

From 2022 to 2025, UHL has made significant progress under its Green Plan across multiple sustainability areas.

- **Climate Change Adaptation** saw the establishment of clear risk assessment ownership, sustainability integration into the EPRR Board, and a review of rising sea level risks.
- **Estates and Facilities** improvements included BREEAM assessments for buildings, stakeholder collaborations, energy audits, LED retrofits, primary oil-use reduction, and district heat network reviews.
- **Food and Nutrition** advancements involved adopting the Government's Social Value Model, forming a Sustainable Procurement Working Group, and enhancing waste segregation.
- **Supply Chain and Procurement** achievements included implementing carbon reduction requirements for new procurements, securing representation at the LLR ICS Green Board, and ensuring net-zero and social value weightings.
- **Sustainable Models of Care** focused on virtual appointments and strategies for care closer to home.
- **Travel and Transport** introduced budget approvals for key transport priorities, an online travel portal, and expanded salary sacrifice schemes for electric bikes.
- **Workforce and System Leadership** initiatives mapped sustainability committees, embedded sustainability into annual CEO briefings and staff training, implemented

agile working policies, incentivised eco-friendly travel, and improved sustainability communication and monitoring.

These efforts collectively drive UHL's commitment to sustainability and a greener NHS.

Waste Management

This year, UHL significantly strengthened its waste management practices, emphasising compliance and behavioural change through monthly audits and targeted training, leading to improved waste segregation Trust-wide. Key achievements included appointing dedicated leadership in waste management and sustainability, achieving a 1.70% reduction in overall waste volume and a notable 9.53% reduction in clinical waste. Furthermore, the Trust reduced carbon emissions from waste by 56.99% since 23/24; implemented improved clinical waste segregation strategies aligned with NHS guidelines, and introduced new clinical waste contracts. Despite these successes, the introduction of recycling schemes and a furniture reuse programme were not achieved and remain priorities for 2025/26, alongside launching 'Simpler Recycling' streams and developing a comprehensive Recycling Roadmap.

Energy

Energy management at UHL saw substantial progress, despite ongoing challenges posed by ageing infrastructure and grid limitations. Highlights included appointing a dedicated energy manager, successfully completing £1.7 million of LED lighting upgrades across two main hospital sites, and launching innovative dashboards to track emissions, utilities consumption, and financial expenditures. UHL maintained strong compliance with UK Emissions Trading Scheme (UKETS) requirements and secured additional funding through NEEF Phase 3 for further energy efficiency enhancements, including Building Management System upgrades and sub-metering installations and LED lighting worth £614,657.70. Plans for 2025/26 involve fully launching an integrated real-time Energy Dashboard, conducting comprehensive energy optimisation studies, expanding Building Management System coverage, and exploring decentralised and renewable energy strategies.

Travel and Access

This year, UHL focused heavily on enhancing sustainable travel options, aiming to significantly reduce commuter emissions by 50% by 2033. Important steps included appointing a Head of Travel, initiating the Hopper bus tender exercise, improving real-time bus stop information, and maintaining weekend bus services in collaboration with Leicester City Council. Additional initiatives supported sustainable commuting through free e-bike loans, cycle maintenance and training sessions, promoting the Betterpoints app, and conducting an extensive travel survey. Although the goal to extend Park and Ride services was not achieved, future plans involve relaunching the Hopper service, extending Park and Ride hours, introducing further cycle training initiatives, and improving travel communications to support sustainable commuting.

Biodiversity

UHL enhanced its commitment to biodiversity through active participation in the Centre for Sustainable Healthcare's NHS Forest Network. At Leicester General Hospital, the

Trust coordinated a community-driven project, successfully planting approximately 1,860 trees with the support of staff, volunteers, and contractors. By introducing 14 diverse tree species, the project contributes to increased tree canopy coverage, creating sustainable habitats for wildlife and enriching green spaces for patients, staff, and the wider community.

Challenges

1. Lack of engagement

During the initial development of the Green Plan, varying levels of engagement and communication across departments presented challenges in establishing clear ownership and consistent support for action point delivery. Since the establishment of a dedicated sustainability team, between July and November 2024, there has been a notable increase in momentum. Completed action points have risen from 2 to 43 out of 79, highlighting the positive impact of UHL's investment in a team focused on promoting, managing, and monitoring sustainability initiatives. This progress has also been supported by strengthened executive leadership, helping to embed sustainability more firmly as an organisational priority and encouraging greater collective involvement.

2. Ownership Challenges

Clear ownership of sustainability actions is essential to effective delivery. In the current framework, some departments are still developing a full understanding of the actions relevant to their areas and how best to deliver them. In addition, two subgroups are in the process of confirming dedicated leads, which will support more structured coordination. These observations point to a valuable opportunity to strengthen responsibility pathways, enhance follow-through, and build the governance structures needed to ensure sustained progress.

3. Communication Gaps

Communication plays a central role in ensuring alignment and momentum. While progress has been made, there is scope to improve consistency in how information is shared across departments and subgroups. In some cases, clearer communication of action points and delivery expectations would help teams navigate their roles more confidently. A more structured communication approach, featuring regular updates, clearer guidance, and improved interdepartmental collaboration, will be instrumental in supporting shared understanding and collective ownership.

4. Time and Resource Constraints

Delivering the Green Plan alongside other organisational priorities requires dedicated time and resourcing. Several subgroups have highlighted the need for increased support in these areas, which would help accelerate the implementation of key initiatives. Balancing competing demands remains a challenge, and scheduling time for engagement, decision-making, and progress monitoring is key. Strengthening resource availability, whether through staffing, funding, or protected time, will support sustained delivery and long-term success.

5. Funding and Investment Shortages

Access to financial resources remains an important factor in delivering the Green Plan's ambitions. Some subgroups have encountered challenges in securing funding for their planned activities, which may impact the speed and scale of implementation. Developing a more robust financial strategy, such as adopting an "Invest to Save" model, can help to unlock the long-term value of sustainability initiatives, demonstrating both environmental and financial benefits. Enhancing financial planning and investment pathways will play a critical role in supporting the successful completion of action points and ensuring lasting impact.

Refreshed Green Plan (2025-2028)

Preparations are well underway for the Refreshed Green Plan, scheduled for implementation from 31st July 2025. This refreshed strategy will include at least 88 action points, carrying forward 36 incomplete actions from the current plan and adding 10 new actions across eight sub-groups. The refreshed plan places increased emphasis on clear accountability, stakeholder involvement, transparent tracking, and robust governance structures.

Key focus areas of the refreshed plan include Workforce and System Leadership, Sustainable Models of Care, Digital Transformation, Travel and Transport, Estates and Facilities, Medicines, Supply Chain and Procurement, Food and Nutrition, and Adaptation. Each sub-group has been tasked with defining their respective action points clearly, ensuring feasibility, relevance, and effective integration into the Trust's broader strategic framework. Monthly check-ins, quarterly Trust Leadership Team updates, annual Audit Committee and Trust Board reporting, and biannual Our Future Hospitals Transformation Committee updates will ensure continuous oversight and accountability.

The timeline for the refreshed plan's development includes critical milestones:

- NHSE Guidelines release: 4th February 2025
- Initial draft shared by April 2025
- Trust Board approval by June 2025
- Official transition from the current to the refreshed plan: 30th July 2025
- Publication of the Refreshed Green Plan: 31st July 2025

Strategy for Implementation of Refreshed Green Plan:

To effectively implement the Green Plan, UHL will follow the following strategic approach:

1. **Governance:** Oversee sustainability efforts through Sustainability Working Group, audit committee, Our Future Hospitals Transformation Committee, and Trust Board.
2. **Stakeholder Engagement:** Involve staff, patients, and partners in co-designing sustainability initiatives.
3. **Target Setting:** Define clear SMART actions (specific, measurable, achievable, relevant, and time-bound) with clear KPIs for each action point.

4. **Legality:** Ensure legal compliance, including obligations to reduce inequalities, fulfil the Public Sector Equality Duty, and consider wider impacts of decisions.
5. **Monitoring and Reporting:** Implement systems to track progress and report outcomes transparently.

Task Force on Climate-Related Financial Disclosures (TCFD)

UHL is committed to aligning its reporting with the TCFD framework, in accordance with the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and HM Treasury's public sector guidance. This year's Annual Report reflects our progress in addressing the Stage 2 TCFD disclosure requirements on a 'comply or explain' basis, with reporting aligned to the three TCFD pillars: governance, risk management, and metrics and targets.

Pillar	Compliance	Explanation
Governance	Full	Robust structure with Board and committee oversight
Risk Management	Full	Integrated into risk register and risk framework, supported by clear processes
Metrics & Targets	Partial	Scope 3 emissions and full KPI dashboard in development for next cycle.

UHL is aware of TCFD governance requirements and is working towards compliancy with TCFD metrics and targets. These will be addressed in the next reporting cycle as part of the implementation of the Refreshed Green Plan 2025-2028. The Trust remains committed to enhancing the transparency and robustness of its climate-related financial disclosures, and to embedding climate resilience as a core aspect of its operational and strategic planning.

Governance

The Trust Board maintains active oversight of climate-related risks and opportunities, and sustainability has become a standing agenda item at Audit Committee meetings. In 2024/25, the Trust strengthened its governance framework by establishing a Sustainability Working Group, which meets monthly and reports regularly to the Trust Leadership Team, Our Future Hospitals Transformation Committee, and Trust Board. This group coordinates sustainability actions across all sub-groups and ensures that climate issues are integrated into strategic decision-making and organisational oversight structures.

The UHL Trust Board maintains active oversight of climate-related risks by conducting discussions quarterly, thereby providing continuous strategic guidance and ensuring alignment with broader sustainability goals. In addition to these quarterly discussions, the Finance Investment Committee (FIC) and the full Board are provided with comprehensive sustainability updates on both a biannual and annual basis. This structured approach helps to reinforce the importance of climate considerations and ensures consistent attention at the highest levels of governance.

Embedding climate considerations into the Trust's decision-making framework occurs systematically through established governance structures. Central to this approach is the Sustainability Working Group, which facilitates detailed evaluations and reporting

directly to the Trust Board, reinforcing the integration of climate-related risks into strategic planning. Additionally, the inclusion of these climate-related risks within the Operational Risk Register ensures that sustainability considerations are formally acknowledged, monitored, and managed across all levels of organisational decision-making.

Several dedicated Board committees have clear responsibilities for overseeing climate-related issues, ensuring comprehensive coverage across various strategic aspects. The Audit Committee, Finance Investment Committee (FIC), and Trust Board collectively monitor sustainability efforts, confirm alignment with strategic objectives, and ensure regulatory compliance. This collaborative oversight structure ensures robust governance and accountability across multiple strategic and operational dimensions.

To effectively review and track progress toward climate-related targets, the Trust employs multiple structured reporting mechanisms. Quarterly updates from the Trust Leadership Team provide ongoing operational insights, while biannual reviews by the FIC allow deeper strategic oversight. Additionally, annual sustainability reports and focused internal audits specifically targeting the Green Plan and climate-related objectives ensure transparency, thoroughness, and continuous improvement in the Trust's sustainability performance.

Forum	**Frequency**
Sustainability Working Group	Monthly meeting
TLT	Quarterly update
Audit Committee	Annual update
FIC	6-monthly update
Trust Board	Annual sustainability report and update
OFHTC	3-monthly update
Quality Committee	Annual
CEO (Starting April 2025)	Monthly update

Senior leadership at UHL plays a pivotal role in overseeing climate-related risks, with key positions including the Sustainability Working Group Chair, the Director of Estates and Facilities, the Associate Director of Sustainability, and the two Heads of Sustainability. Together, these leaders provide strategic direction, ensure accountability, and foster robust management practices to address climate risks across the organisation.

Climate-related risks are actively monitored, managed, and reported through structured and systematic processes. Regular risk assessments, internal audits, and quarterly reports to both the Sustainability Working Group and Trust Board form the core components of this monitoring framework. All key findings and associated risk mitigation measures are continuously documented, reviewed, and updated to ensure accuracy and effectiveness.

Furthermore, UHL management actively engages with external climate risk frameworks to strengthen and align internal practices with broader sustainability standards. These external frameworks include NHS England's sustainability objectives, guidelines from the Task Force on Climate-related Financial Disclosures (TCFD), and regulatory compliance mechanisms such as the NHS Estates Return Information Collection (ERIC) and participation in the UK Emissions Trading Scheme. This external engagement ensures that UHL remains aligned with best practices and regulatory requirements.

Risk Management

UHL is also compliant with the risk management pillar. Climate-related risk was formally added to the Corporate Risk Register, and climate adaptation workstreams have been embedded within the Trust's emergency preparedness functions (EPRR Board). UHL has a fully developed and transparent process for systematically identifying, assessing, and managing these risks. These measures, including enhanced reporting and alignment with the NHS England Green Plan Refresh Guidelines.

UHL identifies climate-related risks through a combination of risk assessments, internal reporting, external audits, and government publications such as the UK Climate Change Risk Assessment. These sources help the Trust stay informed about emerging climate challenges and guide proactive planning.

Climate risks are fully embedded in UHL's wider risk management system, including corporate governance, emergency preparedness, and strategic planning. They are captured in the Operational Risk Register and influence strategic reviews, ensuring alignment with resilience planning, sustainability goals, and NHS net-zero commitments. Climate risk is increasingly recognised as a principal risk and is regularly reviewed to determine its standing within the Trust's risk hierarchy.

Metrics & Targets

The Health and Care Act 2022 made the NHS the first health system globally to embed net zero into legislation, requiring NHS England and all Trusts, Foundation Trusts, and Integrated Care Boards to consider statutory emissions and environmental targets in their decisions, aiming for net zero emissions by 2040 for direct emissions and 2045 for influenced emissions

During the reporting year, UHL maintained compliance with the UK Emissions Trading Scheme (UKETS), implemented LED upgrades across multiple sites, and enhanced its emissions tracking through energy dashboards and sub-metering. Scope 1 and 2 emissions data is actively monitored and reported. However, while Scope 3 emissions are being addressed through initiatives in procurement, travel, and waste, a full quantification of Scope 3 is still under development. Similarly, performance against key performance indicators and SMART targets has been tracked internally through subgroup reporting, but a full dashboard of metrics and outcomes will be launched in 2025/26.

At UHL, the assessment and evaluation of climate-related risks and opportunities utilise a robust set of specific metrics, including tracking of the carbon footprint related to

Scope 1 and 2 emissions, waste reduction targets, measures of energy efficiency, renewable energy utilisation rates, compliance rates for clinical waste, and tailored climate risk impact assessments. These carefully selected metrics enable the Trust to systematically gauge performance and identify areas for continuous improvement in sustainability.

The chosen metrics are strategically aligned with NHS England's broader sustainability objectives, actively supporting UHL's commitment towards reaching Net Zero emissions by 2040 for emissions under its direct control, and by 2045 for indirectly influenced emissions. This clear alignment ensures consistency across local initiatives and national NHS sustainability efforts, facilitating the effective coordination of objectives and enhancing UHL's contribution to national environmental goals.

Financial implications arising from these sustainability metrics include considerable cost savings realised from energy conservation and waste reduction initiatives. Moreover, maintaining compliance rates helps the Trust to avoid financial penalties, thus creating further economic advantages. In addition, the Trust actively pursues funding opportunities that are targeted towards sustainability and climate-related projects, leveraging these financial instruments to further its environmental objectives while also delivering tangible economic benefits.

UHL actively tracks a range of ambitious sustainability targets, including achieving an 80% reduction in direct emissions by 2032 and ultimately reaching net zero emissions by 2040 as defined by the NHS Carbon Footprint standards. Additionally, the Trust has established clear goals for reducing waste, identifying potential renewable energy procurement, enhancing energy efficiency, and achieving robust compliance in clinical waste management practices. Each of these targets reflects a deliberate alignment with broader sustainability commitments and strategic healthcare priorities.

Progress against these sustainability objectives is methodically assessed through a structured programme of quarterly and annual reporting to the Trust Board. This structured monitoring framework is further supported by regular sustainability audits, compliance reviews, and detailed public sustainability reports. These comprehensive reporting mechanisms ensure transparency, continuous evaluation, and accountability in UHL's sustainability performance, facilitating informed decision-making and proactive management of sustainability efforts.

Targets and metrics are periodically reviewed and updated to remain aligned with evolving NHS standards, regulatory guidance, and internal performance assessments. Recently, updates have been made to reflect enhanced standards for clinical waste segregation compliance and advanced energy efficiency objectives. These updates have been driven by the availability of new funding streams, infrastructural advancements, and the Trust's ongoing commitment to continuous improvement in sustainability performance.

UHL Climate Related Risk Register

In the 2023-2024 risk register for the University Hospitals of Leicester (UHL) Trust, there were initially 10 risks identified relating to climate change and environmental impacts. These risks spanned across multiple categories, including general climate

concerns, temperature variations (both heatwave and cold), illness/pandemic-related disruptions, flooding, and issues regarding natural resources.

As we move into the 2024-2025 period, no new climate-related risks have been added to the register. However, significant progress has been made in addressing existing risks:

Four risks have been completely closed:

1. Climate
2. Temperature variation
3. Temperature variation
4. Flood risk

The most critical risk, "Temperature (Heatwave)", originally rated at a high level of 20 (Red), has been actively managed and significantly reduced to a rating of 9 (Yellow). Its status is now "Reduced," indicating effective mitigation measures have been successfully implemented, reducing its severity from high risk to medium.

After closing these four risks and reducing the severity of the highest-rated risk, the UHL Trust currently holds a total of 6 active climate-related risks:

1. Temperature variation
2. Temperature variation
3. Temperature (Cold)
4. Illness/Pandemic
5. Temperature (Heatwave)
6. Natural Resource management

This demonstrates that the UHL Trust has effectively addressed a significant proportion (40%) of their original climate and environment-related risks over the past year. Specifically, the Trust has successfully closed lower-priority environmental risks and markedly reduced their highest-priority risk, indicating positive progress toward climate risk mitigation. Going forward into 2024-2025, the Trust will continue to actively manage and mitigate the remaining open risks, with the aim of reducing their potential impact further.

Embedding Research and Innovation 2024/25

Across the 2024/25 financial year, UHL's Department of Research and Innovation (R&I) continued to excel. Despite operating within and against an uncertain national landscape, the team delivered demonstrable growth in relation to a number of key performance indicators. In addition, the Department also celebrated significant success in securing further funding for research infrastructure through several competitive grant schemes.

In 2023/24, the R&I Department recruited a total of 17,436 study participants. Of this number, 15,253 participants took part in portfolio studies, and 510 participants engaged with commercial projects. In 2024/25, these figures increased substantially, with 27,646 study participants recruited, overall. Of these participants, 25,947 were recruited to National Institute for Health and Care Research (NIHR) studies, whilst 437 took part in

commercial trials. Whilst this evidences a slight decrease (14%) in commercial study recruitment, the Department's total recruitment figure was 58% higher than in 2023/24, with portfolio recruitment experiencing a particularly noteworthy uplift of 70%.

In 2024/25, the Department generated £55m of income, of which £5.4m was produced by commercial research projects. Alongside this continued growth, UHL's Biomedical Research Centre also received a capital award from the NIHR, totalling £4.736m. This funding will facilitate and support the ground-breaking research taking place within the Department, contributing towards the purchase of state-of-the-art equipment such as CT scanners, echocardiographs, rehabilitation equipment, laboratory-grade freezers, ultrasounds, hyperpolarised Xenon MRI scanners, and a mass spectrometer to analyse chemicals in samples taken from patients and volunteers. This investment in cutting-edge research equipment benefits new and ongoing trials, as well as patients and the wider community. Across the last year, these funds have also contributed towards the set-up and maintenance of innovative projects across a range of central research themes addressed by the BRC, supporting studies in the Cardiovascular, Respiratory and Lifestyle fields at the Leicester Royal Infirmary, the Glenfield Hospital, the General Hospital and various Integrated Care Boards (ICBs) throughout the East Midlands. Alongside this, the Department also secured a second NIHR capital award for Aseptic Services, totalling £1.5m. Of this amount, £300,000 was received in 2024/25, with the aim of doubling aseptic capacity across the next 18 months. This expansion will result in the increase of the use of advanced therapies in cancer trials, and will also provide immediate support to cancer care clinics.

Furthermore, after a successful tendering process, the Department announced that UHL had been chosen to host a new NIHR Commercial Research Delivery Centre (CRDC). Based at the General Hospital and replacing the Patient Recruitment Centre (PRC), the CRDC supports a network of researchers in hospitals and GP practices across Leicestershire and Northamptonshire, delivering studies centred on a range of health conditions and acting as a regional hub for pioneering clinical trials. In line with the U.K. Government's 2021 policy paper on the future of the country's clinical research delivery, the CRDC builds on the achievements of the PRC by creating opportunities to test new treatments with the latest equipment and technology. It also supports the rapid set-up of commercial studies funded by the life sciences industry, ensuring that patients can access treatments that are undergoing trials as early as possible, and contributing to the Department of Health and Social Care's (DHSC) vision of a patient-centred research programme embedded into the NHS, tackling health inequalities, bolstering economic recovery and improving the lives of people across the U.K. more widely.

Highlights from across the R&I Department for 2024/25 include:

- The development and launch of a new Research Reflections programme, focusing on using interactive strategies to gather feedback from staff across the Department. These workshops have built on data taken from the UHL 2024 Staff Survey, and have provided opportunities for teams to celebrate success and identify potential areas for improvement, contributing towards the development of a culture of psychological safety across teams. The feedback accumulated throughout this process will be used to produce a clear action plan, ensuring that teams are accountable and transparent when developing positive approaches to change.

- The creation of a group of executive team members who have been collaborating extensively on shared approaches to working between UHL and UHN (University Hospitals of Northamptonshire). This has involved facilitating a series of key stakeholder meetings to strengthen relationships, discuss operational procedures and share ideas towards the development of a strategic plan for the interlinked future of the organisations.

- The UHL Maternity Research team's launch of the Generation Study, a national trial supported by Genomics England that centres on the early identification of more than 200 rare diseases and conditions. Through this study, new parents have the opportunity to find out more about the genetic health of their baby, potentially accessing treatment and intervention at a much earlier stage.

- The initiation of a second round of the Research Experience Programme (REP), offering staff members the opportunity to develop their research skills, receive expert mentorship and guidance, and accentuate their clinical and non-clinical skills whilst learning more about the varied career pathways available within research at UHL.

- The success of the COPD-HELP study, which investigated whether a certain medicine could help to support people with COPD. As a condition that often gets worse over time, COPD can result in sudden flare-ups or 'exacerbations' that make breathing even more difficult. These flare-ups can be serious enough to require emergency care or hospitalisation, placing considerable economic strain on the NHS, with current healthcare costs estimated at around £2 billion annually. Given projections of a 40% increase in COPD prevalence by 2030, healthcare resources will face heightened demand, further amplifying the pressure on the NHS. This study could be a major step forward in improving care for COPD patients, and the Department saw a notable level of interest from participants, with 238 individuals choosing to take part.

- A new photography exhibition which opened in London and featured images of UHL patients who had undergone amputations due to Peripheral Artery Disease (PAD). Created by iconic artist Rankin, these photographs formed part of a showcase revealing the scale of preventable amputations in the U.K., and exploring the impact PAD has on both patients and the NHS. Using the Department's Patient and Public Involvement (PPI) Registry created by Imelda Black, patients were contacted and invited to take part in the exhibition, which was highly successful.

- A collaboration between UHL's academic researchers at the University of Leicester's Centre for Environment Health and Sustainability and the U.K. Health Security Agency (UKHSA), which secured £5.5m to fund a new research unit investigating the health impacts of chemicals, air pollutants and noise. This funding is part of £80m announced by the NIHR for research to protect the public from both long-term threats, such as antimicrobial resistance and climate change, and acute or emerging threats, such as pandemics and chemical, biological, radiological, and nuclear incidents.

- A revolutionary asthma medication trial led by Dr. Sarah Diver, which found that the use of Tezepelumab significantly reduced mucus plugs in asthmatic patients,

improving lung function and levels of inflammation. The results of the study were published in the New England Journal of Medicine and have since led to the NICE approval of Tezepelumab for use in the U.K. as an adjunctive treatment for severe asthma in individuals aged 12 years and over, when treatment with high-dose inhaled corticosteroids plus another maintenance treatment has not worked well enough. Dr Diver's innovative work on this project saw her receive the Early Career Researcher Award at the NIHR Impact Prizes last year.

- The SHIFT project, led by researcher Professor Stacy Clemes as part of Leicester's BRC, which developed and implemented a health programme designed to promote physical activity and positive lifestyle changes to truckers. The project was shown to be effective in increasing HGV drivers' physical activity levels and reducing their daily sitting time, and received a high commendation at the NIHR Impact Prizes last year.

- The 2025 National Scientific and Health Care Achievement Award from the American Diabetes Association (ADA), won by Professor Melanie Davies CBE, Director of the NIHR BRC. The award recognises exceptional contributions in patient-oriented clinical outcomes research that have had a significant impact on diabetes prevention and treatment. The competition for these prizes is such that Melanie is only the second woman to receive this prestigious award, and is the first woman outside of the U.S.A. to do so.

- Researchers at Leicester Diabetes Centre (LDC) successfully starting to use the glucose clamp technique as part of COMBINE, a new diabetes research trial. This gold-standard technique measures how sensitive a person is to the hormone insulin. In the COMBINE trial, the glucose clamp technique will determine how effective a low-energy diet is in improving insulin sensitivity in a South Asian population.

- The Leicester Diabetes Centre (LDC) hosting of the prestigious European Association for the Study of Diabetes (EASD) Scientist Training Course in October of 2024. The course promoted new talents in diabetes research and aimed to foster diabetes research in centres worldwide. Last year, the course was delivered by the LDC's team of world-class experts, who are leading cutting-edge advancements in diabetes research, education, and care.

- Clinical Research Physician, Harriet Morgan, successfully completing the National Institute for Health and Care Research's (NIHR) Associate Principal Investigator (PI) Scheme. The six-month scheme aims to give healthcare professionals who would not normally have the opportunity to work in clinical research in their day-to-day role the chance to experience what it means to work on and deliver an NIHR portfolio trial under the mentorship of a local Principal Investigator (PI). Harriet joined the PRC from Tema General Hospital in Ghana in July 2023, where she began a two-year post as a Clinical Research Physician.

- The achievements of Professor André Ng, Consultant Cardiologist at UHL, who took up the role of President of the British Cardiovascular Society for a three-year term at the organisation's 2024 Annual General Meeting in Manchester.

Health inequalities:

University Hospitals of Leicester's (UHL) vision is to be 'Leading in healthcare, trusted in communities'. This vision will be achieved through the delivery of four strategic goals that are underpinned by a strategic commitment to embed health equality and inclusion in all we do.

Work to address health inequalities is happening across all four of UHL's strategic goal areas and in key enablers of success. This work is aligned to the Statement of Information on Health Inequalities and NHS England's Core20Plus5 frameworks.

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 routinely publish all of this data (the exception being smoking cessation services via the NHSE tobacco dashboard), it is available to all colleagues 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: expanding on the work commenced for over 18s in the previous year, all parents or guardians of under 18s falling into IMD 1 and 2 categories, with planned appointments are now contacted by telephone prior to their appointment. This has led to significant and sustained improvements in attendance rates for this group of under 18s.
- 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, with concerted effort in maternity services specifically.

High Quality Care for All

UHL has developed a programme of health inequalities improvement work that aligns and maps to NHS England's Core20Plus5 framework(s). The projects in this programme are service level workstreams that are led by clinicians and operational teams to address specific disparities highlighted by local, service level data.

Each of the seven Clinical Management Groups at UHL is represented in this programme contributing to the trust wide shift in the approach to health inequalities improvement that is needed to embed health equality and inclusion in all we do. Two case studies are shared below as examples of the work that is underway and the methodology that UHL strives to use to deliver improvement through the lens of equity.

Case Study: Reducing late booking for antenatal care for Black African and Black Caribbean women and birthing people in Leicester City. Late booking for antenatal care

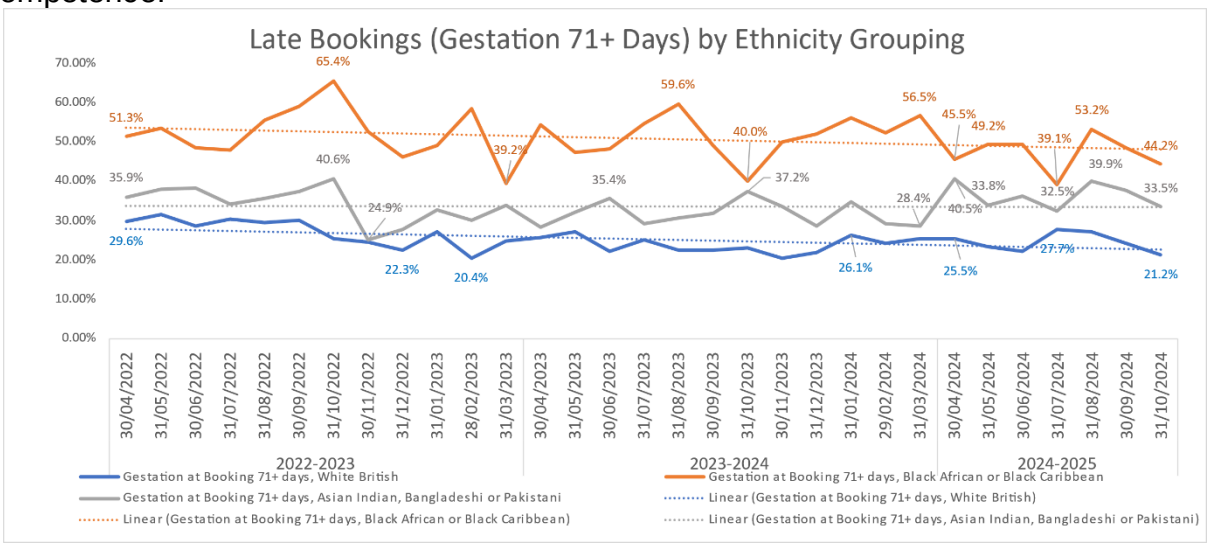
is associated with poorer outcomes for both mothers and babies. As part of the Institute for Healthcare Improvement (IHI) Pursuing Equity programme, colleagues in maternity have worked to intentionally and proactively drive down late booking for antenatal care for Black African and Black Caribbean women. Disaggregation of local data by ethnicity confirmed that Black African and Black Caribbean communities were most likely to book late for care *(figure…)*.

Gestation at booking	White British	Black African or Black Caribbean	Asian Indian, Bangladeshi or Pakistani
<71 days (recommended)	72.3%	48.1%	66.2%
71+ days	27.0%	51.6%	33.6%

Figure

An equity focused quality improvement approach was implemented to identify drivers of this and target interventions through Plan, Do, Study, Act (PDSA) cycles, informed by the local community. Qualitative analysis of feedback from over 100 parents identified five key themes as barriers to timely booking for antenatal care: trust (in the local healthcare system), communication, information, empathy and cultural competence. Interventions have focussed on building trusted relationships with communities through targeted, small scale focus groups let by Consultant Midwives.

UHL has seen a steady improvement in late bookings for antenatal care for Black African and Black Caribbean women *(figure…)*. There is a significant amount of work that remains to be done to sustain this initial progress, particularly with respect to cultural competence.



Figure

Despite progress for Black African and Black Caribbean communities, it is noted that Asian communities appear to show little improvement. The next phase of this work will therefore focus on Asian women and birthing people, as well as deeper intentional focus on deprived communities within both ethnic groups while the current interventions for Black African and Black Caribbean people continue to be implemented.

Case Study: Improving Abdominal Aortic Aneurysm Screening (AAA) for the most deprived patients. Despite the risk of AAA being highest in men, men living in more

deprived areas are less likely to attend for screening, with uptake falling below the acceptable threshold of 75%. Local factors are the most important determinants of uptake, so solutions to improve uptake must be designed at local.

Eighty-two men at a local Primary Care provider were invited to attend AAA screening; the local area was researched to understand the overall relative measure of deprivation. Fishbone analysis was done to identify the causes for non-attendance. From this, counter measures were formed and applied; the public and the professionals were engaged on various occasions prior to the screening clinics. The clinic's start and finish times were arranged in line with the surgery's high attendance hours, invitations with GP endorsement in an envelope with the NHS logo were sent and easy read versions and translated materials were sent out as per their need. Men with mobility issues were booked with extra appointment time and an extra clinic was arranged towards the end of the month for men who did not attend giving them further opportunity to attend at their local primary care provider.

Of the 82 men specifically invited, 78% attended, well above the national threshold of 75%; 17% declined and 5% did not attend. One AAA was detected, equating to 1.2% prevalence, matching national prevalence.

This work showed that when extra investment in terms of time and resources are intentionally directed towards groups less likely to access AAA screening, it is possible to improve access and eradicate the differential between the most and least deprived communities.

Partnerships for Impact: building effective and trusts partnerships with local communities and partners

Central to the continued success of the progress described above is UHL's ability to work effectively with local communities and partners to co-produce solutions and interventions that address inequalities.

The UHL Health Equality Partnership (UHEP) includes over forty local community organisations, convened by UHL, who come together on a quarterly basis to work in a concerted and coordinated way to address common themes in local healthcare inequalities. Acknowledging that health literacy is a significant barrier to access and leads to poorer experience and outcomes, current workstreams largely focus on accessible information, both in terms of language but also different media formats that populations wish to receive healthcare information in.

UHEP was also pivotal in delivering the inaugural UHL Health Equality Summit, co-hosted by the University of Leicester. This event brought more than 200 colleagues from across UHL together with community leaders and academics to share best practice in health inequalities improvement, discuss barriers to access and co-develop interventions. The event was a sell-out success, demonstrating the drive and commitment to improving health inequalities for our patients.

Prevention

UHL is a significant provider of preventative services and has a key role to play in the Government's sickness to prevention shift. The first UHL Prevention Report was published in 2024. As a first of its kind for an acute trust, this was a state of the nation report covering the key preventative services provided by UHL and an overview of the demographic breakdown of admissions at UHL. Aligning to the government's shifts of

increased care in communities and prioritising prevention, UHL's second annual Prevention Report was published in February 2025.
This year's report provides an overview of the population that UHL serves and admissions to UHL with deeper focus on six priorities summarised below:

- Making Every Contact Count
- Tobacco
- Alcohol
- TB and Blood Borne Viruses (Blood borne viruses added for 2025)
- Obesity (New for 2025)
- Workforce Wellbeing

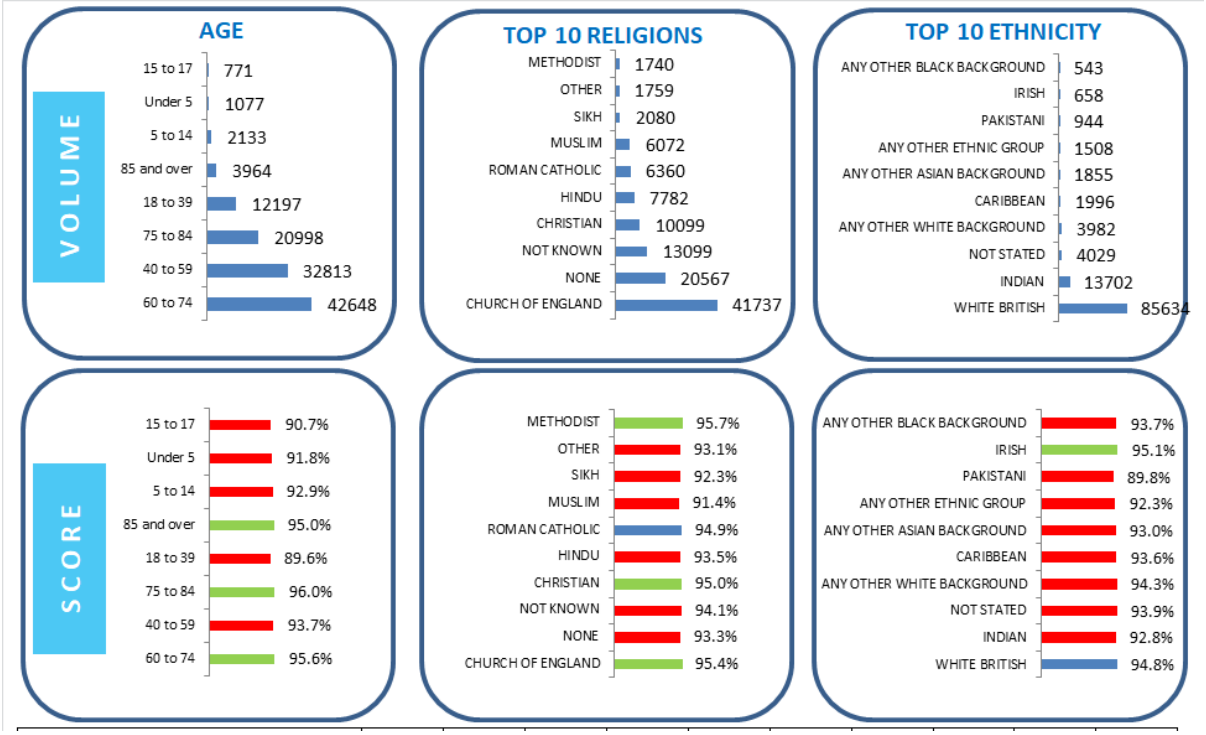
Steady progress has been made since the publication of the first Prevention Report and next steps will focus on delivering more of these services in local neighbourhoods.

Due regard to the aims of the public sector equality duty
UHL recognises its statutory obligation to meet the aims of the public sector equality duty and proactively meets these aims through the work outlined above. In addition, and specifically, focused work to deliver the aims of the Accessible Information Standard and comply with the Equality Delivery System, enable accountability and targeted action.

Friends and Family Test Feedback by protected characteristics
Data linkage at the point of outpatient friends and family test (FFT) collection allows for monitoring of demographics without burdening patients to give information that is already stored in the trust's patient administration systems. This data facilitates a comparison of numbers of responses and % positive score for each demographic dimension. Comparison with attendance data provides an understanding of the process success in reaching a representative population.
In the diagram below analysis of Outpatient Friends and Family Test Data from Oct-2023 to December 2024 (134,946 responses) is shown for the following protected characteristics: Age, Ethnicity and Religion.

Key Observations

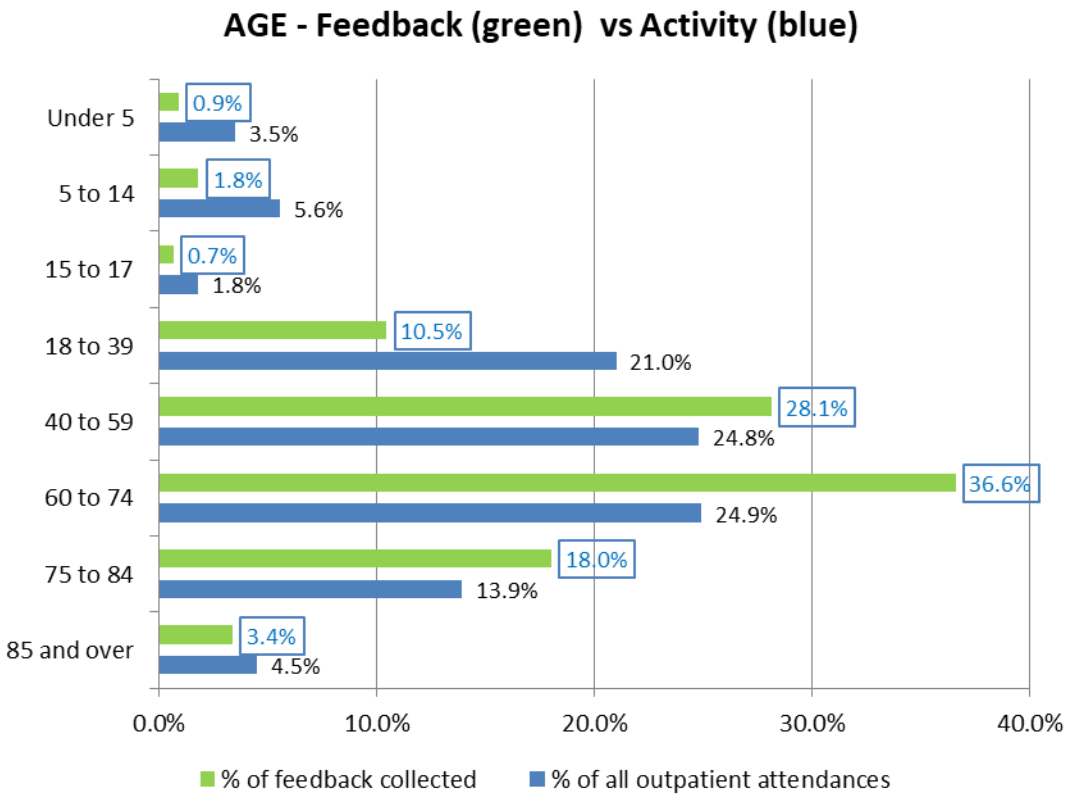
- 60 to 74 year olds are the largest group taking part in the Outpatient FFT at UHL
- Those aged 60 years and over are amongst the most satisfied respondents
- Church of England, Christian and Hindu are the top 3 religions by volume of feedback
- Church of England, Christian and Methodist are amongst the most satisfied respondents
- White British, Indian and 'Any other white background' are the top 3 ethnicity by volume of feedback
- Irish ethnicity respondents are the most satisfied group

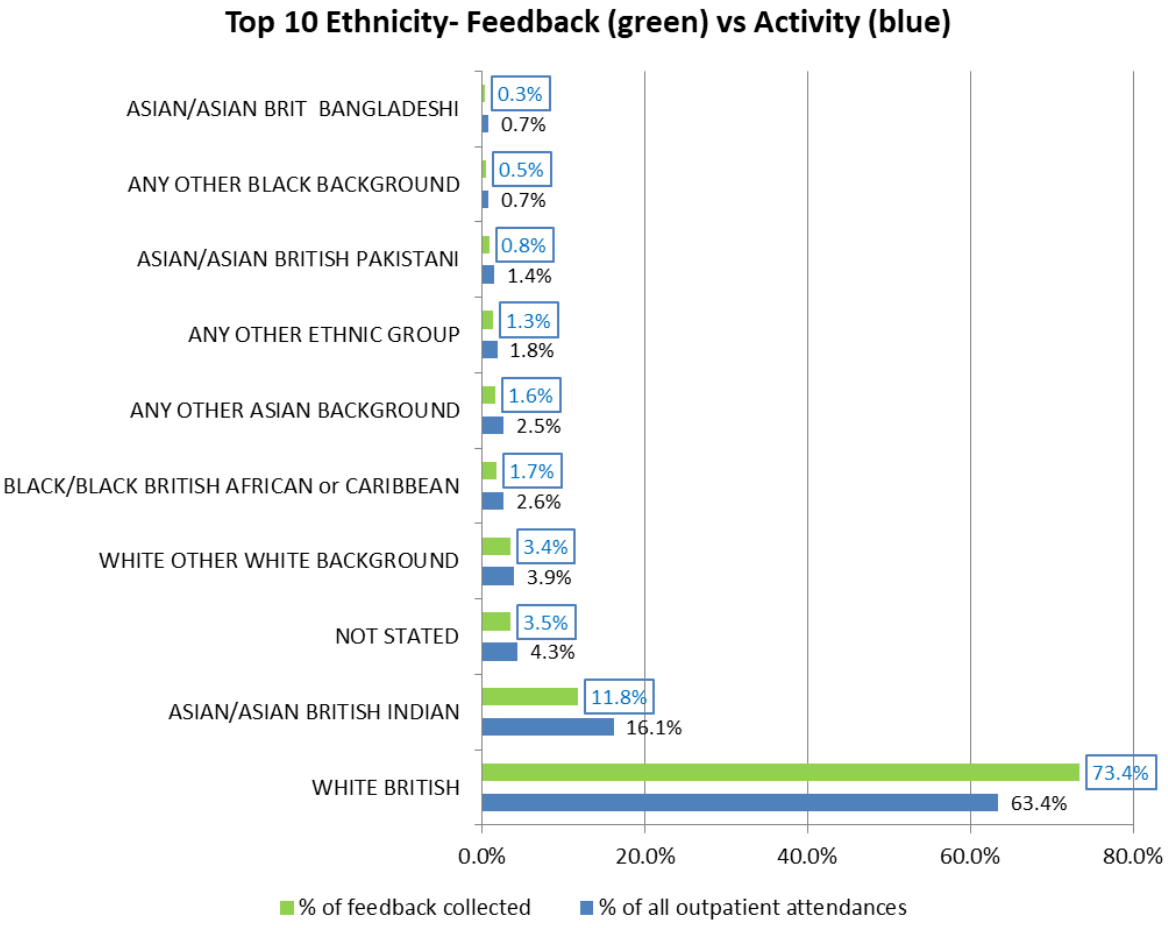


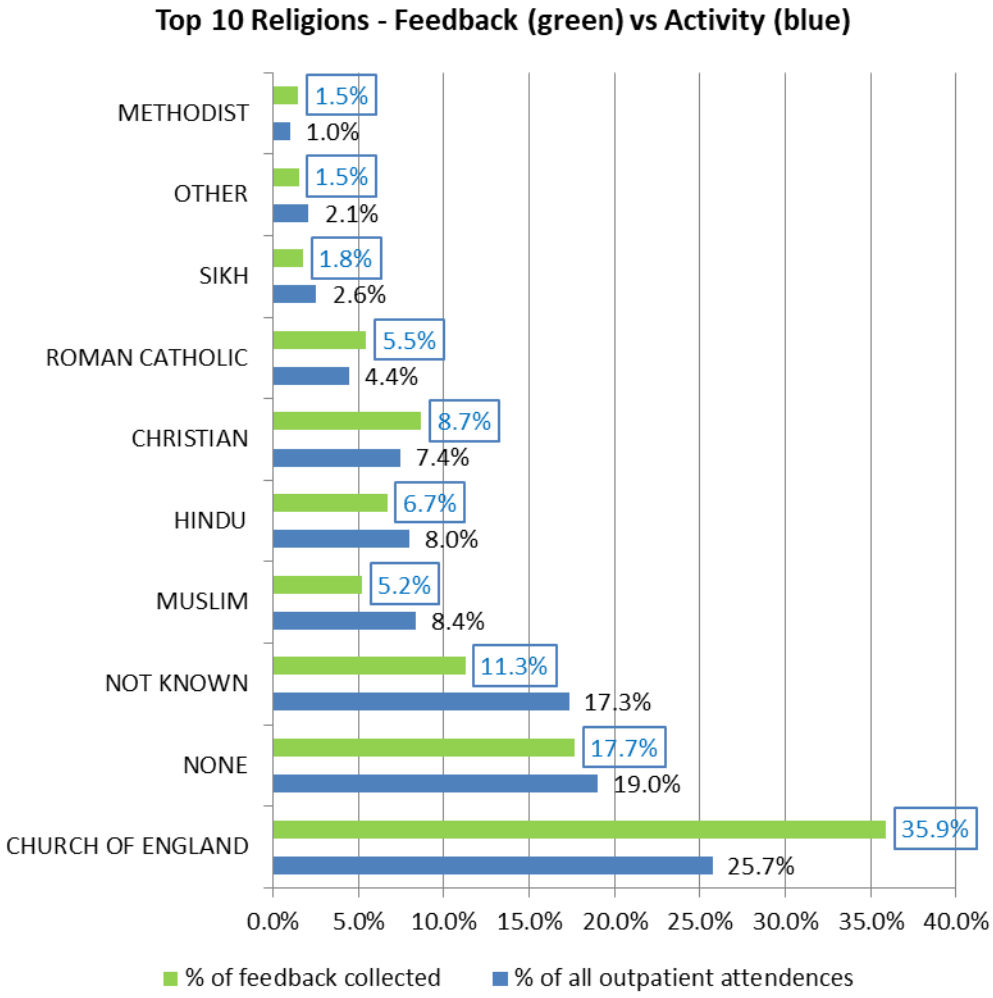
In the diagrams below analysis of Outpatient Friends and Family Test Data from Jan-24 to December 2024 is compared with attendances by protected characteristics: Age, Ethnicity and Religion.

Key Observations

- % proportion of feedback returned is not as high as might be expected for those persons under 40 years of age.
- Those aged 60 to 74 years, previously noted as the largest responding group, might be over-represented in the feedback.
- As the second largest group of respondents, those of Indian ethnicity could be better represented in the feedback with only 12% compared to an expectation of 16%.
- Those of Church of England religion may be over-represented in the feedback returned.


AGE - Feedback (green) vs Activity (blue)
Under 5
0.9%
3.5%
5 to 14
1.8%
5.6%
15 to 17
0.7%
1.8%
18 to 39
10.5%
21.0%
40 to 59
28.1%
24.8%
60 to 74
36.6%
24.9%
75 to 84
18.0%
13.9%
85 and over
3.4%
4.5%
0.0%
10.0%
20.0%
30.0%
40.0%
% of feedback collected
% of all outpatient attendances


Top 10 Ethnicity- Feedback (green) vs Activity (blue)
ASIAN/ASIAN BRIT BANGLADESHI
0.3%
0.7%
ANY OTHER BLACK BACKGROUND
0.5%
0.7%
ASIAN/ASIAN BRITISH PAKISTANI
0.8%
1.4%
ANY OTHER ETHNIC GROUP
1.3%
1.8%
ANY OTHER ASIAN BACKGROUND
1.6%
2.5%
BLACK/BLACK BRITISH AFRICAN or CARIBBEAN
1.7%
2.6%
WHITE OTHER WHITE BACKGROUND
3.4%
3.9%
NOT STATED
3.5%
4.3%
ASIAN/ASIAN BRITISH INDIAN
11.8%
16.1%
WHITE BRITISH
73.4%
63.4%
0.0%
20.0%
40.0%
60.0%
80.0%
% of feedback collected
% of all outpatient attendances



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 'to develop a skilled and compassionate workforce within a supportive and inclusive learning environment, to deliver high quality care for all'. The current Medical Education Strategy has recently been reviewed in line with the new UHL Strategy.

The Trust receives income from NHSE-WTE to support the provision of medical training and the Education Funding Agreement requires 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 September 2023 NHSE launched a sexual safety charter The Trust and Leicester Medical School have signed up to the charter and commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace.

The 2024 Medical Educator Awards were presented at an Education Update event in

November 2024. 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 2024 event which included updates from NHSE-WTE. The GMC and Leicester Medical School. A keynote speech on 'Supporting Neurodiversity' received excellent feedback. The Department of Clinical Education also provide support to UHL Medical Aligned Professions, including Physician Associates (PA). A UHL forum is in place for PAs to discuss their wants, needs and current issues.

We organise a monthly hybrid UHL grand round with talks delivered by UHL colleagues and guest speakers from University of Leicester. This is open to all health care professionals in the trust to attend. We also publish the UHL clinical education newsletters to provide updates to all Resident Doctors and Trainers with the educational activity updates.

Faculty development continues with 6 teaching improvement courses delivered in the last 12 months with capacity added for the new clinical teacher roles and a proportion of places reserved for Locally Employed doctors. Bespoke training is offered to education fellows together with guidance & supervision of improvement projects. The Faculty Focus podcast sits alongside this providing convenient accessible professional development, showcasing work being done across the Trust and signposting resources for our local clinical educators.

UHL Libraries and Information Service and the Clinical Librarian Service completed 372 evidence summaries in the year April 2024-March 2025. 20% of these were for direct patient care decision making purposes, 29% for research projects, 14% for business and quality improvement, and 11% for education and teaching.

The East Midlands Evidence Repository continues to grow (eastmid.openrepository.com) adding UHL authored publications regularly. 176 articles have been added to our collection in the 2024-2025 period, and a further 681 have been identified as published by UHL authors.

In the past year 2723 documents and books were supplied to library users from outside of our own book stock. The library service offers well attended training on Health Literacy, Critical Appraisal of research papers, and literature searching to support evidence-based healthcare. By attending our Critical Reading Made Easy course, attendees reported an increase in confidence of 65% in understanding and making use of research. The Health Literacy course increases understanding of the challenges our patients face in receiving health information by 57%.

The YourHealth online patient information leaflet library has continued to expand, with 328 new and updated leaflets added in the last year.

Undergraduate Medical Education

Leicester Medical School (LMS) is now ranked first in all subjects aligned to Medicine for Overall Positivity*. National Foundation Programme data shows that the number of Leicester graduates who are staying locally for their Foundation training is

approximately 30%.
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 role has been developed by other specialties to support the pressure on senior medical staff to supervise and teach increasing numbers of learners. Service level agreements (SLAs) are in place for each service and a quality dashboard is under development to measure the implementation of the SLAs.

Postgraduate Medical Education

An additional number of trainees were allocated to UHL in 2024 as part of the ongoing expansion of trainee posts and the Trust benefited from an increase in Foundation and Specialty trainees across a range of services. 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. An initiative to promote effective trust level engagement with Resident Doctors has been successfully developed 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

Over the last year we have made progress in a number of domains related to the improving the experience of Locally Employed Doctors/Clinical Fellows working in UHL. We now offer a high quality regular tailored induction experience for out LED/CFP doctors which takes place throughout the year. We have developed a protected teaching session which we offer two Thursdays a month covering a number of different topics. We have appointed a number of CFP doctors to the role of "CFP Champions" which gives them valuable leadership roles. Finally, we have continued to develop our websites, our Educational Supervision support resources and other materials/initiatives to support our LED/CFP workforce. All of these can be accessed from our bespoke padlet website.

The three clinical education centres have benefitted from a recent technology upgrade to improve facilities across the Trust. Staff in the centres continue to support the Royal College of Physicians UK with the delivery of the Practical Assessment of Clinical Examination Skills (PACES) exams in Leicester with excellent feedback following the course in November 2024.

*According to NSS 2023 analysis **on the NSS 2024 data** by Times Higher Education

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 our 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.

The 3 components of Martha's Rule are as follows:

- Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.

- All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.

- This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

Where we are now

The "Call for Concern" initiative and the "Ask Me" campaign were successfully implemented in 2024-25. However, the pilot model for Martha's Rule in Paediatrics faced challenges and was ultimately unsuccessful, providing valuable lessons for future iterations currently under development.

Our initial efforts concentrated on components 2 and 3 of Martha's Rule, which posed the greatest challenges and were prioritised by NHS England for early 2025 deployment. We developed a comprehensive communications plan to ensure staff and

patients at University Hospitals of Leicester (UHL) had access to a dedicated phone number for adult patients. Key elements of this plan included:

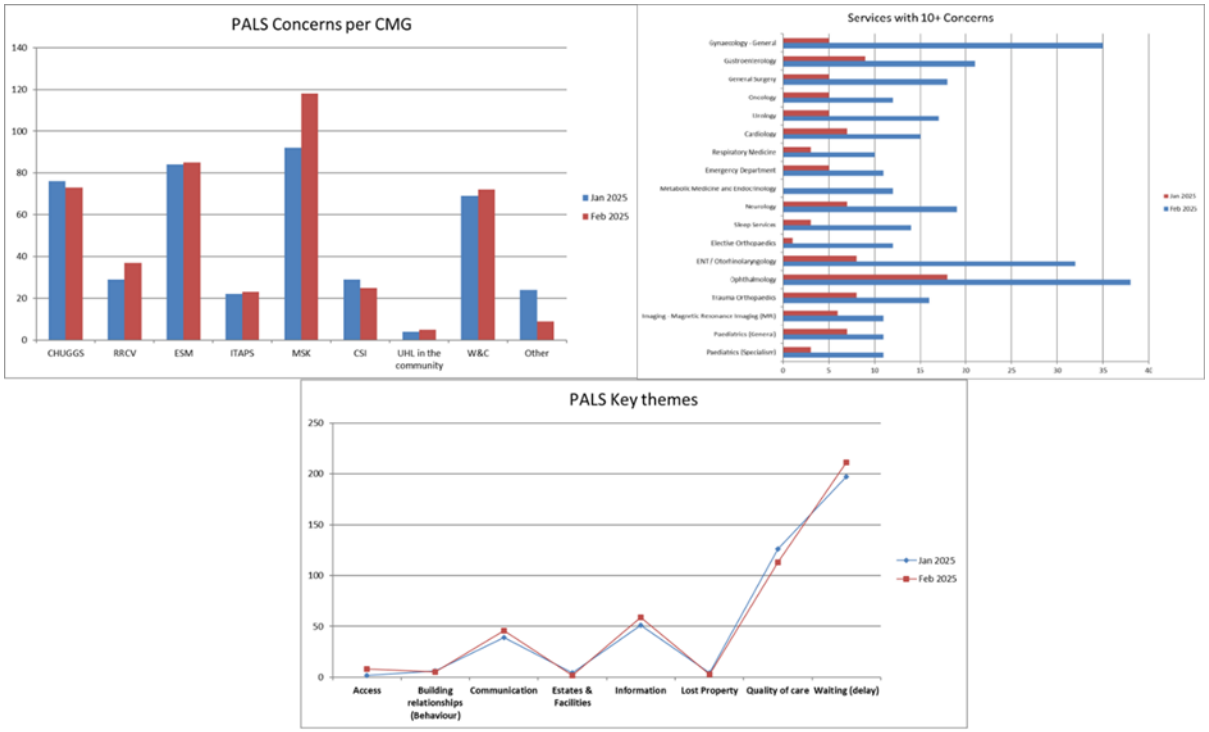
- Communications Plan: Activation of a detailed plan to roll out "Call for Concern," including the creation of leaflets, A5 posters for each ward area, and bedside posters for each patient.
- Internal Communication: Regular updates through Friday Focus, ward leaders/matrons meetings, Clinical Executive forums with Clinical Directors, and follow-up communications post-implementation.
- Website Development: Internal and external website updates, reviewed again three months post-implementation, along with a Facebook LIVE event.
- Standard Operating Procedure (SOP): Development of an SOP for escalation in line with the PALS service.

Full evaluation will take place for both Adult services 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?
Our goal is to provide a responsive service for both adults and children, ensuring that patients' and relatives' concerns are addressed promptly. This service aims to support at-risk patients at the earliest opportunity, preventing further clinical deterioration. By offering an additional layer of assurance, we demonstrate our commitment to delivering safe, compassionate, and integrated care for patients and their families.

(b) The Pals service (Patient Advice and Liaison Service)
The Patient Advice and Liaison Services (PALS) provide confidential advice, support, and information on health-related matters, serving as a vital point of contact for patients, families, and carers. PALS can assist with health-related questions, help resolve concerns or problems encountered while using our services, and encourage greater involvement in healthcare decisions. This service is dedicated to ensuring that patients and their families receive the support they need to navigate the healthcare system effectively and confidently.

Where we are now (Our current performance strengths and weaknesses)



What are we aiming to achieve / what success will look like
In years two and three, we plan to extend the PALS service to General Hospital (GH) and Leicester General Hospital (LGH), and develop a 7-day service. This expansion aims to ensure that patients and families receive timely responses and resolutions to their concerns within 5 working days or less. As the PALS service becomes more embedded, we anticipate a decrease in the number of formal complaints, as concerns will be addressed promptly and effectively.

(c) Implementation of Carers passport:

Where we are now, and our current performance strengths and weaknesses
University Hospitals of Leicester (UHL) has implemented the Carers Passport, which complements the Leicestershire, Leicester, and Rutland Carers Passport. Previously, the Carers' Charter was in place for many years within UHL, but it has now been superseded by the Carers Passport. The Carers Passport was piloted within the MSS Clinical Management Group with exceptional results and is now being rolled out across the Trust. Patient Experience teams are attending all CMGS PNFs to educate Ward Sisters and Matrons about the Carers Passport.

The Carers Passport enables carers to continue supporting the individuals they care for, if they wish to do so. It formalizes visiting and support at mealtimes for carers, ensuring they receive nutrition and hydration during their visits. This initiative not only supports the well-being of carers but also enhances the overall care experience for patients.

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) Sleep Promotion strategy: This project aims to improve patient experience at night as sleep is an essential component to recovering from illness. The sleep promotion group has developed a “sleep Huddle”, a “sleep” staff and patient Charter.

Where we are now
The sleep huddle has been implemented across MSS CMG, with some other CMG’s also trialling, a full communications plan is to be developed for roll out across the Trust.

Our current performance strengths and weaknesses
Our ward Patient Experience surveys show that Noise at Night is a significant concern for patients. By implementing the plan above we aim to reduce this.

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

	TARGET	RESULT		
FFT Area	**2024-25**	**2024-25**	**2025-26**	**2026-27**
Inpatients	**95.0%**	**97.8%**	95.5%	96.0%
Outpatients	**95.0%**	**94.7%**	95.5%	96.0%
Emergency Department	**80.0%**	**81.3%**	81.0%	82.0%
Maternity	**95%**	**93.2%**	95.5%	96.0%

Friends and Family Test Feedback by protected characteristics

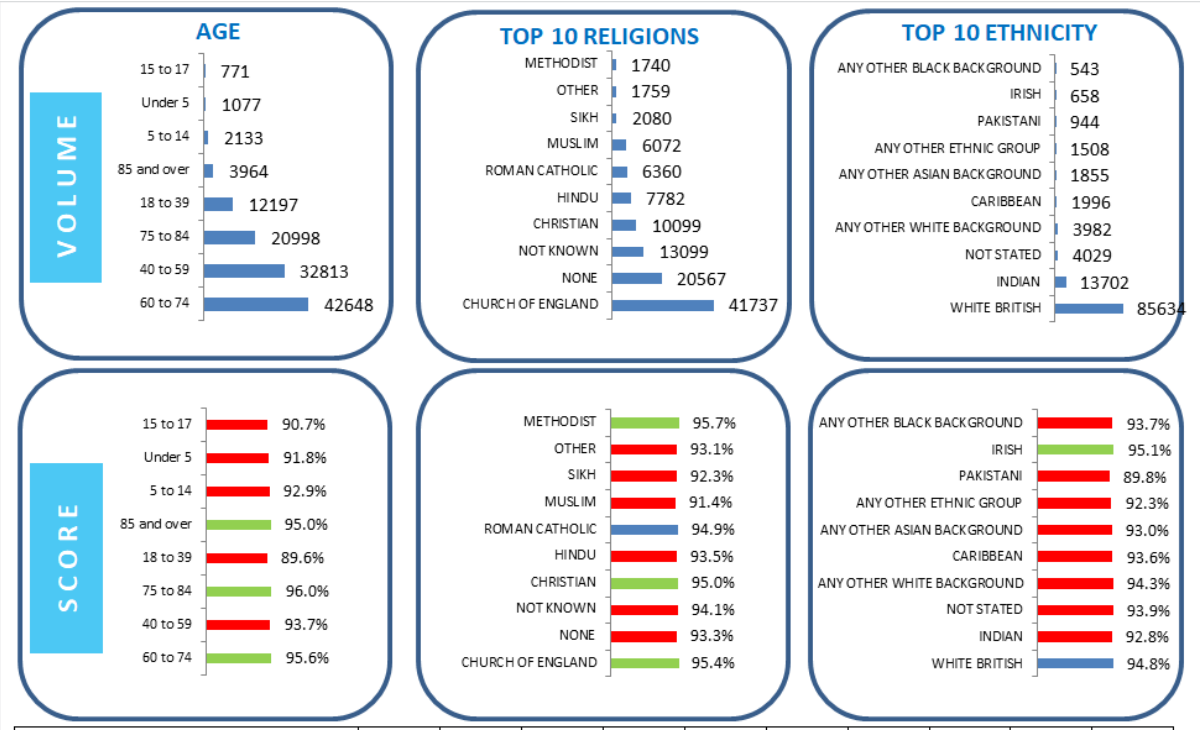
Data linkage at the point of outpatient FFT collection allows for monitoring demographics without burdening patients to provide information already stored in the trust’s patient administration systems. This approach facilitates a comparison of response numbers and

positive scores across various demographic dimensions. By comparing this data with attendance records, we can assess the success of the process in reaching a representative population.

Analysis of Outpatient FFT Data (Oct 2023 - Dec 2024)
The diagram below illustrates the analysis of 134,946 responses, focusing on the following protected characteristics: Age, Ethnicity, and Religion. Key Observations:

- Age: The largest group participating in the Outpatient FFT at UHL are those aged 60 to 74 years. Respondents aged 60 years and over are among the most satisfied.
- Religion: The top three religions by volume of feedback are Church of England, Christian, and Hindu. Church of England, Christian, and Methodist respondents are among the most satisfied.
- Ethnicity: The top three ethnicities by volume of feedback are White British, Indian, and 'Any other white background'. Irish ethnicity respondents are the most satisfied group.

This data provides valuable insights into the demographics of those participating in the FFT and their levels of satisfaction, helping us to better understand and improve patient experience.



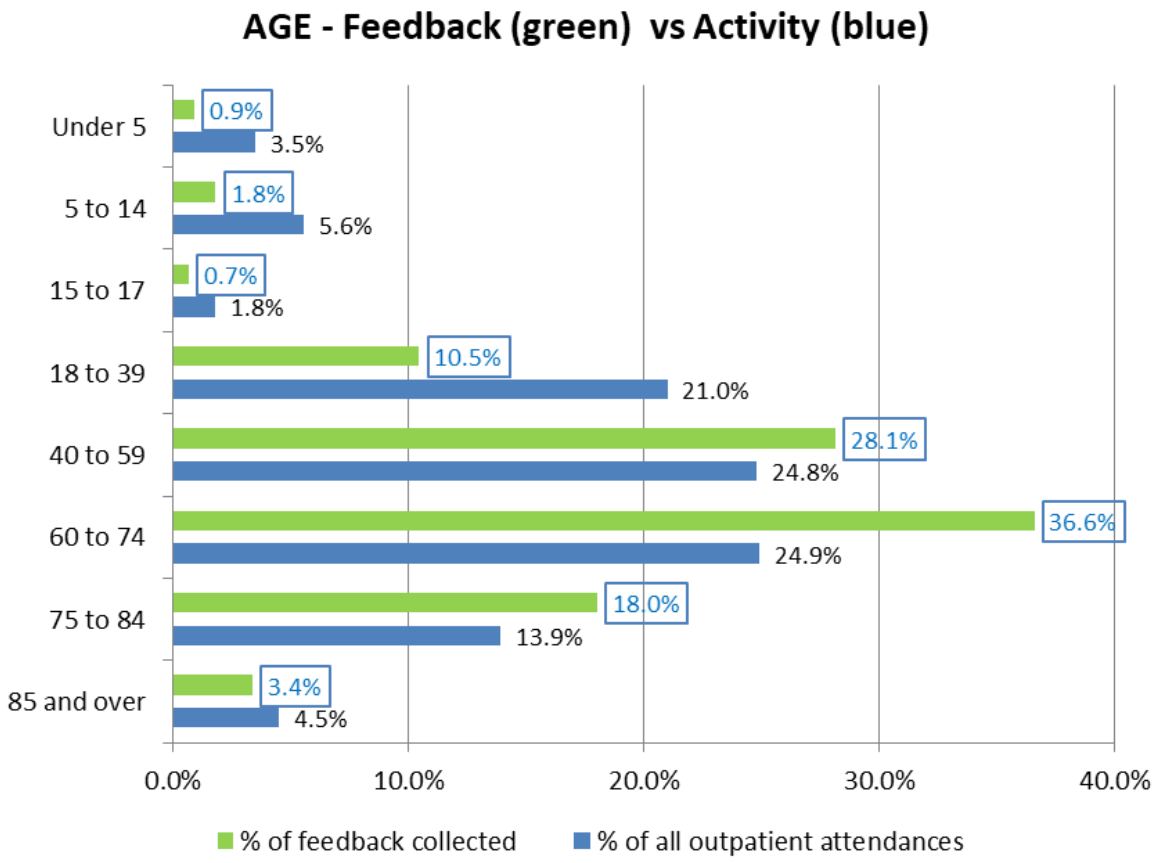
The diagrams below compare Outpatient FFT data with attendance records, focusing on protected characteristics: Age, Ethnicity, and Religion. Key Observations:

- Age: The proportion of feedback from individuals under 40 years of age is lower than expected. Those aged 60 to 74 years, previously identified as the largest

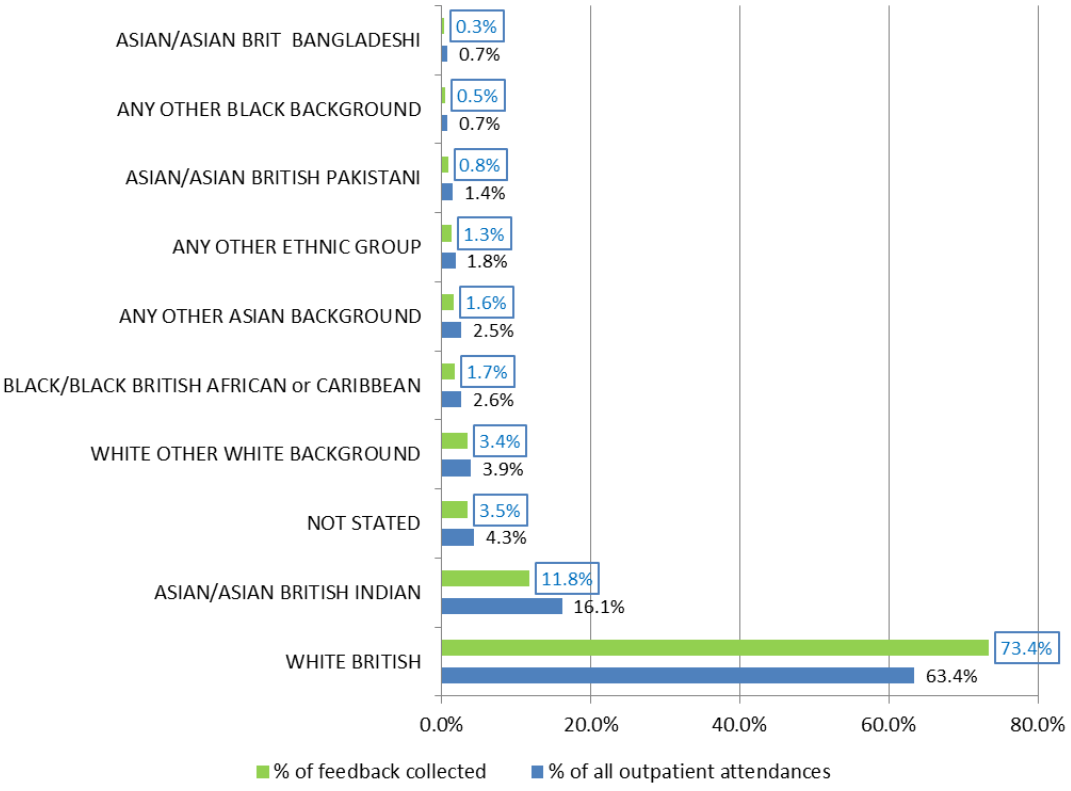
responding group, may be over-represented in the feedback.

- Ethnicity: Indian ethnicity respondents, the second largest group, are under-represented in the feedback, with only 12% compared to an expected 16%.
- Religion: Respondents of Church of England religion may be over-represented in the feedback.

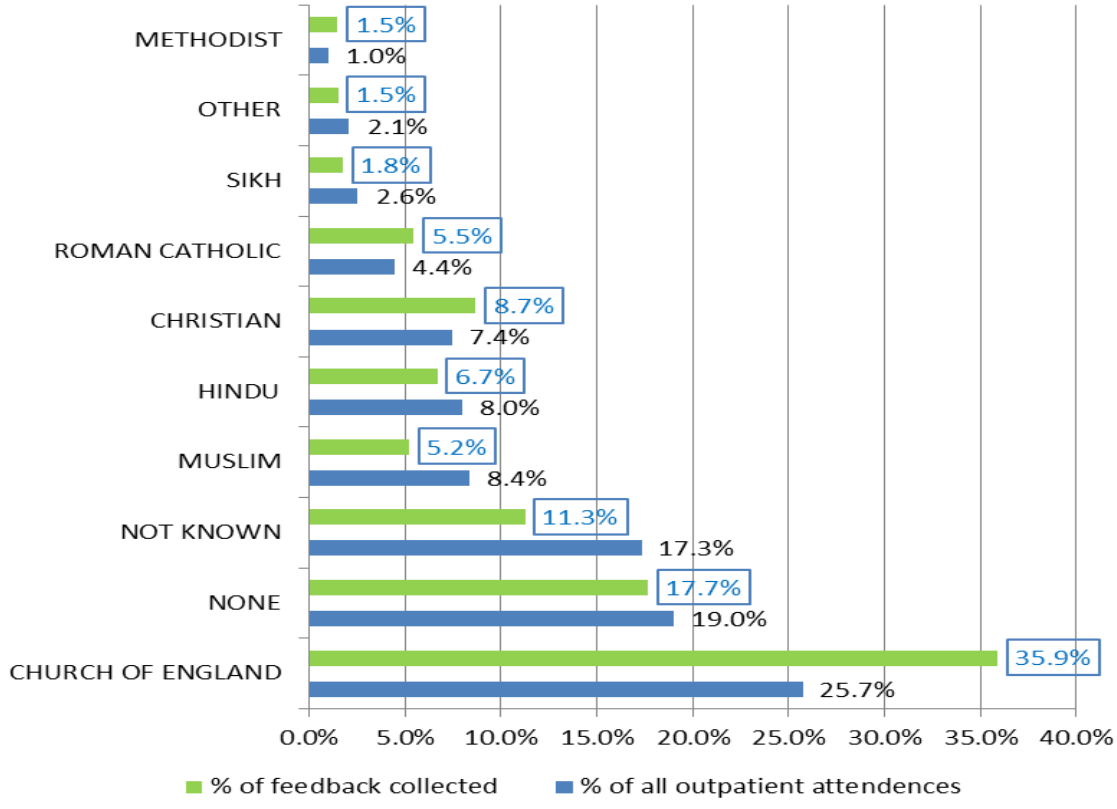
These observations highlight areas where representation in feedback could be improved to ensure a more accurate reflection of the patient population.



Top 10 Ethnicity- Feedback (green) vs Activity (blue)



Top 10 Religions - Feedback (green) vs Activity (blue)



(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 15 steps visit from the Patient Experience Team and people who volunteer within our hospitals.

Our current performance strengths and weaknesses
Our top three positive themes from the visits highlight the excellent staff interaction and communication, the high standards of environment cleanliness and hygiene, and the exceptional patient care and comfort. However, areas identified for improvement include enhancing the visibility and frequency of updates on hot boards and ensuring posters are readily available, improving the accessibility of call bells for patients, and addressing nighttime noise levels to promote better sleep for patients. These observations underscore our strengths while also pinpointing key areas for enhancement to further improve the overall patient experience.

What are we aiming to achieve / what success will look like?
As 15 steps is continually undertaken that wards will demonstrate improvements have been put in place.

(d) Improving Patient Nutrition
Ensuring patients receive meals in a timely manner that are nutritionally appropriate and offer a variety of choices is crucial. Improvement actions will be enacted through the multi-disciplinary group overseeing this workstream. Good nutritional intake is an integral component of patient care, as poor nutrition and hydration negatively impact patients' overall health and wellbeing, reducing their ability to recover from illness.

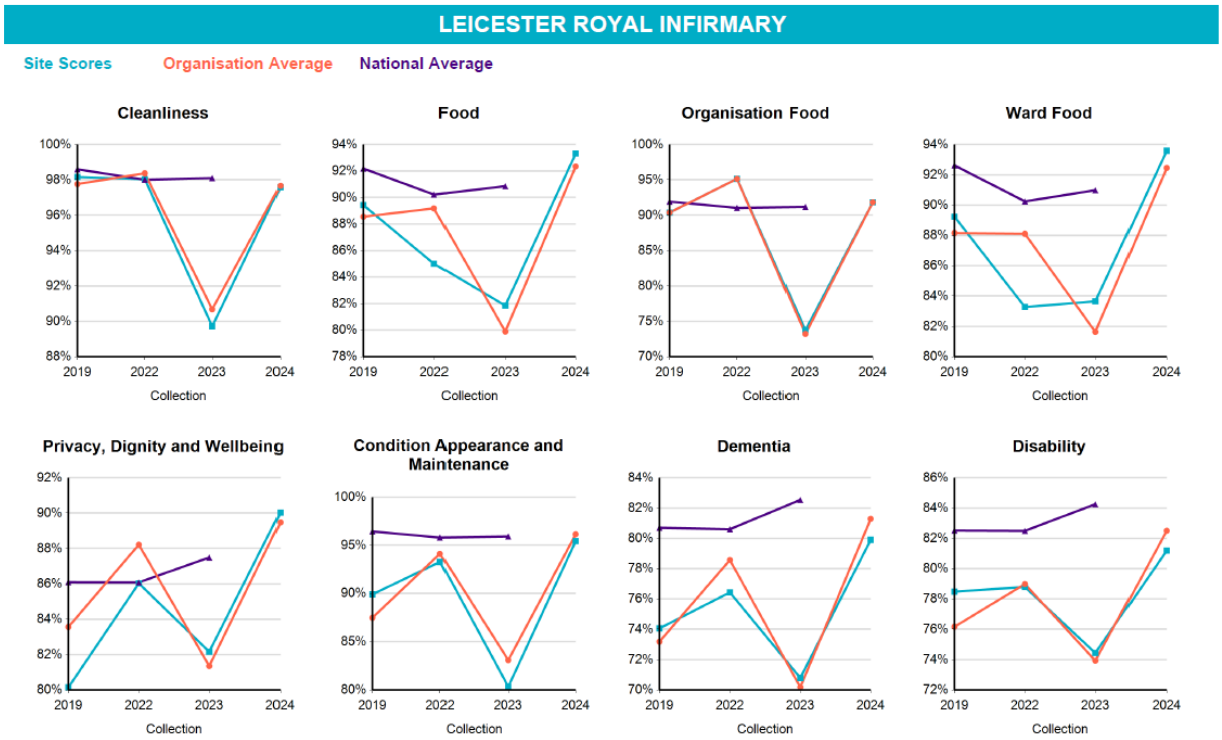
Where we are now.
The PLACE feedback for 2024 has shown a significant improvement compared to last year's audit, as detailed below.

GLENFIELD HOSPITAL

Site Scores Organisation Average National Average

LEICESTER GENERAL HOSPITAL

Site Scores Organisation Average National Average



Our current performance strengths and weaknesses

Some of the feedback from patients highlighted areas for improvement, including the texture of food, limited menu choices, and the absence of menus at the bedside. Additionally, individual catering needs are not always being met. On a positive note, patients have reported that they have sufficient time to eat their meals.

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

Patients will receive meals that align with their preferences and meet all their nutritional requirements.

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

(a) Patient information

We have commissioned an external review to evaluate how we provide patients with appropriate information. Feedback from colleagues has highlighted the need to simplify the development, publishing, and reviewing of patient information, making it more widely available in different formats. Communication with patients at the ward level will include daily updates on their plans for today, tomorrow, and discharge. Outpatient and diagnostic services will keep patients informed about their treatment plans and any subsequent follow-ups. However, translation and interpreting services are used sporadically and can be time-consuming to implement when conveying information to patients and families.

Current Performance Strengths and Weaknesses

Currently, patient information is distributed across multiple platforms, and access to these platforms for patients is part of the external review. Our communication with patients during their stay or visit needs improvement, and we will revitalise the today,

tomorrow, and discharge plans to standardize this communication for all patients. Complaints and concerns from patients have identified a significant issue with patients not being treated with empathy. A new tender is in progress for translation and interpretation services, which will be monitored for agreed key performance indicators.

What We Aim to Achieve / What Success Will Look Like

Translation and interpreting services will be widely available and used 24/7, meeting the key performance indicators. Communication with patients will improve, ensuring that each patient and their family are kept informed of their treatment plan during their stay or visit. Patient feedback will reflect that they have been communicated with empathetically.

Plans for Change

The Board has recently approved the Electronic Patient Record (EPR) business case, representing a significant step forward in our digital patient information strategy. This approval means we will implement the PatientCentre app in 2026, which will serve as a comprehensive hub for patient communications and clinical interactions. The app will allow patients to access their appointment information, receive notifications, view select clinical information, and communicate with their care teams in a secure digital environment.

In the interim period before the PatientCentre app is fully deployed, we are focusing on enhancing patient information through our revamped website, providing a centralised repository for patient information as we transition away from the legacy list system. Our approach to patient information is guided by our strategic commitment to digital transformation while ensuring no one is left behind. All digital patient information solutions will adhere to accessibility standards (AIS), with particular attention to inclusive design that accommodates diverse needs, including those with limited digital access or literacy. We plan to implement a phased approach that maintains traditional information channels (printed materials, telephone support) alongside new digital offerings.

The Digital and Data team is working closely with Patient Experience and Health Equality teams to conduct user research with diverse patient groups. This collaborative approach ensures our patient information systems are designed with real user needs in mind, following the "start with user needs" principle that underpins our digital strategy.

Resolving complaints and patient feedback

Patient feedback, including complaints and concerns, provides crucial insights into the quality of our services and standards of care from the perspectives of our patients, families, and carers. We are committed to listening, learning, and improving based on feedback from the public, HealthWatch, local GPs, and other providers, as well as national reports from the Parliamentary Health Service Ombudsman.

Learning from complaints occurs at multiple levels within the Trust. Each service, department, or specialty identifies immediate lessons and actions that can be implemented locally. Complaint data is integrated with other information, such as patient safety incidents, Freedom to Speak Up data, inquest conclusions, and claims information, to ensure a comprehensive understanding of emerging and persistent issues. Many themes and actions identified from complaints and concerns are incorporated into broader initiatives aimed at enhancing the fundamentals of care.

Improving complaint handling

The Independent Complaint Review Panel continues to convene quarterly, reviewing a randomly selected sample of complaints. The panel provides feedback on what was handled well and what could be improved. This feedback is shared with the Complaints and CMG teams and reported through our Trust Leadership Team (TLT) for reflection and learning.

An external 360 audit of the Trust's complaints handling was completed, and actions are planned to be implemented early in the next financial year in response to the report.

The new Complaints and Concerns policy was rewritten and approved in November 2024 and is available on UHL Connect.

A new internal complaint handling process has also been initiated, with named Complaints Handlers and Managers working closely with assigned CMGs. This approach aims to foster closer working relationships with staff and reduce delays in receiving statements from staff, thereby speeding up the response time to complainants.

Between April 1, 2024, and March 31, 2025, we received 1,343 formal complaints and 0 concerns (as per the previous definition, this does not include PALS concerns). This compares to 1,717 formal complaints in 2023/24.

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

We achieved 55%, 51%, and 60% for the 10-day, 25-day, 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 2025

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Formal complaints	1,467	1,886	2,260	2,534	1,476	2,264	2,165	1,717	1,343
Requests for information	321	143	118	168	113	210	317	84	6
Concern (excludes CCG & GP)	1,288	1,146	1,170	1,488	1,001	1,515	1,937	399	0
Total	4,228	4,031	4,040	4,382	2,808	4,297	4,616	2,200	1,349
Trend	0.2 % increase	4.7 % decrease	0.2 % increase	8.6 % increase	35.9 % decrease	53.02 % increase	7.42 % increase	52% decrease	39% decrease

Reopened complaints

Table Number of formal complaints received, and number reopened by quarter April 2022 to March 2025:

	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4
Formal complaints received	605	561	493	503	423	504	457	333	351	370	294	328
Formal complaints Reopened	37	27	23	21	16	16	19	5	6	10	13	17
% Resolved at first response	94%	95%	95%	96%	96%	97%	96%	98%	98%	97%	96%	95%

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

Parliamentary Health Ombudsman Service (PHSO)

The PHSO is the last stage in complaints about the NHS, and a complainant can approach the PHSO at any stage to ask for an independent complaint investigation.
In 2024–25:

- 4 complaints were upheld / partially upheld, requiring an apology/action plan/compensation
- 4 complaints had a preliminary investigation / full investigation and were not upheld
- 6 enquiries only, with no investigation

This is in line with previous years.

Patient Advice and Liaison Service (PALS)

The development of the PALS team has been instrumental in the early resolution of concerns raised by patients, families, and visitors at UHL. This vital service provides support and advice to those seeking assistance with accessing or using UHL services, thereby reducing the number of formal complaints received by the Trust. Often, PALS is the last point of contact for many service users who may be distressed or bereaved, and the team's supportive approach and empathy are invaluable.

Subject (Primary)	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Waiting (delay)	451	468	499	604	2,022
Quality of care	336	375	421	379	1,511
Information	83	99	125	167	474
Communication	123	91	105	127	446
Building relationships (Behaviour)	16	11	41	13	81
Lost Property	23	16	20	15	74
Access	15	16	18	14	63
Estates & Facilities	10	4	10	6	30
Equality	1	1	0	0	2
Grand Total	**1,058**	**1,081**	**1,239**	**1,325**	**4,703**

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

In 2025/26, we will:

- Streamline our complaints and PALS functions by process mapping to ensure patients and their families receive early resolution to their concerns and timely responses to their complaints.
- Collaborate with the University of Leicester to ensure our responses are compassionate and empathetic.
- Continue working with staff groups to provide educational advice and support regarding complaints and concerns
- The Complaints team will collaborate more closely with the CMGs to offer support, advice, and guidance, aiming to reduce delays in complaint responses

Patient Feedback

Leicester's Hospitals actively seek feedback from patients, family members and carers. 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.

Hot boards are used in the clinical areas to display monthly Friends and Family Test scores, and the changes or actions staff have taken in response to feedback received on a "You said, we did" display. This can be used when there are suggestions for improvement or when the feedback is positive, as both learning points and outstanding practice can be shared and reinforced.

We are delighted to say that during 2024-25 circa 242,549 feedback forms / surveys were received from patients. These surveys included the Friends and Family Test question and of the 242,549 responses, 227,930 contained a positive response, 8,098 included suggestions for improvement and 6,521 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 service was launched in Imaging Departments in Quarter three.
- In Maternity services SMS/texts are used 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
- SMS/texts sent to patients who are discharged from inpatient/day case areas
- 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 2024-25 there have been 1,222 completed Family, Carers and Friends feedback forms received within the Trust and this feedback has been shared with the clinical teams. Patient Experience introduced a Carer's Passport and a Carer's strategy during 2024-25. This was piloted in MSS and has been taken to several professional review meetings in the Trust. It will be completely rolled out within the Trust by December 2025.

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 2024-25 there have been seven winners: three nurses, three midwives and a consultant. Some examples of 2024-25 winners are pictured below.

Staff Nurse	Registered Nurse
Augustin Raj	Charlotte Gardner

Volunteer Services

Volunteer Services are managing a targeted recruitment of committed volunteers to provide a range of services within UHL. Although we 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, we continue to have an issue with retention of volunteers within the service.

Our volunteers have been 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 addition to there are now volunteers in more clinic and outpatient areas including the new EMPCC. Experienced volunteers have taken on the role Shift Leader.
New buggies have just been purchased to help expand and deliver the service across 3 sites. These have been funded by LHC who will also use the buggies to promote and publicise the charity.

We have Patient Visiting Volunteers who completed around 4000 visits across the Trust in 2024. The team of volunteers has grown in number by 30% and some speak languages such as Polish, Gujarati and Turkish 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. During a typical month more than 500 patients across the Trust received a treatment through this service/ Recruitment to develop the hairdressing service is a current priority.

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

Our new shop trolley service is proving to be popular with patients and staff at the Glenfield site. Working in partnership with the retailer we are now able to visit wards 3-4 days a week and offer patients the opportunity to shop for themselves.

We have now signed up 128 Volunteer Champions across the Trust. These champions are staff who provide volunteers support and recognise and promote the roles that volunteers do in their area.

Volunteers can nominate a Star Champion for recognition for their help and support.

Cilla the PAT dog volunteer

Working with partners

In 24/25 UHL developed a partnership strategy as it was recognised that effective partnership-working is critical to the Trust. As a large acute NHS provider, we know that we cannot work in isolation as we strive to achieve our aspirations and deliver integrated place-based care. The strategy provides a framework through which we can work in closer collaboration with our partners to achieve our shared goals.

Our Trust Strategy, 'Leading in Healthcare, Trusted in Communities' (2023-30), shaped through extensive stakeholder engagement with a focus on hearing from those who have lived experience of accessing services, sets out a series of strategic goals to inform our service design and delivery, as well as key underpinning values to guide the way in which we work. Whilst we will strive to deliver these goals within our own organisational context and capabilities, we recognised that successfully achieving our aspirations will require continued and enhanced collaboration with our key strategic partners at both national and local levels. Our focus on partnership-working is reflected throughout the Strategy, and signalled most prominently through the 'Partnerships for

Impact' goal which outlines our vision for strengthened partnerships and seamless integration between our services and those of our key Integrated Care System (ICS) partners, including primary care and community-based services.

Building on this the Partnership Strategy highlights 3 key goals and areas of focus:

- Horizontal Integration with other Acute Trusts
- Becoming a Community Anchor
- Place-based Services and Primary and Community Care Integration

University Hospitals of Northampton

In October 2023, we launched a formal provider collaboration between UHL and UHN. A joint Group Executive Board has been established which includes a shared Chief Executive Officer and Chair as well as Group-level executives covering a range of key portfolio areas. Collectively, the two Trusts support more than two million people in the East Midlands and have many shared services, jointly employing clinicians and delivering world leading research through the Leicester Biomedical Research Centre. With a combined budget of £2.4bn and a 29,000-strong workforce, we are now working at scale with UHN to reduce health inequalities across the region, increase access to services both in and out of hospital, and improve efficiency, productivity and quality.

In 2024/25 we have continued to work closer with University Hospitals of Northampton. We have successfully recruited group execs including a Group Chief Digital Information Officer. Clinical workstreams have been set up in Maxillofacial Surgery, Plastic Surgery and Oncology which are focusing on joint recruitment to attract clinicians to work in a large teaching hospital, reviewing models of care and sharing PTLs to ensure the most urgent patients receive their care in a timely manner.

Nottingham University Hospitals

In 2024/25 we have worked with University Hospitals of Nottingham to re-invigorate the Children's Collaborative working group. By working collaboratively we have established an aim to: Focus on improving population health outcomes and reduce health inequalities across the East Midlands. Enhance productivity and value for money and support broader social and economic development. Keep access to care local, but acknowledge that there may be times when it is in the best interests of patients to deliver care differently in order to maintain or improve high standards in a challenging environment. In 2025/26 the collaboration will determine specific services and deliverable to achieve these aims.

University Teaching Hospitals Lincolnshire

The Partnership Team and UTHL have established a co-operation in 2024/25 between the two acute Trusts where current contracts and partnerships can be reviewed in regards to their efficiency and equity for both Trusts. The aim for the next year is to develop discussions regarding potential future collaborations through joint horizon scanning allowing for creative approaches to addressing care across the East Midlands.

ODNs

In 2024/25 the Partnership Team revitalised the Operational Delivery Network Forum, bringing together managers from networks hosted by UHL, such as the East Midlands Radiology and the East Midlands Congenital Heart networks, to share best learning practices, encourage collaboration and raise concerns where necessary. In 2025/26 the Partnership Team will continue to manage the ODN Forum, encouraging ODNs to think innovatively about shared resources and establish a governance process for networks hosted by UHL.

East Midlands Acute Providers (EMAP)

In 2024/25 we continued to engage the other 6 acute hospitals in the East Midlands region via the East Midlands Acute Providers (EMAP). The vision for EMAP is to bring these acute providers together to agree common approaches to meeting population need and ensuring equity of outcome, access and experience, where it is beneficial to do so at scale.

In the last 12 months, EMAP has improved the way in which we work together and we have the foundations to be able to move into delivery of tangible benefits for our patients. Examples of successes in 2024/25 include achieving national rate cap compliance for agency AfC band 5 and above, releasing savings in the procurement work stream of >£100k in the last quarter of 2024/25 by changing NHS Supply Chain contracts, Trusts collaborating to bring 8 Stroke Consultant trainees into the East Midlands starting in August 2025, digital collaboration with Nervecentre mobilisation and agreeing an EMAP business continuity plan for aseptic preparation of medicines. In addition to these successes, there are 8 professional networks that meet regularly to address 'hot topics', problem solve together and share best practice. These groups have also agreed some enabling functions that meet 'do once' principles such as an EMAP information governance process, a workforce sharing agreement and agreed how to fairly address data requests and analysis.

Primary Care Integration

In 2024/25 we have reviewed how UHL can work closer with primary care by analysing existing models in the country. We have identified key areas of focus for 25/26

- **Strengthen the transfer of care work** that UHL already undertakes with general practice and primary care smoothing patients' pathways and communication but ensure that the Associate Medical Director for primary care and a strategy manager is involved in this work, along with the 3 GP Executives. This should have a focus on communication between general practice and UHL. Underpinning all the above will be the development of a monthly UHL Clinician - GP forum to support continued relationship building. There will be several additional forums/events arranged, these will allow for the relationship & Trust development necessary to make the above interventions successful. As specialties within UHL

develop their strategic delivery plans, focus has been directed to opportunities for further integration with Primary Care.

- **UHL support offer to general practice/primary care** – UHL to form an offer to provide support to supporting functions from our corporate services. This could include digital/IT support, recruitment, finance etc. The edge of this support would be that it is offered a free service to GPs and primary care. It could even be expanded to supported non-clinical workforce within GP/PC.
- **Integrating UHL in the LLR Fuller Review work -** alongside improving relationships and reducing bureaucracy at the Primary and Secondary Care interface, the Fuller review highlights the importance of pursuing new models of service provision to stabilising primary care. To ensure GP job satisfaction and reduce overall system demand, focus should be given to identifying opportunities to reshape services traditionally delivered in Secondary Care. The development of services in primary care to prevent COPD exacerbation, manage Long-Term conditions such as Diabetes and support those identified as Frail, will provide further professional development for GPs (improving overall job satisfaction) as well as prevent future demand growth on UHL services.

In 2024/25 we have :

- Increased capacity within the 'transfer of care' work
- Recruited to the Associate Medical Director for Primary Care/General Practice –.
- Begun work with the relevant corporate services, to clearly develop the corporate services support offer to general practice.

Health and Wellbeing Boards

Ensuring the Partnership Team represented UHL in system, place and local level Health and Wellbeing Boards was paramount for 2024/25 and boards at all levels are now consistently attended. Each of the boards has specific health and wellbeing priorities for their individual districts which feed into the place and system level boards. UHL will continue to support these aims centred on health inequality, access and preventative care through collaborative working throughout 2025/26.

Partnership Tenders

The Partnership Team have secured financial and resource benefits through sourcing tenders for UHL Services. In 2024/25 our successful tenders resulted in a net benefit of over £300k and funding of £1.3M in resources.

In 2024/25 the Partnership Team aided UHL services in tendering for services that required partner support. These were the Psychological Support Service for the Infected Blood Inquiry patients, and the East Midlands Paediatric Critical Care Call Handling Centre, UHL were successful in these bids. Mobilisation required partnering with Leicestershire Partnership Trust for the Psychological Support Service, and a telephony company for the call handling service. For 2024/25 the performance rate for tenders UHL bid for was 77% overall, 100% for retaining contracts held the prior year

and 67% for new tender opportunities. The objective for 2025/26 is to continue to ensure tenders with partnership opportunities are sustainable.

Chaplaincy

The Trust's Chaplaincy team continues to provide pastoral, spiritual, and religious support to patients and their families during their admission. Chaplains are accessible 365 days of the year and provide expert care for anyone experiencing emotional or spiritual distress relating to their feelings and questions about life, death, change, relationships, identity, and the meaning of existence. Leicester's hospitals were the first to employ non-religious chaplains and we continue to be at the forefront of Chaplaincy's modern evolution: hosting and contributing to the Non-Religious Pastoral Support Networks training programmes to prepare the next generation of chaplains for the NHS.

The rich diversity of Leicester, Leicestershire and Rutland's religions and beliefs are reflected in the Chaplaincy team and its growing team of Chaplaincy Volunteers. Drawn from the religions Christian, Hindu, Jewish, Jain, Muslim, and Sikh communities, with a healthy balance of gender and ages, the work of the Chaplaincy reaches all areas of our hospitals. Over the past 12 months there have been more than 9800 patient visits and over 300 urgent referrals for Chaplaincy support.

Meeting our aim to provide better holistic care in 2024/25, the Chaplaincy team developed and implemented an improved and inclusive service for baby funerals: this means that all families who require this vital support feel appropriately recognised and supported. Our other work assisting in the facilitation of Hospital Weddings, conducting Hospital Funerals and the belief specific rituals such as Baptisms, continue to demonstrate the close association between chaplains and important rituals. The Hospital community's demand for prayers and worship continues to rise and with access to the physiotherapy gym at Leicester Royal Infirmary we have been better equipped than ever to provide space for Friday Prayers for our Muslim staff. Christian staff at the LRI and Glenfield hospital also benefit from regular prayer and service opportunities that have been introduced.

Our aim to enhance our delivery of staff support to the hospital community led to additional time and focus on making chaplains more accessible to staff in need and, enabling chaplains to engage more staff – wherever they may be. Statistically chaplains almost doubled the numbers of staff encounters when compared to the previous year and thanks to 24hrs of "Chaplaincy at Night", across two nights another 570 members of staff were reached in a previously unreached cohort: this fantastic initiative is now intended to be a regular part of our work. A more bespoke approach to supporting staff was adopted in partnership with other teams to provide dedicated time each week to the staff working on and around Glenfield's CDU: now well established this connection provides an effective template for more work in support of staff in the toughest environments.

It is the LRI's chapel that provides the private space for a very busy staff food bank. Now active for two years the food bank is a weekly collaboration between Volunteer Services and Chaplaincy. Unseen by many, the food bank is a vital support to so many staff.

Another area of improvement to the chaplaincy service has been the celebrations for more of the major religious festivals (Chanukah, Christmas, Diwali, Easter, Eid and Ramadhan, Guru Nanak Sahib's Gurprub, Vaisakhi) and the highly significant South Asian Heritage Month, Black History Month, and Baby Loss Awareness Week. Chaplains have been active in the Hospitals' restaurants: offering conversation, inspiration, and live music with many hundreds of people of all ages to provide moments of joy and meaning, and to best represent the Trust's celebration of the community's rich diversity. Equally effective in both celebrations and sensitive environments the Chaplains have been called upon to contribute to the great work of other Staff teams in the facilitation of EDI events, The 80th Anniversary of D-Day, Wellbeing Webinars, Memorial Services for patients and staff members and the Hospital Charity's events.

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. We continue to develop relationships with wider community stakeholders and actively contribute to 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

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.

Aims for 2025/26

- To further develop the offer and awareness of Chaplaincy as a support option for staff: establishing a strong link with the staff wellbeing services and Staff Networks – to contribute to the Trust's commitment to be a great employer.
- To begin the redevelopment of the Spiritual Care Centre spaces at the LRI: Creating an environment that is unique in its stillness and further establishing Chaplaincy as a service that is available and accessible "for all".
- To develop greater presence through an excellent IT presence on both internal and external platforms that enables the Chaplaincy Service to be better understood and accessed by service users.

Digital and IM&T

Digital and data are reshaping the future of our hospitals. Over the past year, we have made substantial advancements and established a strong foundation for future transformation. The future of sustainable healthcare is digital and data-driven, and the scale of opportunity ahead is considerable.

In 2024/25, we made significant progress in ensuring our staff are equipped with the tools and technology they need to deliver high-quality care. Our focus has been on modernising the equipment and digital infrastructure that underpin day-to-day working across our hospitals. These improvements are helping to create a more reliable, efficient, and supportive environment for our staff, while laying the groundwork for further

innovation in the years ahead.

Over the past year, significant progress has been made in ensuring our workforce has the right tools to perform effectively:

- Upgraded or replaced 3,685 laptops and PCs, delivering faster, more reliable performance.
- Deployed 1,266 new iPads and iPhones, replacing outdated devices.
- Procured 4,074 additional laptops, PCs, and mobile devices to ensure staff have the technology they need to excel.
- Launched monitor upgrades, with 1,150 screens replaced across departments to improve visibility and efficiency.

This investment ensures our staff are empowered with modern, reliable equipment, enabling them to deliver the best possible care and service.

We are continuing to invest in modernising and improving our Wi-Fi and Network, including mobile phone signal.

- Upgraded the General Wi-Fi across the site, making it faster and allowing for Wi-Fi Calling; the guest Wi-Fi has also been upgraded to allow for this.
- The Core Network refresh programme is improving stability, ensuring a better end-user experience.

2024/25 marked another important year of progress for our Electronic Patient Record (EPR) programme. This work is central to our ambition to become a digitally mature organisation and improve safety, experience and efficiency across our hospitals. Key developments this year included:

- We opened the East Midlands Planned Care Centre (EMPCC) with digital-first pathways from day one, including self-check-in, electronic observations, and electronic prescribing, enhancing patient flow and clinical safety.
- We went live with BadgerNet, our new neonatal electronic patient record, replacing paper records with fully digital documentation for neonatal care teams and visiting specialists.
- We expanded paperless working from the Emergency Department to Emergency Decision Unit.
- We made further improvements in urgent and emergency care, including updates to our sepsis models and observation tools to align with national guidance, supporting faster recognition and treatment of sepsis in the Emergency Department.
- We expanded the use of Criteria Led Discharge, onboarding 18 services to help patients leave hospital more efficiently when they meet agreed clinical criteria, reducing delays and freeing up beds.
- We have installed software to accelerate our software testing and deployment, and simplify onboarding and training, reducing support needs, and helping users make the most of digital tools from day one.
- Our work continues to gain regional and national recognition, with multiple NHS peers visiting UHL to learn from our mobile-first EPR approach.

We are making progress in embedding AI and automation to support both clinical and

corporate effectiveness. This includes:

- exploring how real-time transcription and clinical documentation tools can reduce the administrative burden on clinicians
- advancing AI use in imaging, dermatology, stroke, pathology and cardiology.

Our commitment to ethical and human-centred AI is reflected in our role as the only UK organisation signed up to the European trustworthy & Responsible AI Network (TRAIN) initiative, and we are supporting staff with operational guidance to build confidence in using AI tools as part of everyday care and operations. We have established an AI Governance Oversight Group (AIGO) to provide structured oversight and ensure safe, effective implementation of AI across the organisation.

As we move into 2025/26, we remain committed to building a modern, digital care environment that supports safer care, reduces variation, and improves the experience of patients and staff alike.

- We have completed groundwork for our Maternity EPR replacement and PAS go-live, both of which will go live in 2025/26. These systems are vital to reduce our reliance on outdated technology and improve the way we manage referrals, appointments, theatres and patient records.
- We have made strong progress in preparing Same Day Emergency Care (SDEC) units for paperless working in 2025/26, with detailed requirements gathered across multiple sites and staff actively engaged in redesigning future-state workflows.

This year, we laid the foundation for the future with a group-wide digital strategy for 2025-2028, uniting University Hospitals of Leicester and University Hospitals of Northamptonshire under a single, collaborative vision. By bringing together leadership, infrastructure, and innovation across both organisations, we are not only avoiding duplication and driving efficiencies, but also accelerating our ability to deliver high-impact digital solutions that improve patient care, empower staff, and unlock future opportunities. This unified approach ensures every digital investment benefits the whole Group, aligning our transformation journey with the needs of the communities we serve.

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 and Response (EPRR) Framework, where the Trust is required to have risk assessments, emergency and business continuity plans, provide training and exercising to ensure effective arrangements are in place to respond to disruptive events, collaborate with partner agencies to ensure a cohesive response is available between partners, as well as to warn and inform the public.

An annual self-assessment against NHS England's Core Standards for EPRR was

completed in August 2024, where following reviews from the Integrated Care Board and NHS England, it was confirmed that the Trust is substantially compliant against the standards.

Over the past year, the EPRR Team has led the Trust's response to the COVID-19 Inquiry, which focused on the impact of COVID-19 on healthcare systems, supported the Trust in preparing for, responding to and recovering from multiple series of industrial action, and supported the Trust in responding to a series of events, including responses to infrastructural failures to power, water and digital, as well as a critical incident due to significant operational pressures during January 2024.

Following a Hazardous Materials event in 2023, the EPRR Team has comprehensively redeveloped the Trust's Chemical Biological Radiological Nuclear and explosive (CBRNe) plan to clarify patient pathways, develop clear standard operating procedures and flowcharts to support operational and clinical colleagues respond to disruptive events. Subsequent exercises have been held to enable continuous improvement, validate the plan, and provide staff opportunities to familiarise themselves with the process to manage such events.

In the forthcoming year, alongside updating and exercising a number of plans and providing further training opportunities to staff, the EPRR Team is supporting the Trust's upgrade to its Patient Access System, through developing a UHL NerveCentre Downtime Framework, which aims at developing clear processes to safely maintain patient treatment during any disruptions to the NerveCentre systems.

Richard Mitchell

Chief Executive

25 June 2025

Section 2: Accountability Report

Directors'/Members' report

Information about our current Trust Board members (including their experience and skillset) 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 or all of 2024/25:

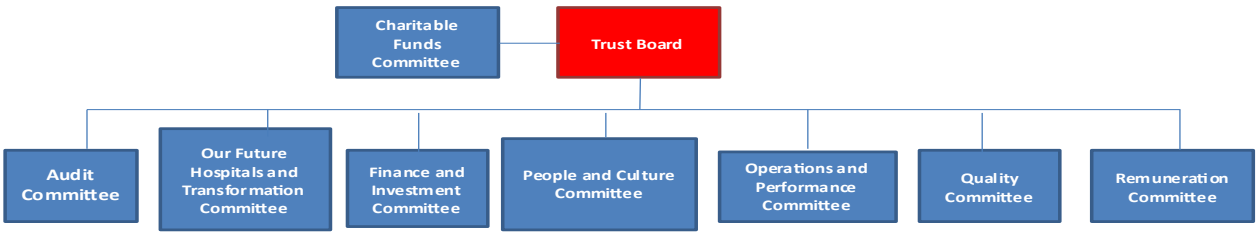
- Vicky Bailey, Non-Executive Director
- Mark Brearley, Interim Chief Financial Officer
- Andrew Carruthers, Chief Information Officer
- Professor Aruna Garcea, Associate Non-Executive Director
- Lorraine Hooper, Chief Financial Officer
- John MacDonald, Trust Chairman
- Ballu Patel, Non-Executive Director
- Jeff Worrall, 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:

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST BOARD AND BOARD COMMITTEE GOVERNANCE STRUCTURE



The Trust's Standing Financial Instructions and Scheme of Delegation, and its Standing Orders are reviewed annually. They 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 2024/25.

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 2024/25 is set out in the table below including,

Trust Board and Board Committee attendance, commencement/ending of post (if after 1 April 2024) and voting status:

Name	**Public Trust Board** (max = 11)	**Audit Committee** (max = 5)	**Finance and Investment Committee** (max = 12)	**Operational Performance Committee** (max = 11)	**People and Culture Committee** (max = 9)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee** (max = 11)	**Remuneration Committee** (max = 8)	**Charitable Funds Committee** (max = 7)
John MacDonald* – Chairman *(until 30 June 2024)*	2/4 50% **(Chair until June 2024)**			0/3 0%				1/1 100%	1/2 50%
Andrew Moore* – Chairman *(from 1 July 2024 – Non-Executive Director prior to that)*	10/11 91% **(Chair from July 2024)**	1/2 50%	1/4 25% **(Chair until May 2024)**	0/8 0%					3/5 60%
Vicky Bailey* – Non-Executive Director *(until 31 December 2024)*	9/10 90%	3/4 75%			4/5 80%			6/8 75%	2/6 33%
Ivan Browne* –Non-Executive Director *(from 1 Sept 2024 – Associate Non-Executive Director prior to that)*	10/11 91%	1/3 33%			9/9 100% **(Chair from July 2024)**	11/12 92%		4/4 100%	
Mark Farmer – Associate Non-Executive Director	8/10 80%					8/9 100%			4/6 67%
Professor Aruna Garcea – Associate Non-Executive Director	8/11 73%			9/10 90% **(Chair from Sept 2024)**			5/11 45%		
Steve Harris – Associate Non-Executive Director	5/11 45%		11/12 92%						
Dr Andrew Haynes* – Non-Executive Director	8/11 73%	3/5 60%		11/11 100%	6/9 67%	10/12 83% **(Chair)**	10/11 91% **(Chair)**	5/8 63% **(Chair)**	

Name	**Public Trust Board** (max = 11)	**Audit Committee** (max = 5)	**Finance and Investment Committee** (max = 12)	**Operational Performance Committee** (max = 11)	**People and Culture Committee** (max = 9)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee** (max = 11)	**Remuneration Committee** (max = 8)	**Charitable Funds Committee** (max = 7)
Jill Houghton* – Non-Executive Director *(from 1 January 2025)*	1/1 100%				2/2 100%	3/3 100%			
David Moon* – Non-Executive Director	11/11 100%	5/5 100% **(Chair)**	11/12 92% **(Chair from August 2024)**				10/11 91%	8/8 100%	
Ballu Patel* – Non-Executive Director *(until 31 July 2024)*	5/5 100%	2/2 100%	0/3 0%	0/3 0%	1/1 100% **(Chair until May 2024)**		3/4 75%	2/4 50%	
Professor Thompson Robinson* – Non-Executive Director	4/11 36%					2/12 17%	4/11 36%		7/7 100% **(Chair)**
Jeff Worrall* – Non-Executive Director *(until 31 August 2024)*	6/6 100%		3/5 60%	5/5 100% **(Chair until August 2024)**		3/5 60%	0/4 0%		
Richard Mitchell* – Chief Executive	9/11 82%								
Dr Ruw Abeyratne – Director of Health Equality and Inclusion	10/11 91%				7/9 78%	7/12 58%			
Simon Barton – Deputy Chief Executive	11/11 100%		11/12 92%				9/11 82%		
Lee Bond* – Chief Financial Officer *(from 9 Sept 2024)*	4/5 80%	2/3 67%	7/7 100%	3/6 50%			2/8 25%		
Mark Brearley* – Interim Chief Financial Officer *(from June 2024 – 8 Sept 2024)*	3/3 100%	1/1 100%	2/3 67%	1/2 50%			1/2 50%		

Name	**Public Trust Board** (max = 11)	**Audit Committee** (max = 5)	**Finance and Investment Committee** (max = 12)	**Operational Performance Committee** (max = 11)	**People and Culture Committee** (max = 9)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee** (max = 11)	**Remuneration Committee** (max = 8)	**Charitable Funds Committee** (max = 7)
Andy Carruthers – Chief Information Officer *(until Sept 2024)*	6/6 100%		4/4 (100%)		1/4 25%		10/11 91%		
Becky Cassidy – Director of Corporate and Legal Affairs	11/11 100%	5/5 100%	10/12 83%		9/9 100%	10/12 83%	10/11 91%		7/7 100%
Mr Andrew Furlong* – Medical Director	9/11 82%		5/12 42%	9/11 82%		7/12 58%	3/11 27%		
Julie Hogg* – Chief Nurse	9/11 91%			9/11 82%	2/9 22%**	11/12 92%			6/7 86%
Lorraine Hooper* – Chief Financial Officer *(until June 2024)*	2/4 50%	1/2 50%	1/3 33%	0/3 0%			0/2 0%		
Jon Melbourne* – Chief Operating Officer	10/11 91%		10/12 83%	10/11 91%	6/9 67%	10/12 83%			
Will Monaghan – Group Chief Digital Officer *(from 12 August 2024)*	5/5 100%		5/8 63%						
Michelle Smith – Director of Communication and Engagement	11/11 100%						6/11 55%		7/7 100%
Clare Teeney - Chief People Officer	10/11 91%				7/9 78%				

***** voting members of the Trust Board

** since assuming a Group Chief Nurse role, the UHL Chief Nurse has been committed elsewhere at People and Culture Committee meeting times, and a Deputy Chief Nurse has therefore attended

Corporate Governance report

The table below provides information on the declarations of interests entries made by Trust Board members and attendees for the year 2024/25:

NAME	POSITION	INTEREST(S) DECLARED
Andrew Moore *(Chair from 1 July 2024)*	Group Chair, UHL-UHN (formerly UHL and KGH Non-Executive Director)	• Vice Chair Breast Cancer Now (charity) • Non-Executive Director, Kettering General Hospital NHS Foundation Trust (until 30 June 2024) • Member of the UHL Corporate Trustee Board
John MacDonald *(until 30 June 2024)*	Trust Chairman	• Member of the UHL Corporate Trustee Board • Chair of the University Hospitals of Northamptonshire NHS Group (UHN: Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust) Boards 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 *(until 31 December 2024)*	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
Lee Bond (from 9 Sept 2024)	Chief Financial Officer	• Trustee of the Healthcare Financial Management Association (HFMA) (registered charity) • Member of the UHL Corporate Trustee Board
Mark Brearley *(from June 2024 until 8 Sept 2024)*	Interim Chief Financial Officer	• Director and ownership of Unique Health Solutions Limited (company has been a delivery associate of PA Consulting and Deloitte on specific projects – none currently) • Member of the UHL Corporate Trustee Board
Professor Ivan Browne *(from 1 Sept 2024 – Associate Non-Executive Director prior to that)*	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 *(Board member until Sept 2024)*	Chief Information Officer	• Community Governor, Sir Jonathan North Girls College, Leicester
Becky Cassidy	Director of Corporate and	• Company Secretary for Trust Group Holdings Ltd

NAME	POSITION	INTEREST(S) DECLARED
	Legal Affairs	
Mark Farmer	Associate Non-Executive Director	• Chair Fibromyalgia Friends Together (Volunteer) • Voting Member of NHS England Board's Quality Committee (honorarium paid) • Co-lead of the Adult Mental Health Network at NHS England (worker status) • Associate Visiting Lecturer on the Postgraduate CBT programme for Severe Mental Health problems at the University College of London (worker status) • Chair of the People's Council Leicestershire Partnership NHS Trust (Bank employee) • 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	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	• 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 • Associate, Birmingham City University • Member (Chief Nurse representative), 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

NAME	POSITION	INTEREST(S) DECLARED
(until end June 2024)		
Jill Houghton (from 1 January 2025)	Non-Executive Director	• Non-Executive Director of University Hospitals of Northamptonshire NHS Group • University Hospitals of Northamptonshire Nominated Trustee of Northamptonshire Charities • School Governor at Robert Smyth Academy, Market Harborough.
Jon Melbourne	Chief Operating Officer	• Company Director of (and shareholder in) Ten Five Four Homes Ltd • Member of the UHL Corporate Trustee Board
Richard Mitchell	Chief Executive	• Member NHS IMPACT: National Improvement Board • Chair, East Midlands Acute Providers Network • Deputy Chair, National Cancer Leadership Forum Steering Group • Chair, East Midlands Pathology Network • Chair, East Midlands Cancer Alliance • Chair, Regional Talent and Leadership Board • External consultancy work not exceeding £500-£1000 per year • Member of the UHL Corporate Trustee Board • CEO of University Hospitals of Northamptonshire (UHN) Group
Will Monaghan *(from 12 August 2024)*	Group Chief Digital Information Officer	• advises on the NHS digital academy content and lectures on the course with Imperial College London. Provides occasional ad hoc advice to technology firms based on experience gained in a previous role and not connected with suppliers at UHL
David Moon	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) • Family member has a training contract with PwC • Member of the UHL Corporate Trustee Board
Andrew Moore *(up to 30 June 2024)*	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 *(until 31 July 2024)*	Non-Executive Director	• Management Committee member, Leeds Asian Blind Association • Associate Non-Executive Director, Kettering General Hospital NHS Foundation Trust • Associate Non-Executive Director for East Midlands Ambulance Service • 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) • Member of the UHL Corporate Trustee Board (and Chair of the UHL Charitable Funds Committee)

NAME	POSITION	INTEREST(S) DECLARED
Michelle Smith	Director of Engagement and Communications	• Confirmed no declarations to be made
Clare Teeney	Chief People Officer	• Confirmed no declarations to be made
Jeff Worrall *(until 31 August 2024)*	Non-Executive Director	• Chair of Trust Group 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 (until June 2024)
Andrew Moore	Trust Board (from July 2024) Finance and Investment Committee (until May 2024)
Professor Ivan Browne	People and Culture Committee (from July 2024)
Professor Aruna Garcea	Operations and Performance Committee (from Sept 2024)
Dr Andrew Haynes	Our Future Hospitals and Transformation Committee Quality Committee Remuneration Committee
David Moon	Audit Committee Finance and Investment Committee (from August 2024)
Ballu Patel	People and Culture Committee (until May 2024)
Professor Thompson Robinson	Charitable Funds Committee
Jeff Worrall	Operations and Performance Committee (until August 2024)

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

Role	Non-Executive Director
Senior Independent Director	Vicky Bailey until December 2024, followed by Professor Tom Robinson
Board champion for Maternity Safety	Vicky Bailey until December 2024, followed by David Moon
Board lead for Maintaining High Professional Standards	Allocated on a case by case basis
Vice Chair	Dr Andrew Haynes
Board champion for Freedom to Speak Up	Ballu Patel until July 2024, followed by Professor Ivan Browne
Board champion for EPRR	Jeff Worrall until August 2024

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. Part-way through 2024/25 the Committee moved to quarterly meetings.

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 monthly with a deep dive session every other month, and amongst the standing items which feature on its regular 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, cancer, and elective care. It meets monthly.

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, and meets monthly.

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 2024/25 the UHL Remuneration Committee met on 8 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 2024/25 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 2025 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.

Internal Audit took account of outcomes from their work, including a review of the Board Assurance Framework, in reaching their Head of Internal Audit Opinion for 2024/25.

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.

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 Trust's strategic risks in 2024/25 (as featured on the Board Assurance Framework) are set out below, along with any in-year changes:

Risk event	Executive Lead owner	Oversight Committee	Highest Current Rating	Tolerable Rating	Aim	2024/25 in-year changes
There is a risk of failure to maintain and improve patient safety, clinical effectiveness, and patient experience. This risk arises due to the lack of a fully embedded Quality Governance and	CN / MD	Quality Committee	20	12	6	Sub risk 1 re quality standardisation – no change to score (20) Sub risk 2 re patient experience – reduced from 20 to 16 (Sept 2024). Sub risk 3 re training - reduced from 20 – 12 (Sept 2024). Sub risk 4 re QI & effectiveness - reduced from 20 to 12

Assurance framework						(Sept 2024). Sub risk 5 re Research - reduced from 20 to 12 (Aug 2024) and from 12 to 6 (Sept 2024). Sub risk 6 re clinical staffing – reduced from 20 to 16 (Sept 2024).
There is a risk of failure to meet national standards for timely urgent, elective, and cancer care. This risk arises due to demand overwhelming capacity and delaying access to services	COO	Operations & Performance Committee	20	12	9	UEC, Cancer and Elective care risks remain at risk score 20 (no change).
There is a risk of being unable to address statutory requirements, such as health and safety standards and legislation, and to address backlog maintenance requirements (concerning medical equipment, estate, and IM&T). This risk arises due to insufficient capital funding	CFO	Finance Investment Committee	16	12	9	Capital risk - reduced from 20 to 16 (May 2024).
There is a risk of failure to deliver in line with the financial plan. This risk arises due to significant financial challenges across the LLR system to meet both operational and inflationary pressures	CFO	Finance Investment Committee	20	12	8	Financial sustainability risks reman at risk score 20 (no change).

There is a risk of being unable to provide safe, high-quality, modern healthcare services. This risk arises due to IT infrastructure that is unfit for the future	GCIO	Finance Investment Committee & Our Future Hospitals and Transformation Committee	20	12	9	Sub risk 1 re PAS / technology – reduced from 16 to 12 (Nov 2024). Sub risk 2 re clinical safety process – no change to score (16). Sub risk 3 re cyber and business continuity – no change to score (20). Sub risk 4 re digital procurement – reduced from 16 to 9 and closed (Jan 2025). Sub risk 5 re digital capital – no change to score (16). Sub risk 6 re digital benefits - reduced from 16 to 12 (Nov 2024). Sub risk 7 re digital roles and culture – reduced from 16 to 12 (Nov 2024).
There is a risk of being unable to provide safe, high-quality, modern healthcare services. This risk arises due to estate infrastructure that is unfit for the future	IDEF	Finance Investment Committee & Our Future Hospitals and Transformation Committee	16	12	9	Estates infrastructure risks reman at risk score 16 (no change).
There is a risk of insufficient workforce capacity, capability, and diversity. This risk arises due to failure to recruit, retain, redesign, and transform the workforce	CPO	People and Culture Committee & Finance Investment Committee	20	12	9	People services risks remain at risk score 20 (no change).

Following the launch of the new Trust Strategy at Trust Board in October 2023, 'leading in healthcare, trusted in communities', the strategic risks were 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, backlog maintenance 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 (CQC) and overall the Trust has a rating of Requires Improvement. This has been in place following a well led inspection in 2022. The Trust works closely with the CQC and provides update on performance and service through regular engagement meetings.

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

CQC Inspection Reports 2024-25

In June 2024 the CQC published their Inspection reports for Maternity Services at the Leicester Royal Infirmary and the Leicester General Hospital and Urgent and Emergency Care at the Leicester Royal Infirmary following their Inspection of these services on 10th and 11th January 2024. The reports reflected the Improvements that had been made since both Services since their previous Inspections.

Maternity Services

Following the previous Maternity CQC Inspection in February 2023, when the service was rated as 'inadequate' for the safe domain and 'requires improvement' overall. The CQC issued a Section 29A warning notice to the Trust. A comprehensive improvement programme was put in place to address the concerns raised through the inspection reports and as part of the warning notice.

The CQC report published in June 2024 recognised the significant improvements that had been put in place across the Maternity Service since their last inspection and the Section 29A warning notice was lifted. Maternity Services at both the Leicester Royal Infirmary and the Leicester General Hospital had made improvements that their rating was upgraded to 'requires Improvement' for the safe domain and remains at 'requires Improvement' overall.

Maternity Services are continuing to implement and embed their continuous improvement plan to ensure it improves, treatment, care and services for women and birthing people.

Urgent and Emergency Care

Urgent and Emergency Care at the Leicester Royal Infirmary CQC rating remains overall as Requires Improvement as reported in June 2024. The service had received a Section 29A warning notice following its previous Inspection In April 2022 and this was lifted in 2024, in response to the improvements made throughout the Urgent and Emergency Care service.

Continuous Improvement work continues in both Urgent and Emergency Care and Maternity Services within the Trust and across the System to drive improvements in patient care and experience. The Trust recognises that it will take time to make fundamental and long-lasting change and are committed to making the Trust a great organisation to receive care in and a great organisation to work for.

2024 Services Ratings

Leicester Royal Infirmary

2024	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Maternity	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

2024	Safe	Effective	Caring		Well Led	Overall Rating
Urgent and Emergency Care	Requires Improvement	Not Inspected (Previously Good)	Not Inspected (Previously Good)	Require Improvement	Good	Require Improvement

Leicester General Hospital

2024	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Maternity	Requires Improvement	Not Inspected	Not Inspected	Not Inspected	Require Improvement	Requires Improvement

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). In 2024/25, we carried out an preliminary desktop assessment of our position against the 8 Quality Statements underpinning the CQC question "Is the organisation well led ?", and presented this assessment to the UHL Audit Committee.

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

Implemented in January 2022, UHL's Green Plan sets clear targets to achieve net-zero carbon emissions for Scope 1 and 2 by 2040 and Scope 3 by 2045. The plan strategically focuses on reducing carbon emissions, single-use plastics, and air pollution, enhancing the sustainability of patient care and staff environments.

Structured into several dedicated sub-groups, the Green Plan targets specific sustainability areas:

11. **Workforce and System Leadership:** Empowering NHS staff and leaders to champion sustainability initiatives.
12. **Sustainable Models of Care:** Redesigning care pathways to minimise environmental impact.
13. **Digital Transformation**: Leveraging digital technologies to reduce carbon emissions.
14. **Travel and Transport:** Promoting sustainable travel options for staff and patients.
15. **Estates and Facilities:** Enhancing the sustainability of NHS buildings and facilities.
16. **Medicines:** Reducing the environmental footprint of pharmaceuticals.
17. **Supply Chain and Procurement:** Ensuring sustainable practices in procurement processes.
18. **Food and Nutrition:** Providing sustainable and healthy food options.
19. **Adaptation:** Preparing for the impacts of climate change on healthcare delivery.
20. **UHL Carbon Footprint:** Baseline carbon footprint of UHL.

In 2024, two additional areas were introduced to enhance sustainability efforts:

3. **UHL Sustainability Plan**
4. **Green Team**

Since its implementation in January 2022, the Green Plan has been a guide for UHL's commitment to environmental responsibility and NHS England's Net Zero objectives, aiming to reduce carbon emissions, air pollution, and single-use plastics. With the existing plan concluding in 2025, the Sustainability Working Group has been actively monitoring and updating progress to ensure a smooth transition into the Refreshed Green Plan. The release of the NHS England Refresh Green Plan Guidelines on 4th February 2025 has set a deadline of 31st July 2025 for approval and publication of the Refreshed Green Plan, reinforcing the Trust's need to prioritise sustainability efforts. Additionally, in 2025, the failure to prioritise Green Plan actions will be formally added to the Trust's risk register, highlighting the importance of continued focus and accountability in delivering on sustainability commitments.

The Green Plan is aligned with the Trust's Quality, Clinical, People, and Digital Strategies, operating within the framework of the Trust's overarching corporate priorities and strategic drivers.

To effectively implement the Green Plan, UHL will follow the following strategic approach:

1. **Governance:** Oversee sustainability efforts through Sustainability Working Group, audit committee, Our Future Hospitals Transformation Committee, and Trust Board.
2. **Stakeholder Engagement:** Involve staff, patients, and partners in co-designing sustainability initiatives.
3. **Target Setting:** Define clear SMART actions (specific, measurable, achievable, relevant, and time-bound) with clear KPIs for each action point.
4. **Legality:** Ensure legal compliance, including obligations to reduce inequalities, fulfil the Public Sector Equality Duty, and consider wider impacts of decisions.
5. **Monitoring and Reporting:** Implement systems to track progress and report outcomes transparently.

UHL is committed to aligning its reporting with the Task Force on Climate-related Financial Disclosures (TCFD) framework, in accordance with the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and HM Treasury's public sector guidance. This year's Annual Report reflects our progress in addressing the Stage 2 TCFD disclosure requirements on a 'comply or explain' basis, with reporting aligned to the three TCFD pillars: governance, risk management, and metrics and targets.

UHL is aware of TCFD governance requirements and is working towards compliancy with TCFD metrics and targets. These will be addressed in the next reporting cycle as part of the implementation of the Refreshed Green Plan 2025-2028. The Trust remains committed to enhancing the transparency and robustness of its climate-related financial disclosures, and to embedding climate resilience as a core aspect of its operational and strategic planning.

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

As Accountable 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 Accountable 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 (IG). The Group Chief Digital 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 (DSPT). This financial year the DSPT has also encapsulated a Cyber Assessment Framework (CAF) to ensure Organisations can assure a more embedded Cyber Security environment. The DSPT contains 18 principles of good practice, spread across the 5 domains identified below:

A. Managing Risk
B. Protecting against Cyber Attack and Data Breaches
C. Detecting Cyber Security Events
D. Minimising the impact of incidents
E. Using and sharing information appropriately

Due to the addition of CAF - this represents a significant change in the way DSPT is reported from previous years and NHSE have stipulated that full compliance in the 5 domains is achieved by 2029. The Trust has developed a strategy to meet this compliance that details the resource and funding requirements.

We can confirm for the financial year 2024/25 we logged no concerns with the Information Commissioner's Office (ICO) that were deemed suitable for escalating. ICO reported 2 breaches to us which were upheld and learning was put into place to ensure processes were robust. 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 Information Governance Team have continuously worked towards forming robust ongoing IG assurance and have automated business as usual information governance processes via our Dashboard Tool. We are now working to include the Digital and Technical Assessment Criteria (DTAC) into our tooling that will also incorporate Artificial Intelligence (AI) applications we introduce to our environment. This will ensure that we

continue to meet the digital demands of supporting the Trust by ensuring safe and effective governance processes.

The Information Governance Team is supporting the wider Digital & Data strategy to ensure that we are aligned to our one digital programmes and initiatives and NHS England 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 chaired monthly by the Group Chief Technology Innovation Officer, provides assurance on the quality of data reported to the Trust Board. The forum is a multi-disciplinary panel includes representation from 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. We have a Data Quality dashboard that is used to support administrative leads in the specialties to reduce data inaccuracies.

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 NHS Digital Data Quality Maturity Index is used for benchmarking against 17 peer Trusts. Data quality and clinical coding audits are conducted in line with Data Protection and Security Toolkit ensuring compliance with mandatory standards. 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 working with partners to explore artificial intelligence and automation solutions to address workforce capacity challenges in clinical coding.

The Trust Leadership Team receives quarterly reports on the Data Quality and Clinical Coding, reinforcing a commitment for continuous improvement and excellence in data management.

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 Trust's 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 2024/25, 9 opinion-based audits were completed (in addition to 4 advisory reviews [no formal opinion] and 1 NHSE opinion level review) and the status of those audits at the end of the year was:

Audit	Opinion
Clinical Management Group governance	Significant Assurance
Board Assurance Framework	Significant Assurance
Accounts Receivable	Significant Assurance
Accounts Payable (split opinion)	Significant Assurance
Budget setting, reporting and monitoring and revisit of journal and control account reconciliation controls	Significant Assurance
Complaints	Significant Assurance
Data quality: outpatients	Moderate Assurance
Procurement	Moderate Assurance
Equality, diversity and inclusion	Moderate Assurance
Accounts Payable (split opinion)	Weak Assurance

Leadership and Strategy

Outside of our formal meetings, the Trust Board has continued to hold development sessions throughout the year, to enable deep dives into a variety of topics.

Head of Internal Audit Opinion

A "*significant assurance*" opinion was provided concluding that *"there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently".*

The opinion *recognises the improvements the Trust has made to its internal control environment, particularly in respect of key financial systems where, in the main, significant assurance opinions have been provided. This indicates a positive direction of travel for the Trust despite the overall financial challenges. Internal processes for implementation of actions has improved with 77% of high and medium risk actions being implemented by the dates agreed. The overall implementation rate is good at 94%. However, there is scope to improve the timely completion of high risk actions as only five of nine were closed on time.*

For transparency and comparison, below shows the overall opinion over the last three years.

Opinion 22/23	Opinion 23/24	Opinion 24/25
Limited	Moderate	Significant

The table above shows the improvement year on year to strengthen the internal control environment at UHL. The organisation has been through unprecedented financial challenges over previous years, and the efforts taken place over those years to repair and re-establish systems and processes has been significant. The progress in obtaining an improved Head of Internal Audit Opinion over the last three years shows positive progress and it is now important that as an organisation it continues to embed and sustain a robust system of internal control.

Financial oversight

Following the completion of an intensive amount of work in a concentrated period of time, the Trust secured a clean unqualified audit opinion for the first time in 5 years in 2023/24, which has been maintained in 2024/25, as the improvements in financial reporting controls implemented in previous years were embedded.

The Trust submitted its 2024/25 accounts in accordance with the national timetable to ensure consolidation with the National NHS accounts.

In 2024/25, the key requirements for acute providers within health systems was to maintain the increase in urgent and elective capacity established in 2023/24, complete agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients, within agreed financial envelopes. The overall financial regime remained unchanged, including the commissioning payment approach used to support elective recovery.

The original financial plan for 2024/25 forecast a £65m deficit. The Trust was allocated non recurrent financial support through its main commissioner contract, equivalent to this sum, such that the plan target was reduced to breakeven. 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 £37.2m deficit, against this revised break-even plan. This was driven by non-delivery of the savings program, increased costs of providing urgent and emergency care as a result of unplanned growth in demand, and other pay pressures.

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

The Trust remains committed to achieving sustained financial recovery and using its resources as productively as possible to optimise the care of its patients, recognising the size of the financial challenge continues to be unprecedented.

The Trust delivered £69.4m of savings in 2024/25 against an exceptionally challenging efficiency target of £92m (under delivering by £22.6m). This target increased substantially from £64m in 2023/24. The Trust is developing a medium-term financial plan aligned with system partners that focuses on a return to a sustainable financial position.

The Trust has an established programme of workstreams to help deliver financial sustainability through strengthened grip and control, a continuous focus on efficiency and improving year on year productivity. Specific improvement programmes focus on elective care (theatres, outpatients), urgent and emergency care (UEC), patient safety, and continuous improvement. Each of these work programmes directly or indirectly enables our operational and corporate areas to deliver their targeted financial improvement.

The Trust has agreed an operational plan for 2025/26 in conjunction with its system partners which continues to include a challenging CIP requirement of £92 million, in order to deliver a £65m deficit, representing c9% of operating expenditure.

Discussions have been and continue to be held with NHSE, which confirms the intention to agree a long-term financial plan which secures a breakeven position by 2027/28. Previous plans submitted have been superseded by changes in the NHS financial regime and Trust performance. The Trust remains committed to achieving financial sustainability and financial recovery in the longer term, but this remains a weakness until this state is achieved. Key to achieving sustainable finances is delivery of a challenging but achievable cost improvement programme (CIP). In 2024/25, the target set was £92m, with £70.0m relating to recurrent savings. The Trust fell short of achieving this target, achieving total CIPs of £69m, being £28m recurrent and £41m non-recurrent (and therefore more heavily weighted to non-recurrent savings than initially planned). Looking forward, the Trust has identified CIPs of £92m for 2025/26, within our planned adjusted financial performance of breakeven. As at June 2025, the current level of identified CIPs totals £49m and we are currently performing a number of activities in order to identify the remaining schemes, including but not limited to; identifying both CMG and Executive-led work streams, establishing a cross-functional Results Delivery Office (RDO) with weekly meetings to monitor progress/interrogate delivery data/and agree key decisions, monthly CFO/COO meetings with each CMG specifically on CIPs and the development of a framework for identifying a structured pipeline of high impact schemes. Despite this improvement, considering the non-achievement of the identified 2024/25 CIPs as well as the current level of ‘unidentified’ CIPs, the Trust is again at risk of not meeting the CIP plan. The arrangements to identify robust CIP schemes and weakness therefore remains.

Financial Governance

Work continued throughout 2024/25 to embed the financial improvements made to the financial control environment in 2023/24 and preceding years. This was reflected with a significant assurance opinion (moderate in 2023/2024) received from our internal auditors in relation to our key financial systems.

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. The Trust Leadership Team ensures 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 outsourced the internal audit function to 360 Assurance during 2024/25. External audit is undertaken by KPMG. The implementation of recommendations made by Internal and External Audit are systematically overseen by the Audit Committee.

Conclusion

I believe the 2024/25 annual governance statement has demonstrated the improvements which have been made in continuing to strengthen the grip and internal control at the Trust. Despite the progress made, there remain internal weaknesses relating to the Medium Term Financial Plan and Cost Improvement planning, as noted in the financial oversight section above. I fully acknowledge there are 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 significant assurance opinion issued for the 2024/25 Head of Internal Audit Opinion. I believe the progress made in year is noticeable and this will continue into 2025/26.

Richard Mitchell
Chief Executive

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
25 June 2025

Staff Report:

Staff numbers (Headcount)

	2024/25	2023/24
Summary	Headcount	
Medical and Dental	2,577	2,417
Administration and Estates	5,537	5,443
Healthcare Assistants and other support staff	3,723	3,755
Registered Nursing and Midwifery	5,903	5,428
Scientific, Therapeutic and Technical	2,169	2,093
TOTAL	**19,909**	**19,136**

Staff composition (by gender)

Senior Manger Gender Split by Pay Band as @ 31st of March 2025

	Headcount		WTE		Totals	
					Headcount	WTE
	Male	Female	Male	Female		
Band 8A	151	514	141.89	464.73	**665**	**606.62**
Band 8B	72	131	69.75	123.85	**203**	**193.59**
Band 8C	25	74	24.00	70.63	**99**	**94.63**
Band 8D	15	32	14.80	30.46	**47**	**45.26**
Band 9	15	22	14.80	21.91	**37**	**36.71**
Very Senior Manager (VSM) PayBand	8	9	8.00	8.60	**17**	**16.60**
Senior Manager Totals	**286**	**782**	**273.23**	**720.18**	**1068**	**993.41**
Overall ESR Staff Total	**4,873**	**15,036**	**4,566**	**12,979**	**19,909**	**17,545**

Sickness absence data

Clinical /Corporate	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Cumulative Position
358 Clinical CMGs	4.54%	4.63%	4.60%	4.82%	5.08%	4.71%	5.15%	5.65%	5.34%	5.59%	5.49%	5.46%	5.09%
358 Corporate	4.36%	4.11%	3.92%	4.38%	4.43%	4.35%	4.91%	5.01%	5.24%	5.20%	4.64%	4.31%	4.57%
UHL	4.51%	4.54%	4.48%	4.74%	4.97%	4.64%	5.11%	5.54%	5.32%	5.52%	5.35%	5.26%	5.00%
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 (7%)

	2024/25	2023/24
Summary	WTE	
Medical and Dental	2,427	2,277
Administration and Estates	4,768	4,659
Healthcare Assistants and other support staff	3,172	3,220
Registered Nursing and Midwifery	5,256	4,799
Scientific, Therapeutic and Technical	1,922	1,846
TOTAL	**17,545**	**16,801**

Staff engagement – the NHS National Staff Survey

The NHS Staff Survey was carried out in October and November 2024, 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.

The annual staff survey is the primary measure of UHL's culture and the lived experiences of our 18,700 colleagues. A full census survey was undertaken, which means that all staff were eligible to take part and would have received a survey to complete. We have doubled our staff survey response rate from 33% in 2020 to 65.7% (12,700 colleagues) in 2024. We have also seen significant improvements over the past 4 years across all themes of the survey (We are compassionate and inclusive, we are recognised and rewarded, we each have a voice that counts, we are safe and healthy, we are always learning, we work flexibly, we are a team, engagement, and morale) and most sub themes. These improvements have resulted in UHL being above benchmark average for Acute Trusts across all themes of the staff survey. A key staff survey engagement question is, 'Would you recommend your Trust as a place to work?' In the 2024 survey, 65.5% of UHL colleagues did, which ranks us 29th (top quartile) in the NHS out of 122 Acute trusts, up from 38th in 2023.

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. These improvements have been made against a challenging national picture. UHL will continue to use the staff survey results to further improve the experiences of all colleagues who work at the Trust and who make these improvements happen.

Our aspiration for 2025 is to continue to build on our progress in 2024 and to work together to make UHL a place where more people feel:

Recognised: 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 what they need to carry out their roles and becoming an organisation you can rely on.

Implementing the People Strategy, including developments in Occupational Health

Our People Strategy, A great place to work, 2025-2030 is underpinned by our Trusts strategic framework, values and behaviours and aligns to our EDI strategy and National People Plan. Our people are our most valuable resource and each one of our 18,000 staff play an important role in ensuring we deliver safe, effective, and high-quality care to the 1.1 million population we serve across Leicester, Leicestershire and Rutland. Our core aim is to be a great place to work;

Innovation and new ideas are the cornerstone of organisational improvement, and we recognise that these only come from our people. We want our people to always feel able to suggest new ways of doing things and, as an organisation, we want to listen and learn from our people.

Our People strategy describes three key themes for action over the coming five years to support and care for our people and strengthen our capabilities as an organisation. They are:

- Culture – promoting a culture that embodies our Trust values and behaviours
    - Staff and learner experience and engagement
    - A sense of belonging for all (equality, diversity & inclusion)
    - Compassionate and inclusive leadership that promotes healthy cultures that foster psychological safety

- Capability - Harnessing and developing the talents of all our people, to ensure we are a high performing, capable and skilled organisation
    - A safe & healthy workplace and workforce.
    - Harnessing the talents of all our people.
    - High performing leadership and management development framework.

- Using our resources well to ensure that we are maximising our organisational capacity to optimise productivity.
    - Maximising partnership working with our partners.
    - Accelerate the use of digital (systems, processes and skills).
    - Strategic workforce planning to enhance productivity.

Health and Wellbeing

From the 2024 survey results we saw an improvement in the proportion of colleagues feeling that UHL takes positive action on health and wellbeing (61.5%) as well as an improvement in those that think their immediate manager takes a positive interest in their health and wellbeing (70.7% to 71.2%)

During 2024 we introduced three levels of mental health training for line managers and

colleagues. Level 1 – Mental Health Awareness training, that had 180 places booked up within 2 weeks, Level 2 – REACT MH training and Level 3 – Suicide Awareness Training for Managers which launched in June 2024 and have now trained over 130 managers.

The Report + Support portal went live for colleagues on 23 October as an additional route to report sexual harassment, as well as other unwanted behaviours such as racism, bullying and discrimination. This is in line with the Sexual Safety Charter. If colleagues leave contact details, they are followed up with a Care + Support conversation with a member of the Health and Wellbeing Team.

The Winter Health and Wellbeing Hubs were set up to take information out to colleagues and be on hand to talk to them about their health and wellbeing. They commenced in September 2024 and ran every week for 6 months. We held 26 hubs, speaking to over 600 people about their health and wellbeing.

UHL celebrated World Menopause Day on 18 October. Information stands were held in restaurants, and 130 colleagues came along to talk and pick up support information. 40 colleagues joined us for the Wellbeing Webinar, 'Me and my Menopause' and 15 people joined the online Schwartz Round. The new, UHL Menopause Policy also went live on this day, as part of the 'You Matter Colleague Support Policy'.

Amica

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 Utilization: The referral rate into our counselling services has seen a 14% increase since 2024-25, resulting in over 3788 one-to-one client sessions. The feedback from clients indicates significant and substantial reductions in distress levels. Additionally, we have facilitated 366 online support conversations.

Client Satisfaction: Feedback from our clients reflects a remarkable overall satisfaction rate of 4.8 out of 5.

Resource Utilization: The Amica website's resource page has been visited 3,001 times. It has been added to our web page on UHL Connect which increases this to 6930. Furthermore, our 24/7 phone support line, accessed 3865 times, ensures continuous mental health surveillance and safety. The SilverCloud CBT program has been utilized in 1263 sessions with a 94% satisfaction rate.

Outreach and In-person Support: In 2024-25, Amica has delivered over 639 sessions of outreach across UHL, equating to over 910 hours. Our dedicated team of Counsellors

and Clinical Psychologist have extended specialised support to various departments, including the Emergency Department, Maternity, and Neonatal teams.

Occupational Health

- Over 4,900 employment checks have been undertaken for UHL staff. This has resulted in 'New Starter/EPP clearance/Pre employment screening' appointments (1,400) being provided by Occupational Health
- Approximately 2,500 management referral appointments have been provided. These important assessments of fitness for work and provision of advice surrounding disability and reasonable adjustments help support both staff and managers.
- Approximately 11,000 Flu and Covid vaccinations delivered safely
- Approximately 14, 200 tests and other vaccinations delivered in accordance with Occupational Health standards
- The OH service retains its external quality assurance kitemark (SEQOHS) following an independent inspection.
- The OH service continues to contribute to the Trust's wider Health and Safety and Infection Prevention and Control agenda

Learning and Development Service Overview

Ensuring all of our employees have access to the right skills and knowledge at the right time and in the most accessible way has continued to be to be key during 2024/25. Through a range of sub teams and work streams within Learning and Development, the department has provided a flexible blend of learning across our whole portfolio to meet the needs of our learners and the Trust during the last year and continues to support the attraction, recruitment and development of our workforce.

Appropriate learning and development needs continue to be identified through the appraisal process within CMG's and enables employees to work towards gaining the skills and qualifications that will meet both the needs of the organisation to improve patient care, delivery of services and develop the individual within their role and long-term career.

Core Learning and Development Activities

Induction
The department continued to support welcoming new starters to UHL and co-ordinating the organisation's Corporate Induction programme. This process includes issuing the

new starter with their email address and name badge to enable them to be up and running as soon as possible. April 2024 saw the relaunch of the face-to-face weekly induction and the launch of the first 90 days programme which provides new starters with a warm welcome and the tools to support them at the start of UHL journey. During 2024/25, 2005 of 2063 (97%) colleagues attended across weekly face-to-face or one of four remotely hosted induction.

Ad hoc Courses
During 2024/25 Learning and Development continued to support and enable our hospital to provide a service to our patients, there were nine core business courses (Appraisal, Assertiveness, Planning for Retirement, Manager Workshops, Mentoring, Telephone Skills, Minute Taking, Job Hunt and Being Interviewed) led by the team that continued to run to support the core service which were attended by 362 employees. Bespoke training and support was offered and well received by a UHL department facing Agenda for Change, during the latter part of 2024, comprising job application and interview skills

Through the team UHL offers a wide range of apprenticeships and other courses e.g. telephone skills, report writing, mentoring, academic writing and minute taking. This is achieved by working together with local colleges and private training providers to support workforce development needs. The department also work with People Partners to support bespoke pieces of work linked to e.g. redeployment exercises.

Core Training Team

Learning Management System

The Core Training Team are responsible for the management of the HELM system on behalf of the Trust. They are the central cog within the Trust which enables colleagues to access their Statutory and Mandatory Training.

Monitoring Mandatory Training Compliance for UHL

Learning and Development monitor the compliance on behalf of UHL and compile monthly reports. Employees compliance on 31/03/2025 remained at 94% against a target of 95%.

More than 130,000 targeted reminders have been sent to non-compliant employees as well as bespoke work to support Q4 compliance improvements across all CMG's.

CMGs are still encouraged to ensure that action plans are in place to sustain/improve performance against all programmes. Mandatory Training continues to be supported by the provision of e-learning programmes aligned to the national Core Skills Training Framework (Skills for Health).

eLearning Authoring Service

In 2024/25 Learning and Development authored 20 new programmes in partnership with subject matter experts. A further 150 programmes have been updated and amended.

UHL currently now has 32 eLFH live on HELM for staff to access. There are currently 247 modules live on HELM for colleagues to access.

Learning and Development capacity was redirected (from HELM helpdesk, admin and IT Training team) to support this continued increase in volume of work and the recently purchased tool called Vyond has also been utilised.

HELM User Utilisation and Support

Across all eLearning topics 2024/25 has seen over 306,000 modules being completed on HELM.

Subject Matter Experts have been supported as they navigate 2024/25 including ensuring Post Graduate Doctors in Training receive the right training on joining UHL at different points of the year.

More than 500 new accounts have been set up outside of the automated feed from ESR to ensure colleagues can complete their training before or on joining UHL.

HELMs live dashboard functionality has more than 2950 managers and employees with access to live training data.

The Pure Reporting functionality on HELM gives almost 1,300 of the senior administrators of the system access to data interrogation functions to help them manage their local risks and training plans.

User feedback suggests they find it easy to navigate and use. Managers and trainers are finding the Dashboard beneficial in chasing non-compliance and the CQC were happy with the training data they received from HELM. This has proved an important tool to ensure 24/7 quick access to training data in support of safety when colleagues are moving to areas of work or roles they typically haven't worked in previously.

HELM Functionality Development Work

Development work on the structure of the course directory has occurred in 2024/25 to support the Trusts' focus on the acquisition and utilisation of training data. The Dashboard reporting function on HELM has had new data fields added to enable more granular data reports to be generated. The Course Catalogue has been expanded to allow easier search functionality for users. The Dashboard has also been expanded to allow training data to be gathered without the need for it to added to staffs 'Required Training' pages, this means staff are not allocated the training but levels of compliance can still be monitored.

Functional Skills

Learning and Development host the NHS funded BKSB tool for UHL. This tool enables all employees, but more specifically apprentices, to assess where they are with English, math and Digital Skills levels. This shows if they could take an exam, if their knowledge has slipped since they gained a qualification and also helps them to define a learning pathway bespoke to them, for free, at their own pace. The BKSB tool also hosts the Dyslexia and Dyscalculic indicator tools which colleagues can access.

Following national changes, Learning and Development continue to host and utilise ECCTIS, the national tool to check the equivalency of math 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, who support UHL colleagues' access with functional skills qualifications at levels 1 and 2 in English and math. These skills help not only their working lives and career prospects, but home lives, their families and local communities too.

From February 2025, apprentices who started on their programme on or after their nineteenth birthday are no longer required to achieve functional skills qualifications in English and math. Leicester College and the Centre continue to support both younger apprentices and those whose skill require these qualifications for their job role.

The data we collect on participation and outcomes is for all UHL staff, not just apprentices, helps us to understand and support wider workforce development needs across the organisation.

IT Training Team

Over the last 12 months the IT Training Team have continued to deliver training to staff ensuring they have the knowledge and skills needed to use current IT systems. During the last few months the regular training schedule has reduced to support other projects. The main work stream is the teams increased involvement with the implementation of the new UHL IT patient information system, NerveCentre.

NerveCentre will replace many old IT systems currently in use at UHL, LLR and other Trusts who link with UHL to support patient care outside of Leicestershire. As the implementation progresses and the 'go-live' date gets closer, the team are heavily involved helping to develop and test different learning material such as eLearning, user guides as well as testing new functionality and workflows within the application. They have also supported several user workshops to discuss current and future processes.

The IT Training Team also provided training for staff working in the new East Midlands Planned Care Centre, (EMPCC) which successfully opened in December 2024

The team have continued to deliver training to employees responsible for regulating and updating information on UHL's website which allows patients and staff to access accurate, up to date information and guidance.

Apprenticeships

Apprenticeships for UHL Colleagues

Through the apprenticeship levy, which was introduced nationally in May 2017, Learning and Development have supported employees in accessing Apprenticeship Education Programmes.

The Levy pot is funded from the government top slicing the UHL pay budget each month by 0.5%. This money can be spent solely on apprenticeship programme course fees.

During 2024/25 we had access to a levy pot of £8,103,678. UHL spent £2,740,487.54 of levy in 2024/25.

Levy that won't be spent can be transferred to other organisations outside the UHL Apprenticeship and Development Centre's customer base, up to a nationally provided amount of 50%.

UHL's transfer allowance for 2024/25 was £1,926,023. Currently there have been 208 non UHL employees supported by the UHL surplus levy across 34 employers; totaling a commitment of £1,375,717 over the years we have utilised levy transfers.

Unspent levy that isn't being used by UHL and isn't being transferred to another organisation is returned to the Government after 24 months. In 2024/25 UHL returned £609,792.

As a levy employer our internal apprenticeship team have used the levy to meet CMG workforce needs and have now procured, contracted and supported 1966 UHL colleagues on Apprenticeship Education Programmes with 58 providers in a vast range of programmes at levels 2 through to level 7 since 2017. In 2024/25, a record 380 UHL colleagues enrolled on apprenticeship funded programmes, giving UHL's highest number of programme enrolments per year in 8 years and results in 645 colleagues currently in learning on apprenticeship programmes. In 2024/25, 149 colleagues completed their apprenticeship taking the total completions since 2017 to 766.

Around 24% of apprentices are new to the Trust with the remaining 76% being current colleagues at UHL developing their skills, knowledge and behaviours for their current role or career.

From the UHL enrolled colleagues in 2024/25, 26.5% are learning with our own internal UHL Apprenticeship and Development Centre with the remaining 73.5% learning with externally procured training providers. Since the launch in 2017, 742 (38%) apprentices from UHL have had their learning delivered through the UHL Apprenticeship and Development Centre and 1,224 (62%) of programmes have been delivered via external training providers. This helps retains the levy spending within the Trust.

We anticipate the offer of apprenticeships will continue to grow aligned to the emerging standards and digital workforce needs across the system. It has been announced that using levy funding for any new enrolments in Level 7 apprenticeship programmes will likely be stopped in the future, so the growth will come from levels 2 to 6.

We have in place masterclasses and awareness sessions across a range of topics to compliment apprenticeships including a mentoring masterclass and employability skills e.g. The Job Hunt and Being Interviewed. Apprentices can also access modules on Staying Safe Online, Modern Slavery and County Lines, Telephone Skills, Boundary Management, Minute Taking, Workplace Behaviours etc. which have also been sourced and delivered to support learners' development. We have a recorded session for new managers of apprentices on our UHL Connect page and are planning a termly face to face Manager Forum.

We offered a variety of 26 different information sessions to employees during National Apprenticeship Week 2025. The theme, 'Skills for Life' included the opportunity for managers to understand the support available and opportunities to build their team with the levy funds and for potential learners to find out more about the range of apprenticeship opportunities from external providers and our in-house provision.

Promotion of good news case studies on social media, Twitter and UHL Facebook are routinely in place with videos of employees' successful experiences now available our Apprenticeship page on Insite.

UHL Apprenticeship and Development Centre

Our externally accredited UHL Apprenticeship and Development Centre is committed to providing learning and development opportunities to both employees in UHL, LLR and in the wider NHS through hybrid and blended learning approaches. Working closely with employers this work supports us in developing the workforce we need to deliver our services to patients.

The Centre delivers 5 apprenticeships through the Learning and Development Team; Business Administration Level 3, Team Leader Level 3, Customer Services Level 2, Health Level 2 and 3. The Centre also delivers nationally accredited screening qualifications e.g. Newborn Hearing, Diabetes Eye Grading. The Centre delivers 1 apprenticeship through the Nursing Development Team; Student Nursing Associate (NMC 2018) Level 5 and the Department for Education work to support this, comes via

the Learning and Development team.

In 2024/25, the Learning and Development team governed income of £1,108,916.89 for the internal delivery of apprenticeships with £154,302.70 being earned by the Learning and Development team.

Since gaining main provider status with the Education & Skills Funding Agency in 2017 (reconfirmed in 2019 and 2022) we continue to develop and monitor our quality provision and deliver training to Education & Skills Funding Agency and Ofsted requirements.

October 2021 saw a full OFSTED inspection take place where the overall effectiveness of the Centre was evaluated as ‘good’. The themes inspected were quality of education, personal development, leadership and management and apprenticeships; all being evaluated as good. Behaviour and attitude theme was evaluated as outstanding.

OFSTED inspectors noted “Apprentices rightly feel very positively about the new skills, knowledge and behaviours that they develop through their studies” and “They enjoy their learning”. Inspectors found that the Centre had “developed a curriculum that meets the needs of the healthcare profession well” and “have selected and adapted courses to tackle local and national skills shortages in nursing and healthcare assistant roles”. It was positive to read that OFSTED found Centre “Leaders place a heavy focus on apprentices’ personal development, such as supporting apprentices to live healthy lives. Leaders devise activities to help apprentices understand the diverse local population that they serve, the importance of equality at work, and fundamental British Values”.

As a training provider, and in addition to our own robust monitoring of training provision, we welcome partner organisations to monitor our training delivery, including MATRIX accreditation, City & Guilds, Pearson’s and Highfields.

Our Centre team of competent Facilitators and Practitioners support the development of new skills, knowledge and behaviours required in apprenticeship standards and associated qualifications, as well as support and prepare learners to be confident and competent individuals for their journey to the external end point assessment and beyond. The centre achieved a Qualification Achievement Rate (QAR) for the 2023/24 academic year of 75.2% which was a significant improvement on the previous year. The national average QAR was 54.3%.

Programmes continue to evolve and respond to post pandemic employer and learner needs with updated curriculums that support hybrid and blended learning. Recruitment challenges have impacted on new starts in both Customer Service and Business Admin. There were 6 new starts between April 1st 2024 and 31st March 2025 in Customer service and 8 in Business admin compared to 12 and 11 the preceding year.

2024/25 continues to see an increase in the need for additional pastoral support for learners to help them adapt to life, learning and work. This has led to a full review of

learner needs and a successful business case for the Cognassist tool which was purchased in 2024/25. This supports learners understand how they receive, process and retain information. The work with Amica, which enables from enrolment touchpoints without referral continues; they are invited to meet with a counsellor from day 1, without referral and can then reconnect at any point during their learning without additional referral if the need arises. This compliments the termly wellbeing checks all learners receive and the safeguarding checks for those that are highlighted as vulnerable. The ambition of the Centre is to develop and support the whole learner and ensure that enrichment activities and learning occur across the programme to support their life outside of work and their careers/employability.

A third cohort of Trainee Assistant Practitioners (TAPs), from our UHL Theatre Team successfully completed their apprenticeship at the end of 2024. To date 70% of previous apprentices on this programme have progressed to the ODP Degree apprenticeship with the University of Leicester. Despite its high success rate the TAPs will no longer be delivered in house, due to recent Government changes necessitating university delivery/affiliation. One solution, offered by the Centre, to deliver the Programme at Level 3, still meeting ODP entry requirements has not been accepted.

We continue to be the regional provider for the new Public Health England screening qualifications and the national provider for Diabetic Eye screening and Newborn Hearing Screening. Challenges on enabling course fees to transition to the delivery team have been experienced continuously in 2024/25.

So far in 2024/25, we have 20 UHL learners on the screener programme, with 8 UHL learners having successfully completed their Screener Diploma. One of the ongoing challenges is the ability to cross charge within UHL, this can impact funding and internal process. The most recent awarding body visit was very successful, and during a meeting with NHS England it was highlighted that UHL is one of only three providers nationally offering the screener diploma.

Governor's arrangements continue to be robust and well supported with a range of internal and external governors. Learner & Manager Voice remains a useful tool for evaluating our Apprenticeship Education Programmes. Both are collected via e-mail three times a year and fed into Programme Board with further summaries of these programmes at the governors meetings. This supports ensuring delivery of programmes meets employer and learner needs.

Learner Blog newsletters continue to be issued twice monthly and cover a wide variety of current topics and issues including modern slavery, drink awareness, wellbeing and staying safe online. The blog continues to have spotlight features on 'Focus On' which recognise the achievement of a learner or group of learners, 'charity focus', 'citizenship' and 'functional skills' articles.

Success during academic year 2023/24 (ending July 2024) comes in many forms

including the UHL Apprenticeship and Development Centre achieving 91 learner completions; 42 in Learning and Development. 24.2% gained a distinction and 8.8% gained a merit. It should be noted that for some programmes a ‘pass’ is the highest grade available. A further 122 learners from across LLR enrolled on programmes in this period with 7% withdrawing post enrolment. Our Health Levels 2, 3 and 5 continues to have a 100% pass rate for those completing the course.

The graduation event run by Leicester Employment hub was well attended by a range of learners from both UHL and the UHL Apprenticeship and Development Centre. This is a great opportunity to celebrate the learners’ hard work and achievements.

Workforce Development

Work Experience
2024/25 has provided some opportunities for physical work experience due to service pressures. In 2024/25 262 placements took place at UHL. Work experience systems have been maintained and continue to be refreshed with new placement opportunities, career journeys and information. Development work to feed back to the team has been conducted to ensure an overview of accepted placements is known.

Careers Development

Directions Service
In October 2023 and after a 3 day full inspections the Centre successfully regained their full MATRIX Standard external accreditation for offering impartial and confidential Information, Advice and Guidance (IAG) on career development. In 2024 the service was also successful in showing how they continue to develop and improve the service to ensure the Centre meets their yearly review. New processes and improved quality assurance and impact evaluations are being developed.

Careers Café and Learner Celebrations

In September 2024 we launched the first internal Learner Celebration and Careers Cafe where we celebrated the achievements of 23 learners from Apprenticeships, Functional Skills and Graduate Management Trainee Programme. This was well received and a great opportunity for colleagues to look at how they could stretch within their current role and develop their career. Stalls on employability skills, functional skills and a range of apprenticeships were available as well as the Directions Service.

Focus Weeks

Focus weeks for National Apprenticeship Week, National Careers Week, Learning at Work Week and Festival of Learning continue to be planned for and supported by the Learning and Development team. These include a range of information and activities e.g. career café, bite size learning sessions, recommended reading, functional skills

information etc.

Career events

In 2024/25 33 events have been attended this year in partnership with UHL Health and Social Care Ambassadors. These range from traditional stalls, speed networking, interview practice, class talks. The NHS career event was run at Leicester Race Course with approximately 2,500 local residents attending to find out about careers in health and social care. It was well attended by stakeholders including local training providers, Job Centre Plus. There were opportunities to apply for roles from the event.

Health and Social Care Career Ambassadors

Learning and Development continue to maintain the central list of 61 LLR Ambassadors which has increased from 2023/25.

In 2024/25 academic year attraction networks were maintained with LLR Schools, Career Advisors and Health and Social Care Career Ambassadors. For these the LEBC have been invited/kept in the loop which means the national STEM ambassadors, for whom they hold the LLR list, are also included in career updates.

These included;

- termly newsletters to Schools, Career Advisors and Health and Social Care Ambassadors. The aim is to raise awareness of what UHL are doing and where to get support/information
- termly twilight talks for Schools, Career Advisors and Health and Social Care Ambassadors.

Learning and Development have developed a contacts list of schools and colleges and has connected with them a number of times to promote the NHS careers Step into NHS competition (LLR schools have been awarded prizes in this 2 years running), NHS national career webinars, as well as to promote the locally run national careers week.

Workforce Development Events

Unbox Your Future
Unbox Your Future pilot has been scoped and run by the team for 1 large senior school across a 4-week period in partnership with LEBC. This provided career support and information on a range of professions (3 school visits and 1 UHL visit). The students received a tour of UHL, career talks and undertook a competitive project on nutrition between Tuesday 5th March and Monday 22nd April. 150 students took part.

Medical Careers Programme
This programme was launched in 2023/24. In 2024/25 we hosted 32 students from 4

schools across Leicestershire from lower social economic postcodes who have an avid desire to become doctors. The students were invited to attend UHL for career discussions and undertake practical activities on careers in medicine. Follow up group mentoring is offered to the schools for Year 11's to support them until they progress to medical school.

Chef Academy
Chef Academy was launched and piloted in 2023/24 in partnership with Estates and Facilities. A suite of 4 visits were scheduled for UHL chefs to attend senior schools in Leicester. During these visits the chefs provided either a cook along or cooking demonstration. To date 280 pupils have engaged with this initiative. This is complimented with a catering and NHS career talk, recipes sent to schools, and feedback requested for continual monitoring improvement. There are 150 work experience placements to support this work. The Retail manager lead and one of his team members won Merit of the Year at the NHS Chef Showcase, it is great to have attracted National level attention and will be attended by National NHS representatives at the next visit.

Finance Careers
In 2024/25 we launched a new Financial Careers schools taster session for math or business study students, enabling an exploration of careers in NHS finance and procurement professions. The scheme is run by a Deputy Director of Finance, and Learning and Development. We visited 3 schools and colleges with 88 students attending. The session included a lesson sized e.g. 45minute, visit to the school to talk to math or business study students about the range of NHS Finance careers and conduct a short activity.

Employability Programmes

Kickstart
Learning and Development no longer actively run the UHL Kickstart programme post pandemic due to Trust finances and lack of vacancies for the young people to move into. Kickstarters previously had a combination of employability skills developed and undertook a real work placement for 25hours+ per week. They were on national minimum wage. 75% of cohort one achieved employment ranging from apprenticeships to Band 3 posts. 2 of the 30 employees from cohort one went to university (1 x occupational therapy and 1 x management degree) both want to re-join UHL after their degree with one being on the bank at present. 6 employees are on cohort 2. The majority of these placements (4) are currently in work/progressing to work in UHL with 67% of the learners gained either employment or an apprenticeship. They have progressed into the following roles: one has joined the Student Nurse Associate programme, another has secured a fixed-term contract, one has moved into a substantive post, and another has left UHL to gain employment that better suits their home life balance.

Kings Trust

UHL continue to work in partnership with the Kings Trust, this great working partnership has been running for over 10-years. The 'Get Into' programme gives young people the opportunity to experience first-hand working in a health care environment, building confidence, gain life and work skills along with a number of support sessions covering topics such as career advice and development, job applications for vacant roles, improving CV's, interview skills as well as learning work ethics, values & behaviours. UHL are committed to develop our workforce of tomorrow and these work experience programmes offer young people an opportunity to move into healthcare roles at UHL or wider healthcare providers.

UHL ran two cohorts last year, April and Sept 24. April saw 11 young people on programme; 55% had positive destination outcomes with 1 gaining a substantive post, 1 on-going contract in our IT Dept, 2 successful in external roles and 2 going into further education. Our last 'Get Into' programme saw 10 placements with 100% achieving positive destination outcomes; 6 gaining substantive posts, 3 registering to work via our bank admin service and 1 placement withdrawing during placement due to another job offer outside the NHS.

Unfortunately, funding for the programme has now been withdrawn nationally however UHL recognise the importance to running such programmes for our community and future workforce and will therefore continue to work with the Kings Trust in 2025

Due to our ongoing success with the programme two members of the Learning and & Development team were invited to the yearly Kings Trust Awards in London in April 24

Care Leavers

Care Leavers programme scoping has begun to support the transition for a proportion of the 554 LLR care leavers to NHS careers. This work is complimented by a £40,000 funding pot in 2023/24 for which the Learning and Development team provided LLR with recommendations on project and spend plans.

The first programme for 10 students at UHL ran in summer 2024. The ambition was to attract these students to Band 2 positions with an apprenticeship education programme attached (which enables them to access a care leaver bursary). Safeguarding, wellbeing and pastoral support plans were put in place to support this programme too. Eight students successfully completed the programme. One student had to leave due to moving into supported living accommodation, and another withdrew because of ongoing anxiety; 75% completed the programme however unfortunately none secured employment.

2025/26 UHL is hosting the next Universal Family programme in June; there will be opportunities to have 2 full weeks of work experience and employability skills. Information sessions start in May.

Primary Care is aiming to recruit care leavers following the UFP into a Band 2 role for reception duties within GP surgeries. The successful candidates will be able to work towards the Customer Service apprenticeship which will enable them to access the care leaver bursary.

Project Search
Project Search has been run by Health and Wellbeing colleagues in 2023/24 and transitioned to Learning and Development in 2024/25, supported by a Project Manager who has moved into post in March 2024.

Following the successful partnership with Ellesmere College, 3 out of the 7 interns secured a position at UHL. In the 2nd cohort, we welcomed Gateway College who joined the project at the Glenfield Site with 11 interns. Ellesmere College welcomed 6 interns at the Leicester Royal Infirmary. In partnership with the colleges and the support from a variety of managers and mentors across the sites, 5 interns secured employment at UHL from Ellesmere College (1 deferred the course for health reasons).7 secured Employment from Gateway College, 2 left the course for personal reasons, 2 successfully completed the course and continued with further studies.

We are currently supporting 8 interns from Gateway College and 5 at Ellesmere College who are thriving and have gained great skills from the project. At present 2 of the interns from Ellesmere College are gaining further experience within the Community, 1 in a Care Home and the other in LOROS shop, this is strengthening and developing their skills and highlighting the fab work in partnership with Project Search and the College.

Throughout 24/25 the project at UHL have received National Recognition, Ellesmere College and Gateway College in Partnership won Educator of the Year at the Project Search DFN National Conference and the Project Manager and Health and Safety Lead for Estate and Facilities were runner ups for Business Liaison Hosts to the project. At the National Conference, which was held at the Mattioli Woods Leicester Tigers Ground, College staff, the Project Manager and Health and Wellbeing Lead for E&F were asked to undertake breakout sessions at the conference which has increased partnership working with our neighbouring Trusts and other areas such as Police and Charitable Foundations.

Due to the continued success, the project has received several VIP visitors, the Local MP Liz Kendall met with all the interns and families to hear about the successful project, this provided an opportunity to share any challenges they may face; and was very much welcomed by the interns and their families.

Kirsty Matthews CEO for Project Search visited the Leicester Royal Infirmary and other host business sites across Leicester, she was blown away by the integrated working with the Trust, Local Authority and the colleges.

To ensure continual development in the project, there was an external inspection of Ellesmere College, this was a great opportunity for Ellesmere to showcase the great work and support they have achieved in the last 2 cohorts. Gateway College has their Continuous Improvement Review in May 2025 and the outcome of this will be shared in future reports.

T-Levels
T level collaboration with 4 colleges and colleagues across LLR was initiated and led by the UHL Learning and Development team. This scoping and mapping work started in 2023/24.

UHL has hosted 1 T level student on the digital pathway across 3 departments (L&D, ICT and NTT) in 2023/24 and concluded in 2024/25. This has been a successful pilot with the student being offered a role and professional development at the end of their placement; level 6 apprenticeship in Cyber Security.

2024/25 22 T Level learner have attended taster sessions this year with one more session planned and further two more dates requested by colleges.

UHL offered 30 industry placements for T-Level Health learners. 23 T-Level learners were successful in securing a placement and are currently having work experience across the 3 hospitals.

UHL has recruited 3 T level learners onto the SNA programme following their completion of the T level programme. This year UHL has ring fenced HCA and SNA roles for T level learners who will complete their industry placements with us

Discussions across UHL are taking place regarding hosting other T level learner such as IT and BA

Valuing Our Colleagues – Reward and Recognition

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.

Our second UHL Recognition awards took place with more than 650 nominations across 16 categories. We had the usual external judging panel which included sponsors and local dignitaries. In October we hosted our second in-person event since 2019 and this was attended 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 72,000 nominations from its launch, including more than 9,752 since April 2024. 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 2024/25 Learning and Development invited 2,326 colleagues to afternoon teas, planned and hosted these events for UHL in partnership with colleagues, sent vouchers and long service packs to 732 colleagues and issued 3,240 colleagues with long service badges and certificates.

Staff policies

You Matter: Colleague Support UHL Policy

Last year, 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. The policy pulled 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.

Over the last year, following focus groups and engagement with colleagues a new section for peri-menopause support was added to the policy.

Supporting Attendance and Wellbeing Policy

In partnership with our Staff Side colleagues, employees, managers, People Services and Occupational Health, the Sickness Absence Management policy has been updated and amended, to reflect our ongoing commitment to support our colleagues in a person-centered way aligned to the Trust Values.

The new policy aligns to the 'Just and Restorative Learning' approach, whereby, treating each person as a unique individual, with their own needs, preferences and values. There has been a change in language within the policy, and introduces disability leave and strengthens the links with the Trust's You Matter: Colleague Support Policy.

The following guides have also been designed to help colleagues and managers work through the management of attendance process:

- Managing short term sickness absence
- Reasonable adjustment examples
- Wellbeing meeting (return to work)
- Short-term sickness meeting guide
- Long-term sickness meeting guide
- Stage three hearing preparation
- Disability leave
- Statutory leave carry-over guidance

The new policy comes with new template letters and training for line managers.

Disciplinary and Management of Performance Policy and Procedure for Medical and Dental Staff

In April 2024 the policy was re-written to align to the national Maintaining High Professional Standards in the Modern NHS (MHPS) document.

The aim of this procedure is to ensure that when concerns are raised, the Trust will ascertain quickly what the nature of the concern is and the reasons behind the concern, identify ways to reduce or manage the risks arising, put in place a robust and speedy process to tackle any underlying problems and ensure that doctors and dentists are treated fairly.

The policy incorporates the Responsible Officer Advisory Group (ROAG) which supports and enables consideration of identified issues, taking account of just culture factors, risk factors and complexity. The ROAG comprises of the Responsible officer, Medical and People Services representatives, Lay members and co-opted profession specific advisers.

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 2025/2026, prioritising the following policies and ensuring alignment to the "Just & Restorative Culture" approach:

- Disciplinary,
- Resolution,
- Performance Management (Capability).

Armed Forces Veteran Aware Accreditation

In January 2024, UHL achieved reaccreditation as a Veteran Aware Trust. In applying for reaccreditation, the Trust was required to evidence actions which demonstrate the Trusts ongoing commitment to the care for the armed forces community. This was assessed across 8 standards including areas such as links to the armed forces community, supporting the Armed Forces as an employer and identification and care for patients from the armed forces community.

This demonstrates the Trusts continued commitment to the care of our Armed Forces community and recognises the Trusts work in identifying and sharing best practice across the NHS and being an exemplar of the best standards of care for the Armed Forces community. It also demonstrates that we recognise both the sacrifices made, as well as the unique circumstances and health service needs of those who serve, veterans and their families.

Sexual Safety

On the back of the NHSE sexual safety charter which UHL has signed, throughout 2024 UHL has continued to work to reduce instance of sexual harassment and assault. Notable activity through 2024 has included policy development, the roll out of mandatory training for all colleagues, senior leadership development, specialist training for key colleagues in handling and investigating incidents, launching additional routes to raise concerns and seek support, targeted work with identified groups, and more recently a trust wide communications campaign aimed to set expected behaviors, but also signpost to support.

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 for our workforce. At the Trust we have engaged an external partner, The Guardian Service, to provide our speaking up service. The Guardian Service is an independent, 24/7, 365 days, 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 Guardian's 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 that we provide. Listening and acting upon matters raised means that Freedom to Speak Up will help us be the best place to work.

The internal reporting arrangements within the Trust are 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. These reports are available in the public domain through the Trust's external website https://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/ The Guardians have direct access to the Chief Executive and meet 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.

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 2024/25 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.

Transparency in Supply Chains – Modern Slavery Act Statement

Our Modern Slavery Act Statement is set out in full below, and is also available on our public website at the following link:
https://www.leicestershospitals.nhs.uk/patients/patient-welfare/safeguarding/modern-day-slavery/

Section 54 of the Modern Slavery Act 2015 requires organisations to set out the steps that the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place, within the organisation or its supply chains. University Hospitals of Leicester NHS Trust (UHL/the Trust) was established on 1st April 2000. Our organisation is formed of seven Clinical Management Groups (CMGs) supported by several Corporate Directorates. The CMGs and Corporate Directorates are overseen by our Trust Leadership Team and Trust Board.

We are one of the biggest and busiest NHS Trusts in the country, serving the one million residents of Leicester, Leicestershire and Rutland. Our nationally and internationally-renowned specialist cardio-respiratory. ECMO, cancer and renal services reach a further two to three million patients from the rest of the country. Our Children's Hospital, split across the Leicester General, Glenfield and Leicester Royal Infirmary, helps us meet the needs of our youngest patients for emergency and sometimes life-long care needs.

We're proud to be a teaching hospital and we work closely with partners at the University of Leicester and De Montfort University to nurture and develop the next generation of doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with us.

Our strategy 2023-2030 (leicestershospitals.nhs.uk) Leading in healthcare, trusted in communities, has four goal areas underpinned by our values: **compassionate, proud, inclusive and one team.**

We make every effort to prevent slavery and human trafficking in our Trust, and in our supply chains, by ensuring our employment standards, training, remuneration and policies reflect our commitment to be a high-quality employer conscious of safeguarding.

Slavery and human trafficking is highlighted as a category of abuse that we should all be aware of. Our Safeguarding Adults and Children Policies are designed to minimise the risk of slavery and human trafficking, and our mandatory Safeguarding training for staff also covers this aspect.

In addition to the training and policy, we are committed to employment practices that are fair and equal, both internally and through our suppliers of services and equipment.

We fulfil the Standards for recruitment of staff set by NHS Employers and in line with the Care Quality Commission's Standards. This includes (but is not limited to) pre-employment checks for new candidates:

- Verification of Identification
- Right to Work
- Employment History
- Work Health Assessment
- Disclosure of Criminal Background (DBS) Check (where applicable)
- Professional Registration & Qualification Checks (where applicable)
- Health Professionals Alert Notice (HPAN) Check (where applicable)
- Fit and Proper Person Check (where applicable)

This also includes any Agency or Bank staff we utilise within UHL.

We are strongly committed to ensuring our supply chains are free from ethical and labour standards abuses. All new contracts awarded are done so under the standard NHS Terms and Conditions of Contract for the supply of goods and services which include clauses mandating our suppliers to adhere to all relevant policies and legislation relating to anti-slavery, and that they notify the Trust immediately of any actual or suspected incidents in their Supply Chain. Our suppliers must use good industry practice to ensure that there is no slavery or human trafficking in their supply chains.

NHS England have launched the Evergreen Sustainable Supplier Assessment which the Trust will utilise as part of procurement processes. This includes the requirement for suppliers to publish an ethical sourcing policy, supply chain risk assessment and conduct Modern Slavery audits in hotspot areas of their supply chain. All procurement staff have also undertaken the Modern Slavery and Labour Standard Assessments, produced by NHS England, where thorough risk assessments indicate if a category or country is high risk.

The UHL procurement and supplies team have received all relevant training in relation to Modern Slavery, including the Chartered Institute of Public Finance and Accountancy (CIPFA) Ethics E-Learning, and qualified MCIPS (Member of the Chartered Institute of Purchasing and Supply) staff are required to undertake the CIPS Ethical Procurement and Supply Training on an annual basis.

We have also adopted central government's Social Value Model (Procurement Policy Note 06/20), which requires a minimum 10% weighting in all procurements dedicated to Net Zero and Social Value Themes. The Social Value Themes cover the five topics, Fighting Climate Change, Wellbeing, Equal Opportunity (which covers compliance with the Modern Slavery Act 2015), Tackling Economic Inequality and Covid-19 Recovery.

In addition to our Safeguarding Adults and Children Policies, other supporting UHL policies and procedures include:

- Preventing Illegal Working (Visa Requirements) Policy
- Disclosure & Barring Service policy
- Counter-Fraud, Bribery and Corruption Policy
- Guidance Supporting Staff Subject to Domestic Violence
- Recruitment and Selection Policy
- Recruitment and Selection Policy for Medical Consultants
- Core Training Policy
- Freedom to Speak Up - Raising Concerns Policy
- Equality Diversion and Inclusion Policy

Equality, Diversity and Inclusion

For the first time we now have a dedicated Equality, Diversity, and Inclusion Strategy: Together we can: achieve a sense of belonging for all 2025-2030 that is underpinned by the Trust's Strategic framework and is aligned to our People Strategy. This strategy sets out our commitment to anti-racism and anti-discrimination, which is not just a

statement of intent, but an active guide to building a genuinely fair and inclusive organisation for our staff, patients, and communities.

In NHS organisations like ours, we know that people from Black, Asian and other minority ethnic backgrounds are more likely to experience unfairness. This is a similar picture for other minoritised groups, such as women, disabled people, people from LGBTQ+ or religious communities. This is not acceptable and, whilst we have made progress to become a fairer and more inclusive organisation, we have much more to do. We are clear that discrimination displayed in any forms including, but not limited to, language, behaviours, unequal treatment, harassment, exclusion, stereotyping, or denying access to opportunities, will not be tolerated.

We have set out our commitment as an organisation to take a systematic approach to challenging and changing everything we do. Our central aim is to be an organisation where people feel that they belong and are valued, that we continue to help our people to be highly skilled and talented individuals who enjoy working at UHL and also do their very best to help achieve their goals. Our core aims are:

- To transition from short-term annual actions to long term delivery
- Embed culture changes recommended by staff in our engaging for equity and inclusion programme
- Provide a comprehensive cross functional model for delivery.
- Deliver against our staff pledge

The national NHSE EDI Improvement Plan will be our baseline for improving outcomes for staff from diverse groups, supported by the data and evidence collected against our 2024 and previous years' 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 - Leicester's Hospitals

For the second year UHL Hosted BINA Annual conference on 29 November 2024. Approximately 400 colleagues joined us and the event concluded with an awards ceremony which saw UHL receive the Ally of the Year Award and five of our nursing colleagues shortlisted and received the highly commended awards across five categories reflecting their exceptional dedication and achievements

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 2024/25 can be found on pg 80.

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 24/25, 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 2024/25.

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 2024/25 (subject to audit)

	2024-25						2023-24					
Name	Salary Bands of £5,000	Expense Payments (Taxable if applicable) To the nearest £100	Performance pay and bonuses Bands of £5,000	Long term performance pay and bonuses Bands of £5,000	All pension related benefits Bands of £2,500	Total Bands of £5,000	Salary Bands of £5,000	Expense Payments (Taxable if applicable) To the nearest £100	Performance pay and bonuses Bands of £5,000	Long term performance pay and bonuses Bands of £5,000	All pension related benefits Bands of £2,500	Total Bands of £5,000
Executive Directors												
A Furlong, Medical Director	255-260	-	-	-	80-82.5	**335-340**	245-250	500	-	-	0-0	**240-245**
A Carruthers, Chief Information Officer (until 11th August 2024)	40-45	-	-	-	20-22.5	**60-65**	130-135	7,500	-	-	0-0	**130-135**
R Cassidy, Director of Corporate & Legal Affairs	140-145	-	-	-	50-52.5	**190-195**	125-130	200	-	-	107.5-110	**230-235**
L Hooper, Chief Finance Officer (until 30th June 2024)	50-55	200.00	-	-	0-0	**50-55**	170-175	1,100	-	-	0-0	**170-175**
J Melbourne, Chief Operating Officer	205-210	-	-	-	77.5-80	**285-290**	180-185	500	-	-	222.5-225	**405-410**
R Mitchell, Chief Executive	155-160	5,800.00	-	-	100-102.5	**260-265**	190-195	300	-	-	0-0	**190-195**
L Abeyaratne, Director for Health Equality and Inclusion	80-85	100.00	-	-	27.5-30	**110-115**	95-100	500	-	-	157.5-160	**255-260**
C Teeney, Chief People Officer	180-185	1,200.00	-	-	197.5-200	**380-385**	165-170	10,000	-	-	0-0	**175-180**
J Hogg, Chief Nurse	130-135	-	-	-	0-0	**130-135**	175-180	200	-	-	0-0	**175-180**
M Smith, Director of Communications & Engagement	135-140	-	-	-	35-37.5	**170-175**	120-125	200	-	-	30-32.5	**155-160**
S Barton, Deputy Chief Executive	200-205	-	-	-	137.5-140	**340-345**	165-170	100	-	-	0-0	**165-170**
W Monaghan, Group Chief Digital Officer (from 12th Aug 24)	50-55	-	-	-	385-387.5	**440-445**	0-0	-	-	-	0-0	**0-0**
L Bond, Chief Financial Officer (from 09 Sept 2024)	120-125	-	-	-	95-97.5	**215-220**	0-0	-	-	-	0-0	**0-0**
M Brearley, Interim Chief Financial Officer (17 Jun 24 - 08 Sept 2024)	25-30	-	-	-	0-0	**25-30**	0-0	-	-	-	0-0	**0-0**
M Simpson, Director of Estates and Facilities**	0-0	-	-	-	0-0	**0-0**	140-145	500.00	-	-	35-37.5	**175-180**
Non-Executive Directors												
A Moore, Trust Chairman (from 1 July 2024)	30-35	-	-	-	0-0	**30-35**	0-0	-	-	-	0-0	0-0
J MacDonald, Trust Chairman (until 30 June 2024)	10-15	5,500.00	-	-	0-0	**20-25**	60-65	4,000	-	-	0-0	**65-70**
B Patel, Non-executive Director (until 31 July 2024)	0-5	-	-	-	0-0	**0-5**	10-15	-	-	-	0-0	**10-15**
I Brown, Associate Non-executive Director (until 31 Aug 24)	10-15	-	-	-	0-0	**10-15**	0-5	-	-	-	0-0	**0-5**
V Bailey, Non-executive Director (until 31 Dec 24)	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	0-0	**10-15**
J Houghton, Non-executive Director (from 01 Jan 25)	0-5	-	-	-	0-0	**0-5**	0-0	-	-	-	0-0	**0-0**
T Robinson Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	0-0	**10-15**
S Harris, Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	0-0	**10-15**
A Haynes, Non-executive Director	10-15	-	-	-	0-0	**10-15**	10-15	-	-	-	0-0	**10-15**
J Worrall, Non-executive Director (until 31 Aug 24)	5-10	-	-	-	0-0	**5-10**	10-15	-	-	-	0-0	**10-15**
A Moore, Non-executive Director (until 30 Jun 24)	5-10	-	-	-	0-0	**5-10**	0-5	-	-	-	0-0	**0-5**
D Moon, Non-executive Director	15-20	-	-	-	0-0	**15-20**	0-5	-	-	-	0-0	**0-5**
A Garcea, Associate Non-executive Director	10-15	-	-	-	0-0	**10-15**	0-5	-	-	-	0-0	**0-5**
M Farmer, Associate Non-executive Director	10-15	-	-	-	0-0	**10-15**	0-5	-	-	-	0-0	**0-5**
G Collins-Punter, Associate Non-executive Director**	0-0	-	-	-	0-0	**0-0**	10-15	-	-	-	0-0	**10-15**
G Sharma, Associate Non-executive Director**	0-0	-	-	-	0-0	**0-0**	0-5	-	-	-	0-0	**0-5**
M Williams, Associate Non-executive Director**	0-0	-	-	-	0-0	**0-0**	10-15	1,700	-	-	0-0	**10-15**

Notes

1. R Mitchell was also CEO for the University Hospitals of Northampton (UHN), he continued his role within UHL and was paid via UHL and recharged 25% Northampton Trust and 25% Kettering Trust.
2. J Hogg was also the Chief Nurse/Interim Chief Nurse for UHN, and continued her role within UHL and was paid via UHL and recharged 25% Northampton Trust and 25% Kettering Trust. Dual role with UHN started 8.7.2024
3. A Moore was a Non-Executive Director until 30th June 2024, and from 1st July 2024 he undertook the role of Chairman for UHL for which he was paid by UHN and is recharged to UHL for the salary on a 50% basis.
4. J MacDonald also held a position as Chair for UHN until 30th June 2024 for which he was paid via UHL and recharged 25% Northampton Trust and 25% Kettering Trust.
5. J Houghton also held a position as a Board member for UHN during the year. The recharge value for UHL is £13k per annum, prorated to £3250.
6. W Monaghan also held a position as a Board member for UHN during the year which he was paid via UHL and recharged 25% Northampton Trust and 25% Kettering Trust. Dual role started 12.8.24

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 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2025 £'000	Employees contribution to stakeholder pension
A Furlong, Medical Director	5-7.5	5-7.5	75-80	210-215	1,743	107	1,992	25,636
A Carruthers, Chief Information Officer	0-2.5	0-0	40-45	95-100	714	-	795	16,227
R Cassidy, Director of Corporate and Legal Affairs	2.5-5	0-0	25-30	0-0	291	30	358	17,615
L Hooper, Chief Financial Officer	0-2.5	0-0	40-45	100-105	736	-	785	6,040
J Melbourne, Chief Operating Officer	2.5-5	5-7.5	40-45	100-105	633	61	754	17,252
R Mitchell, Chief Executive	5-7.5	2.5-5	60-65	150-155	1,037	71	1,217	39,082
L Abeyratne, Director for Health Equality and Inclusion	0-2.5	0-0	30-35	0-0	351	19	404	10,489
C Teeney, Director of People and Organisations	10-12.5	0-0	90-95	0-0	1,227	180	1,509	20,749
M Smith, Director of Communications and Engagement	2.5-5	0-0	10-15	0-0	131	17	174	16,929
S Barton, Deputy Chief Executive	5-7.5	10-12.5	55-60	140-145	1,023	137	1,252	23,003
W Monaghan, Group Chief Digital Officer (from 12th Aug 24)	12.5-15	0-0	50-55	0-0	399	160	696	12,127
L Bond, Chief Financial Officer (from 09 Sept 2024)	2.5-5	0-2.5	80-85	220-225	1,717	52	1,953	15,189

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

	Total 2024/25 No.	Permanent 2024/25 No.	Other 2024/25 No.	Total 2023/24 No.
Medical and dental	**2,392**	2,172	220	2,295
Ambulance Staff	**14**	14	0	0
Administration and estates	**3,178**	3,095	83	3,140
Healthcare assistants and other support staff	**3,293**	3,200	93	3,169
Nursing, midwifery and health visiting staff	**5,532**	5,223	309	5,382
Nursing, midwifery and health visiting learners	**36**	2	33	3
Scientific, therapeutic and technical staff	**1,853**	1,791	62	1,795
Healthcare science staff	**975**	970	5	943
Total average numbers	**17,273**	**16,468**	**805**	**16,727**
Of which:				
Number of employees (WTE) engaged on capital projects	**124**	62	62	52

Exit Packages (subject to audit)

There was 1 compulsory redundancy, and 1 other exit package agreed in 2024/2025.

	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					0	0		
£10,000 - £25,000	1	11	1	10	2	21	1	10
£25,001 - £50,000					0	0		
£50,001 - £100,000					0	0		
£100,001 - £150,000					0	0		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total	**1**	**11**	**1**	**10**	**2**	**21**	**1**	**10**

Expenditure on consultancy (subject to audit)

We spent £4.6m on consultancy services in 2024/25 (£1.3m in 23/24).

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 2024/25 was £255,000-£260,000 (2023/24, £240,000 - £245,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

In 2024/25, 26 employees received remuneration in excess of the highest-paid director (49 employees in 2023/24). Remuneration across the Trust ranged from £12k to £384k (2023/24 £10k-£627k).

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 2023/24 and 2024/25 there has been no significant movement in the ratio of the highest paid Director's pay to that of the workforce.

2024/25	25th Percentile pay	Median pay	75th Percentile Pay
Total remuneration (£)	28,696	37,842	50,844
Salary component of total remuneration (£)	25,674	36,483	44,962
Pay ratio information	9.0	6.8	5.1
2023/24			
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

		Percentage change in remuneration	
		Highest paid Director	All Other Employees
2024/25	Salary and allowances	4.46%	4.58%
	Total pay	4.46%	4.58%
2023/24	Salary and allowances	3.34%	-4.67%
	Total pay	3.28%	-4.78%

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 2024/25 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:

- All off-payroll engagements as of 31 March 2025, for more than £245 per day.
- All new off-payroll engaged during 24/25, for more than £245 per day.
- Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025.

The Trust had 18 relevant off-payroll engagements as of 31 March 2025, 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 2025, for more than £245 per day.

	Number
Number of existing engagements as of 31 March 2025	18
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	14
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	1
over 4 years at the time of reporting	3

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

For all off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 and 31 March 2025	15
Of which...	
No. not subject to off-payroll legislation	15
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	0
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 2024 and 31 March 2025.

	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.	0

Richard Mitchell

Chief Executive

25 June 2025

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 2024/2025.

Other contingent liabilities
The Trust reported no contingent liabilities of in 2024/2025 in respect of outstanding legal claims.02

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 2024/25 Financial Position

Although our financial performance is currently below the standard of a high performing provider, our staff continue to deliver improvements in productivity and in the quality of the services they deliver to patients. This has been achieved in the face of rising costs and demand, unprecedented industrial action and long-term underinvestment in capacity and productivity-improving technology.

Our productivity has continued to improve, enabling us to deliver more care for patients. The Trust surpassed the efficiencies delivered in 2023/2024 – achieved through innovation and reform, continuous improvement, investment in technology, data and new capacity, and better workforce retention. These steps provide the springboard for us to transform services as part of the 10 Year Health Plan.

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 original financial plan for 2024/2025 forecast a £65m deficit, noting this was adjusted to breakeven upon receipt of matched non recurrent deficit funding of £65m. However, there were known risks at that time, which materialised within the financial position, such that the final outturn was a deficit against plan of £37.2m. This is mainly driven by CIP non delivery, urgent and emergency care pathway costs and pay pressures.

The Trust remains committed to achieving sustained financial recovery and the best use our taxpayers money in delivering the highest standards of patient care. This requirement to be more productive and effectively do more with less year on year was reflected by the Trust delivering efficiencies of £69.4m against its target of £92m, compared with £64m in 2023/2024.

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 operating costs do not exceed income in a single financial year, which is known as the break-even duty. Although the Trust did not achieve the break-even financial duty or deliver its adjusted financial performance target, the Trust did achieved its other 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 2024/2025 from a financial point of view were:

- a revenue deficit of £37.2m, after technical adjustments, following deficits of £52.8m and £12.5m in 2023/24 and 2022/23 respectively.
- Capital investment of £103.8m (following £122.0m in 2023/24, £96.5m in 2022/23 and £75.3m in 2021/22).
- Delivery of a Cost Improvement of £69.4m (following £64.2m in 2023/24, £35m in 2022/23 and £17.1m in 2021/22).
- Year on Year cash balances maintained at £40.7m (£39.7m at 31 March 2024).
- Maintained high achievement against the Better Payments Practice Code for paying suppliers promptly of 93% (94% in 2023/24).

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

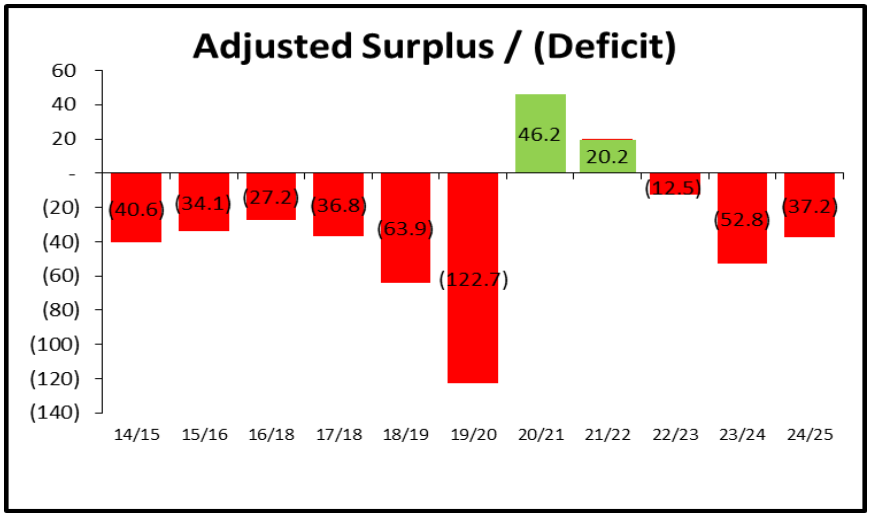
	Group	
Adjusted financial performance (control total basis):	**2024/25**	**2023/24**
	£000	**£000**
Surplus / (deficit) for the period	(77,773)	(65,326)
Remove impact of consolidating NHS charitable fund	1,874	2,295
Remove net impairments not scoring to the Departmental expenditure limit	45,175	12,225
Remove I&E impact of capital grants and donations	(6,514)	(2,205)
Remove net impact of DHSC centrally procured inventories	-	180
	(37,238)	(52,831)

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.

Following the completion of an intensive amount of work in a concentrated period of time, the Trust secured a clean unqualified audit opinion for the first time in 5 years in 2023/2024, which has been maintained in 2024/25, as the financial reporting controls implemented in previous years were embedded.

The Trust submitted its 2024/25 accounts in accordance with the national timetable to ensure consolidation with the National NHS accounts.

Adjusted retained surplus/(deficit)



Income and Expenditure Summary

The Trust faces unprecedented financial and operational challenges. 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.

Total income from patient care activities increased by £179.8m (12.5%). The table below illustrates the income received in 2024/25 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	2024/25 Actual £000s
NHS England	258,067	288,791	305,886	350,224	380,632	395,912	472,791	503,843	274,384
Integrated Commissioning Board	513,658	522,902	542,245	539,952	685,583	765,772	848,594	924,425	1,334,281
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	3,466
Other income from Patient Care	5,993	5,766	2,894	34,491	1,515	2,131	2,702	4,628	4,711
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**	**1,616,842**
Other operating income	143,687	127,958	129,845	144,616	212,142	68,632	69,527	52,026	50,980
Education training, and Research						84,956	93,548	97,661	118,011
Other Operating Income	**143,687**	**127,958**	**129,845**	**144,616**	**212,142**	**153,588**	**163,075**	**149,687**	**168,991**
Total Income	**924,269**	**948,289**	**994,316**	**1,090,575**	**1,281,513**	**1,320,143**	**1,490,515**	**1,586,730**	**1,785,833**

The Trust continues to largely operate to fixed or block funding envelopes, although elective healthcare commissioned between providers and NHS commissioning bodies has been subject to an aligned payment and incentive (API) payment for the last few years. Under these rules, providers 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 increased by £19.3m, largely as a consequence of an increase

in education and research funding (£20.4m).

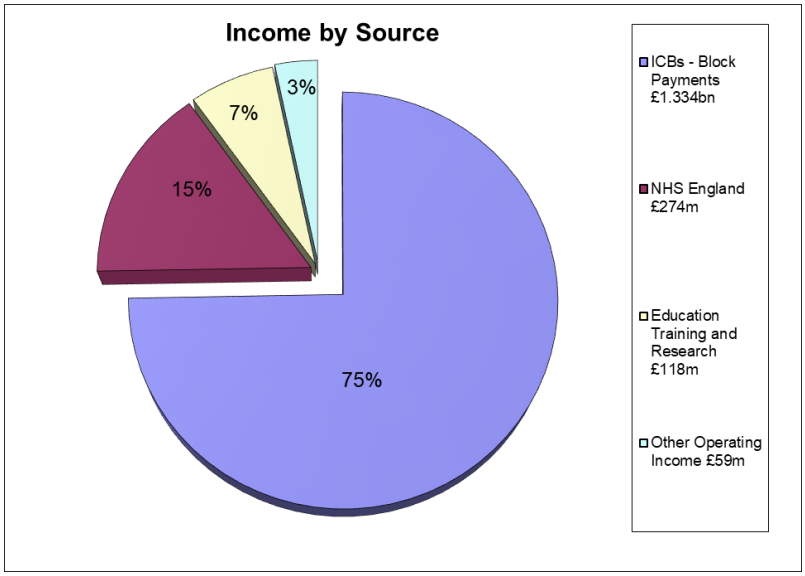
Employment costs accounted for 61% of our total operating costs (62% in 23/24) increasing by £136.3m during the year. This reflected an overall increase in the workforce (average WTE worked) of 546 (3.26%) to 17,273 (permanent and temporary) during 24/25, as the Trust recruited substantively to vacancies. There remained a sustained focus on reducing temporary pay costs during 24/25, such that no substantive staff reduced by 317 WTE to 805 WTE (28%) The Trust also has had to account for and additional £25.7m of DHSC funded pension costs in 24/25 compared with 23/24.

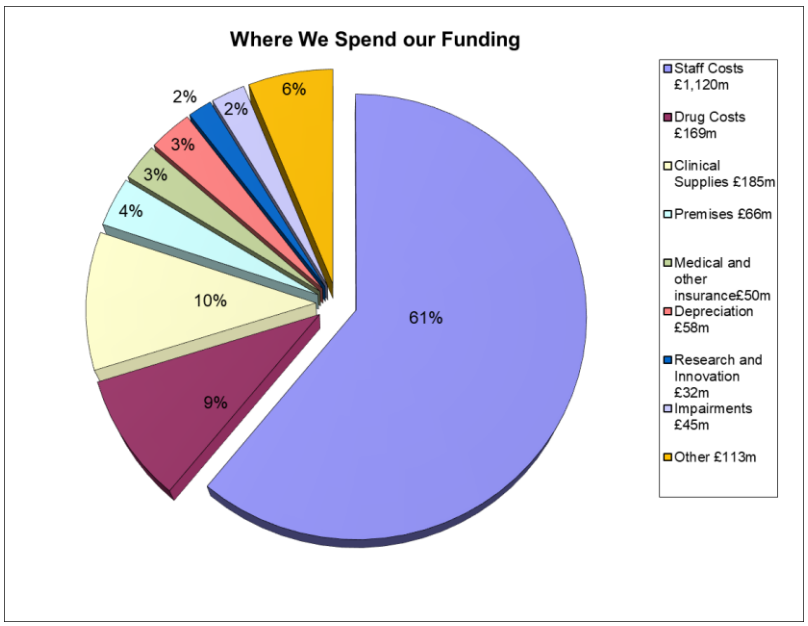
There was a sharp increase in impairments costs which increased by £33.1m year on year, largely driven by the impairment of NHP assets under construction (£24.3m) following the announcement of a pause in the programme. There was an overall reduction reflects and overall 1.9% reduction in the valuation of Trust properties pre-capex additions and some significant downward valuations on completed projects like EMPCC

	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	2024/25 Actual £000s
Staffing	575,895	597,876	629,537	698,996	745,371	777,761	897,482	1,006,581	1,120,219
Drugs	102,168	105,789	102,124	107,139	124,239	127,949	144,487	152,807	169,323
Clinical Supplies and Services	103,653	109,211	117,635	124,593	128,314	142,808	167,500	166,509	184,758
Depreciation and Amortisation	26,407	27,663	32,176	34,991	37,030	39,499	51,730	54,581	57,884
Clinical Negligence	23,724	27,398	30,664	31,927	34,744	38,204	38,824	48,002	49,610
Premises	33,308	33,753	43,469	54,976	48,019	52,572	58,928	64,507	66,306
Research and Development	22,932	34,376	35,763	36,124	35,254	38,680	42,610	48,002	32,057
Impairments	24,826	2,735	1,509	3,480	-80	-3,042	12,958	12,225	45,308
Other Operating costs	53,390	46,800	59,753	104,386	59,100	65,140	90,262	79,069	113,054
Total Expenditure	**966,303**	**985,601**	**1,052,630**	**1,196,612**	**1,211,991**	**1,279,571**	**1,504,781**	**1,632,283**	**1,838,519**

In delivering its year end position, the Trust generated efficiency savings of £69.4m. 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 Trust has developed 5 workstreams which are proposed to help deliver financial sustainability. These cover operational productivity, coding, non-pay (procurement and pharmacy), commercial and workforce. Each of these work programmes (including the Strategic Initiatives) directly or indirectly enables operational and corporate areas to deliver their targeted financial improvement. 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 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.





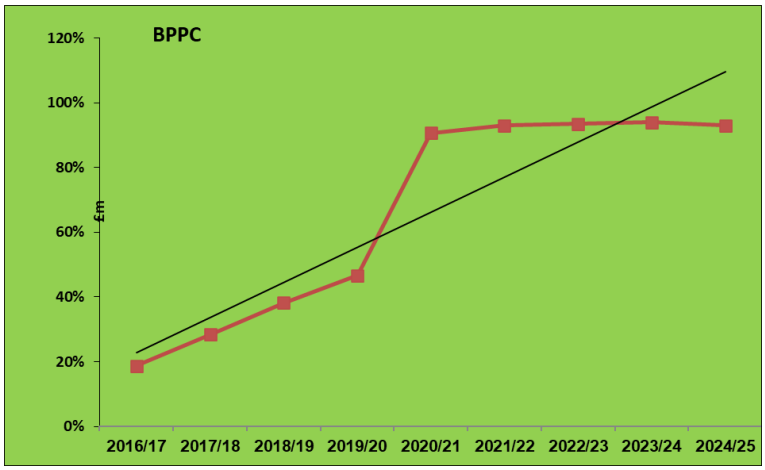
Better Payments Practice Code (BPPC)

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 93% (92.4% Non NHS and 99.7% NHS) of valid supplier invoices(in terms of value) 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. Despite cash

challenges at various points of the year, we make every effort 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.

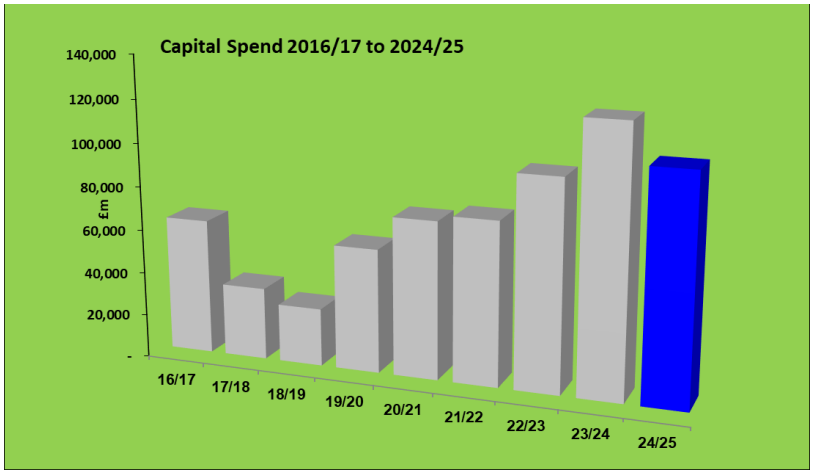


Capital Investment

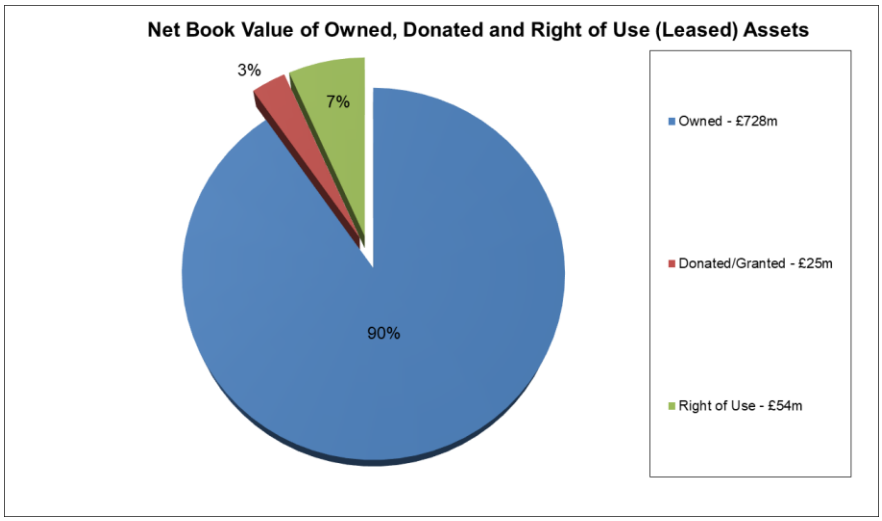
In 2024/25, the Trust delivered a major capital investment programme of £103.8m, including the following highlights, which will help to meet some of the access challenges set out in the national 2025/26 NHS plan.

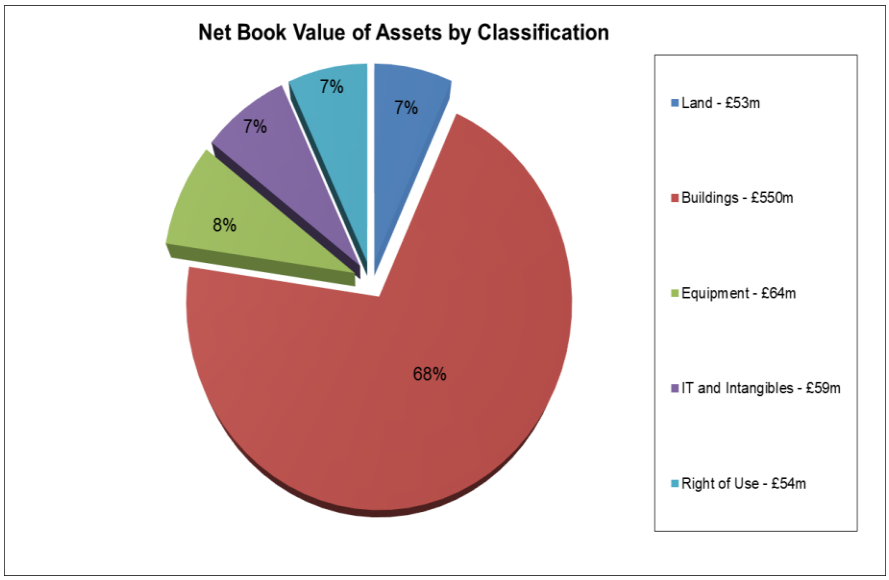
- Opening of the East Midlands Planned Care Centre (EMPCC) at the Leicester General Hospital at a cost of £44m, which is a state-of-the-art new facility designed to help reduce the number of patients experiencing long waits for appointments and treatment.
- Construction started on a brand new £18m Endoscopy Centre at the Leicester General Hospital that will expand endoscopy services for patients and feature six procedure rooms, as well as 20 pods for patients before and after their procedures.
- A new Community Diagnostics Centre (CDC) at Hinckley (£11.3m) opened and will provide a one-stop-shop for health checks, scans and tests allowing people to have an illness or other problem diagnosed closer to home, so they do not need to travel into a hospital.
- Investment in urgent and emergency care capacity (£7.9m), including redevelopment of Preston Lodge.
- Extension of the Diabetes Centre at Leicester General Hospital to enable it to provide "future-proof" diabetes research. (£5.4m)
- Continued deployment of electronic patient record (EPR) (£8.1m), fundamental for the digital collection, processing and availability of patient data for clinical care, research and training as well as driving financial savings by removing the requirement to maintain and transport manual records.

In addition, the Trust continued to invest significantly in its core critical infrastructure by replacing medical and imaging equipment and investing in digitisation and its estate, to ensure staff are equipped to undertake their roles and healthcare services are provided to our patients in appropriate and safe surroundings. The level of investment required to replace assets that wear out far exceeds the level of funding available, so difficult choices have had to be made relative to the risks that exist for these areas of the programme and still ensure continuity of service.



The categorisation and classification value of assets held by the Trust at 31 March 2025 is shown in the charts below:





Financial Outlook

System Working

As set out in the ICB and NHS finance business rules, all local healthcare systems have a breakeven requirement as well as a duty to seek to comply with the system resource limits. The Trust continues to develop its medium-term financial strategy to inform the development of the annual financial plan for the Trust. The Leicester, Leicestershire and Rutland (LLR) System and the Trust are working together to plan and deliver a triangulated financial plan, recognising that for 2025/26, the Trust and System will remain in deficit.

For 2025/26, the contract mechanism 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 continues to face rising operational and financial pressures. System working on this challenge will be the key area of focus to achieve a financially sustainable position.

Priorities, Funding and Operating Environment

The urgent and emergency pathway continues to present the largest operational and financial challenge. Although more people are completing treatment in A&E within 4 hours, a growing number are facing waits of 12 hours or more. In elective care, despite record levels of activity being delivered, continued high demand means improvements are not yet nearly enough to allow everyone to access services in a timely or convenient way.

In 2025/26, health systems will be given greater financial flexibility to manage constrained budgets. Beginning in 2025/26 there will be move to a more devolved system where ICBs and trusts can earn greater freedom and flexibility and patients have more choice and control. In mature, highly performing systems, it is expected that providers will be able to take on more responsibility for leading the planning and transformation of local services within a strategic framework set by ICBs.

While this provides effective real-terms growth in the NHS budget, the NHS must cover final pay settlements for 2025/26, increased employer national insurance contributions, faster improvement on the elective waiting list and new treatments mandated by NICE. Overall, this means NHS organisations, like UHL, will need to reduce their cost base by at least 1% and achieve 4% improvement in productivity, in order to deal with demand growth alone.

This year's planning guidance is more focused – setting out a smaller set of national headline ambitions and the key enablers to support organisations to deliver them, alongside local priorities. This reflects the direction of travel towards earned autonomy for systems, with support, oversight and intervention based on their specific needs and performance. The key areas of focus nationally are:

- Reduce the time people wait for elective care.

- Improve A&E waiting times and ambulance response times.
- Improve patients' access to general practice and improve access to urgent dental care.
- Improve patient flow through mental health crisis and acute pathways and access to CYP mental health services.
- Address inequalities and shift towards prevention.
- Making the shift from analogue to digital.
- Live within our means, reducing waste and maximising productivity, through:
    - Reduce spend on temporary staffing and support functions. As a minimum all systems are expected to deliver reductions of 30% and 10% on agency and bank based on current spending.
    - Improve procurement, contract management and prescribing (non pay).
    - Drive improvements in operational and clinical productivity. To this end, UHL is expected to; develop plans that address the activity per WTE gap against the pre-Covid level; avoid duplication and low-value activity, including a renewed focus on minimising inappropriate spend against evidence-based intervention (EBI) procedures; and systematically implement all elements of the People Promise to improve the working lives of all staff and increase staff retention and attendance to improve productivity and patient outcomes

The specific targets are set out in the table below

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more

Priority	Success measure
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
	Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)
Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

Difficult decisions will need to be made to balance operational priorities within the funding available, while continuing to lay foundations for future reforms. The Trust will need to reduce or stop spending on some services and functions and achieve productivity growth in others. Open and ongoing conversations are taking place with our staff, the public and stakeholders about what it's going to take to improve productivity, reduce waste and tackle unwarranted variation. This includes taking a forensic look at our workforce and what we spend our money on. We anticipate we will need to review our spend on non-frontline staff again for 2025/26 to prioritise frontline care, further reducing our headcount.

The 10 Year Health Plan sets out the plan for a better future, but we must also change how we work now. A relentless focus on improvement is needed now more than ever – to deliver services for our patients who need them today but can be afforded within the financial envelope. This can only be achieved by through achieving sustainable long term financial balance. Higher performing providers will receive financial incentives, including release of additional capital and financial freedoms. Our staff will, be key to success this year. Taking the opportunities and rising to the financial challenges of this coming year will require exceptional leadership and the ability to innovate and deliver better value for money for patients.

Consistent with 2024/25, for 2025/26, the LLR system plan is a forecast deficit of £80m at the end of March 2025. As in 2024/25, UHL accounts for £65m of this position and an assumed delivery of an ambitious £92m CIP programme. Long term financial sustainability is dependent upon CIP improvements being delivered recurrently.

Delivery of the 2025/26 financial plan is realistically possible if the Trust can generate a productivity improvements and minimise 'unwarranted' pay and non-pay costs.

There are 3 overarching goals for financial sustainability:

- Minimise / eliminate, all unwarranted cost pressures. This will necessitate enhanced grip and control across all three drivers: pay, non-pay and income.

- Fix and deliver the basics to 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.

- Reduce pay and non-pay costs by £92m.

Capital

The 2024 Autumn Spending Review provided the NHS with a 1-year capital settlement covering 2025/26. The 2025/26 NHS capital allocation is split into 3 categories as follows:

- A system-level allocation to fund day-to-day operational investments to manage and prioritise operational capital. Systems have the autonomy to determine the optimal deployment of this allocation (£47.5m).
- Previously committed funds to support previously committed and announced schemes from the previous Spending Review period, specifically the New Hospital Programme (NHP) (£1.5m), noting that the Trust's investment programme has been deferred by up to 3 years.
- Other national capital programme investments, including enhancing performance in elective recovery, diagnostics, urgent and emergency care (UEC), estates safety, advancing technology initiatives and driving progress towards net zero commitments (£21.9m).

The Trust also plans to receive £6.3m of charitable donations and grant funding. For UHL, this translates into an opening capital programme of £77.2m.

The Estate funding (£7.2m) is intended to mitigate critical infrastructure and safety risks, addressing the poorest quality estate and ensuring a safe, sustainable environment for healthcare delivery and the investment in elective, diagnostics and UEC (£21.9m) is aimed at improving NHS performance against constitutional standards.

Key strategic and operational investments in 25/26 will include the opening of a new Endoscopy Unit, Diabetes Centre, Preston Lodge and the commencement of the development of an Urgent Treatment Centre (UTC). These initiatives will help to improve patient flow through the Trust and provided much additional bed capacity and ensure our patients receive the highest quality care they need within appropriate timeframes and setting.

To promote sound financial management and ensure equitable resource allocation, NHS England is continuing the financial incentive scheme for Systems. This scheme is aligned with the NHS's broader financial framework and is designed to reward effective financial

performance while encouraging systems to manage resources responsibly. Systems that deliver revenue financial performance in line with or better than their plan will receive capital bonuses, while those that underperform financially will face capital deductions.

The scheme applies specific capital adjustments based on financial performance. For the LLR system this represents deduction 10% (included in the core capital allocation set out above). Systems that achieve breakeven or a surplus receive a capital bonus equal to 30% of the difference between their breakeven or surplus position and their fair share allocation. This structure continues to provide both incentives for strong financial performance and consequences for underperformance, supporting the NHS's goal of sustainable financial management.

Despite the additional national funding that UHL will receive, capital funding remains severely constrained, in particular the amount of money available to invest in core Estates, medical equipment and digital infrastructure. Projects have been rigorously prioritised relative to the risks that exist for these areas of the programme, to ensure the optimal use of every pound spent on capital.

Cash

The Trust enters 2025/26 with effectively no better than a break-even cash position, despite cash balance of £40m at 31 March 25, as this is offset by 2024/25 capital cash expenditure that will come through in the first quarter of 2025/26, for which funding was received in 2024/25.

Securing cash support in 2025/26, beyond being funded for the deficit plan of £65m is going to be difficult. The starting point for any national cash support moving forward is the expectation of balanced revenue plan, for which only non recurrent revenue funding for the agreed deficit is likely to be supported through commissioners in cash terms. Clearly 2025/26 will represent a very challenging year from a cash perspective for the Trust.

The Trust will continue to make prompt payment for goods and services received, wherever possible.

Summary

The Trust will to continue to provide safe and high quality healthcare to its resident population, but must do so within sustainable finances, including improving productivity, utilising an 'affordable' workforce and at the same time delivering an unprecedented efficiency target. Despite these financial challenges, the Trust will, through strong partnership working with System partners and supported by new ways of working, work towards achieving a sustainable financial position in the medium term, with the aim of moving the Trust into the cohort of higher performing providers in the next 2 to 3 years.

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 2024/25 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 2024/25 Group Accounting Manual issued by the Department of Health and Social Care. They represent a "true and fair view" of our activity in 2024/25, 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 £280k (excluding VAT) for The Trust and £20k (excluding VAT) for TGH. We did not receive any non-audit services from KPMG in 2024/25.

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 2025 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:

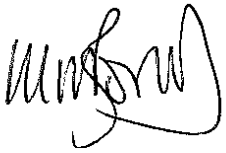
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and 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
25 June 2025

Lee Bond
Chief Financial Officer
25 June 2025

Independent auditor’s 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 2025 which comprise the Group Statement of Comprehensive Income, Group and Trust Statement of Financial Position, Group Statement of Changes in Taxpayers Equity, Group and Trust Statement 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 2025 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 2024/25; 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 the Trust's services or dissolve the Group and the Trust without the transfer of their 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 the 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 financial performance targets 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/ other reasons specific to this audit, 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 Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom, we recognised 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 performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included cash and borrowing journals posted to unusual account combinations, and those posted as part of the year end close procedures that reduced the level of expenditure recorded.
- Inspecting a sample of invoices of expenditure and cash payments, in the period around 31 March 2025, 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.

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

As outlined in the section of the report dealing with other legal and regulatory matters, we made a section 30 referral to the Secretary of State on 20 May 2025 in respect of the Trust's breach of its "breakeven duty".

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 laws, anti-bribery, employment law, recognising the nature of the Group's and the 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.

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 2024/25.

Directors', Accountable Officer's and Audit Committee's responsibilities

As explained more fully in the statement set out within the Accountability Report, 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, within the Accountability Report the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

The Audit Committee is responsible for overseeing the Trust's financial reporting process.

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 Weaknesses –Financial Sustainability

We have previously identified significant weaknesses in the Trust's arrangements in relation to financial sustainability in our audits for the periods ended 31 March 2022, 31 March 2023 and 31 March 2024. This was due to the Trust's challenges in agreeing a Medium-Term Financial Plan (MTFP) with its commissioners and NHS England, as well as the Trust's arrangements surrounding Cost Improvement Programme planning.

Whilst the 2024/25 financial plan was achieved, this was only through additional non-recurrent funding from NHS England. The Trust did not achieve the agreed 2024/25 efficiency plan, with any savings achieved being through a higher proportion of non-recurrent savings than planned.

The financial plan for 2025/26 is a breakeven position, for both the Trust and the Integrated Care System as a whole. However, this position is only achievable assuming £65.0 million deficit support funding is received, as well as the system as a whole meeting challenging efficiency plans. Financial sustainability should not be reliant upon non-recurrent deficit support funding or non-recurrent efficiency savings.

We have therefore concluded that the significant weaknesses remain over the arrangements that the Trust has in place to deliver financial sustainability.

Recommendation

We recommend that the Trust ensures that there is a robust process for ensuring Cost Improvement Plans are deliverable without dependency on non-recurrent funding, that will support the agreement of a Medium-Term Financial Plan that is not reliant on non-recurrent deficit support funding or non-recurrent efficiency savings.

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 within the Accountability Report, 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 are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

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 issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the Trust under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- 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.

We have nothing else to report in these respects.

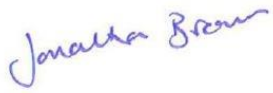
THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of University Hospitals of Leicester NHS Trust 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 Directors 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 Directors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of University Hospitals of Leicester NHS Trust NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.



Jonathan Brown
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
27 June 2025

Appendix A

Annual accounts 2024/25

University Hospitals of Leicester NHS Trust

Annual accounts for the year ended 31 March 2025

Consolidated Statement of Comprehensive Income

		Group	
		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	1,616,842	1,437,043
Other operating income	4	168,990	149,847
Operating expenses	7,9	(1,840,975)	(1,632,283)
Operating surplus/(deficit) from continuing operations		**(55,143)**	**(45,393)**
Finance income	11	3,060	4,233
Finance expenses	12	(3,535)	(2,980)
PDC dividends payable		(21,969)	(20,455)
Net finance costs		**(22,444)**	**(19,202)**
Other gains / (losses)	13	(166)	(486)
Corporation tax expense		(20)	(85)
Surplus / (deficit) for the year		**(77,773)**	**(65,166)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(6,769)	(12,537)
Revaluations	19	12,720	25,698
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	23	61	393
Total comprehensive income / (expense) for the period		**(71,761)**	**(51,612)**
Surplus/ (deficit) for the period attributable to:			
University Hospitals of Leicester NHS Trust		(77,773)	(65,166)
TOTAL		**(77,773)**	**(65,166)**
Total comprehensive income/ (expense) for the period attributable to:			
University Hospitals of Leicester NHS Trust		(71,761)	(51,612)
TOTAL		**(71,761)**	**(51,612)**

Statements of Financial Position

		Group		Trust	
	Note	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Non-current assets					
Intangible assets	16	32,292	29,130	32,292	29,130
Property, plant and equipment	17	720,763	718,930	720,755	718,919
Right of use assets	20	54,016	51,744	54,016	51,744
Other investments / financial assets	23	5,392	5,347	4,000	4,000
Receivables	26	4,417	3,019	4,417	3,019
Other assets	28	-	-	-	-
Total non-current assets		**816,880**	**808,170**	**815,480**	**806,812**
Current assets					
Inventories	25	28,567	27,797	25,706	25,880
Receivables	26	37,549	39,566	36,820	38,623
Cash and cash equivalents	27	41,751	42,391	39,001	37,347
Total current assets		**107,867**	**109,754**	**101,527**	**101,850**
Current liabilities					
Trade and other payables	28	(164,296)	(165,728)	(163,514)	(165,206)
Borrowings	30	(9,125)	(9,434)	(9,125)	(9,435)
Provisions	31	(9,305)	(12,087)	(9,254)	(12,041)
Other liabilities	29	(4,650)	(4,812)	(4,650)	(4,813)
Total current liabilities		**(187,376)**	**(192,061)**	**(186,543)**	**(191,495)**
Total assets less current liabilities		**737,371**	**725,863**	**730,464**	**717,168**
Non-current liabilities					
Trade and other payables	28	-	-	-	-
Borrowings	30	(43,101)	(34,373)	(43,101)	(34,372)
Provisions	31	(3,634)	(3,595)	(3,635)	(3,596)
Other liabilities	29	-	-	-	-
Total non-current liabilities		**(46,735)**	**(37,968)**	**(46,736)**	**(37,968)**
Total assets employed		**690,636**	**687,895**	**683,728**	**679,200**
Financed by					
Public dividend capital		924,805	850,303	924,805	850,303
Revaluation reserve		223,681	217,730	223,681	217,730
Income and expenditure reserve		(464,017)	(388,118)	(464,758)	(388,833)
Charitable fund reserves	24	6,167	7,980	-	-
Total taxpayers' equity		**690,636**	**687,895**	**683,728**	**679,200**

The notes form part of these accounts.

Name **Richard Mitchell**
Position **Chief Executive**
Date **25 June 2025**

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

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 2024 - brought forward	**850,303**	**217,730**	**(388,118)**	**7,980**	**687,895**
Surplus/(deficit) for the year	-	-	(78,463)	690	**(77,773)**
Impairments	-	(6,769)	-	-	**(6,769)**
Revaluations	-	12,720	-	-	**12,720**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	61	**61**
Public dividend capital received	74,502	-	-	-	**74,502**
Other reserve movements	-	-	2,564	(2,564)	**-**
Taxpayers' and others' equity at 31 March 2025	**924,805**	**223,681**	**(464,017)**	**6,167**	**690,636**

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**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2023 - restated	**797,141**	**202,796**	**(323,314)**	**9,722**	**686,345**
Surplus/(deficit) for the year	-	-	(65,808)	642	**(65,166)**
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)**	**7,980**	**687,895**

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 xx

Statements of Cash Flows

		Group		Trust	
		2024/25	2023/24	2024/25	2023/24
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		(55,143)	(45,393)	(53,101)	(43,420)
Non-cash income and expense:					
Depreciation and amortisation	7.1	57,884	54,581	57,881	54,578
Net impairments	8	45,308	12,225	45,308	12,225
Income recognised in respect of capital donations	4	(5,549)	(834)	(8,113)	(3,611)
(Increase) / decrease in receivables and other assets		1,580	23,522	1,602	22,975
(Increase) / decrease in inventories		(770)	(5,134)	174	(5,230)
Increase / (decrease) in payables and other liabilities		4,484	(26,102)	4,204	(25,431)
Increase / (decrease) in provisions		(2,798)	(1,349)	(2,803)	(1,254)
Movements in charitable fund working capital		216	104	-	-
Tax (paid) / received		(20)	(84)	-	-
Other movements in operating cash flows		(2,548)	1	-	-
Net cash flows from / (used in) operating activities		**42,644**	**11,537**	**45,152**	**10,832**
Cash flows from investing activities					
Interest received		2,846	4,017	2,846	4,017
Purchase of intangible assets		(15,503)	(8,861)	(15,503)	(8,861)
Purchase of PPE and investment property		(73,180)	(90,657)	(73,180)	(90,657)
Sales of PPE and investment property		-	2,460	-	2,460
Receipt of cash donations to purchase assets		5,549	822	5,549	3,599
Net cash flows from charitable fund investing activities		214	216	-	-
Net cash flows from / (used in) investing activities		**(80,074)**	**(92,003)**	**(80,288)**	**(89,442)**
Cash flows from financing activities					
Public dividend capital received		74,502	53,162	74,502	53,162
Capital element of lease liability repayments		(11,065)	(14,195)	(11,065)	(14,195)
Other interest		(29)	(6)	(29)	(6)
Interest paid on lease liability repayments		(3,451)	(2,933)	(3,451)	(2,933)
PDC dividend (paid) / refunded		(23,167)	(21,151)	(23,167)	(21,151)
Net cash flows from / (used in) financing activities		**36,790**	**14,877**	**36,790**	**14,877**
Increase / (decrease) in cash and cash equivalents		**(640)**	**(65,589)**	**1,654**	**(63,733)**
Cash and cash equivalents at 1 April - brought forward		**42,391**	**107,980**	**37,347**	**101,080**
Cash and cash equivalents at 31 March	27	**41,751**	**42,391**	**39,001**	**37,347**

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 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the 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 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 2024/25 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 Consolidation

NHS Charitable Funds

The trust is the corporate trustee to Leicester Hospitals 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 2024/25. TGH's

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain 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.
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 are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

Revenue from 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 1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

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

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 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension 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. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the 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 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be 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 2025.

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	2024/25	2023/24	National Factor	Local Factor	Combined Factor
TPI	399	390	1.023		
LRI/LGH/Glenfield	101	102		0.990	1.013
Lincoln	98	99		0.990	1.013
Loughborough	100	101		0.990	1.013

· **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		170,935	27,398	(7,830)	190,503
LGH		91,852	N/A	(74,543)	17,309
GFH		78,536	26,733	N/A	105,269
Total		**341,324**	**54,131**	**(82,374)**	**313,082**

· **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 2025. 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 2025 valuation.

Assumption		Baseline Adjustment Factor	Assumption value (£m)	Sensitivity (+ 5%) (£m)	Sensitivity (- 5%) (£m)
Build Cost Index		1.023	12.376	26,905	(26,905)
Obsolescence Factor		(1.040)	(22.019)	(29.506)	29.506
Land value / acre		(1.100)	(4.819)	(2.409)	2.409

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.

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
Buildings, excluding dwellings	1	90
Dwellings	5	48
Plant & machinery	7	20
Transport equipment	8	15
Information technology	3	12
Furniture & fittings	8	30

Note 1.9 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised 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 where it meets recognition criteria.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. 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
Internally generated information technology	3	12
Software licences	3	12

Note 1.10 Inventories

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

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust 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. Distribution of inventories by the Department ceased in March 2024.

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 1.1 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 1.2 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. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

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 1.3 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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

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 1.4 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

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

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 31.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.5 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 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 32, 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 1.6 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 1.7 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 1.8 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 1.9 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 1.10 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.11 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 1.12 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 1.13 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 1.15 Early adoption of standards, amendments and interpretations

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

Note 1.16 Standards, amendments and interpretations in issue but not yet effective or adopted

NHS bodies will be required to apply international financial reporting standard (IFRS) 17 Insurance contracts from 1 April 2025. The standard brings stricter accounting requirements to existing accounting rules over insurance contracts and requires providers to split the profit from the insurance element of the contract from the rest of the contract income. The standard comes into practice in 25/26 however 24/25 comparatives will need to reflect the changes.

From 1 April 2025, IFRS 17 must be applied to all insurance contracts. An insurance contract is a contract where the issuer agrees to take on the risk of something happening in the future that will cost money to fix or resolve, in return for which the policy holder pays a fee for the insurance coverage. NHS bodies will need to demonstrate that they have considered the new standard and have satisfied themselves that they have not issued any insurance contracts. The majority of NHS providers income is for the provision of healthcare under the NHS standard contract. HM Treasury's IFRS17 application guidance excludes services provided as a result of legislation and regulations, as these are not contractual agreements between a citizen and the Government. Therefore, although unlikely, the Trust must demonstrate it has considered the new standard and satisfied itself that we have not issued any insurance contracts. In the event that there are contracts of this nature, then these would require separate disclosure. This standard has to be adopted retrospectively so all contracts, not just ones issued after 1 April 2025 need to be considered.

The Trust is currently in the process of reviewing its contracts and so far we have not identified any arrangements that indicate that we have any insurance contracts that would fall under IFRS17 reporting requirements.

Note 1.17 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:
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 2025. 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 1.18 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. Detailed considerations (including sensitivity analysis of the key assumptions) have been included at note 1.8.

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 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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2024/25	2023/24
	£000	£000
Income from commissioners under API contracts - variable element*	324,802	285,511
Income from commissioners under API contracts - fixed element*	1,047,618	955,135
High cost drugs income from commissioners	163,990	150,697
Other NHS clinical income	6,199	-
Private patient income	3,466	4,147
National pay award central funding***	3,958	706
Additional pension contribution central funding**	62,280	36,622
Other clinical income	4,529	4,225
Total income from activities	**1,616,842**	**1,437,043**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

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

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2024/25	2023/24
Income from patient care activities received from:	**£000**	**£000**
NHS England	274,384	503,843
Integrated care boards	1,334,281	924,425
Non-NHS: private patients	3,466	4,147
Non-NHS: overseas patients (chargeable to patient)	2,642	2,903
Injury cost recovery scheme	1,887	1,322
Non NHS: other	182	403
Total income from activities	**1,616,842**	**1,437,043**
Of which:		
Related to continuing operations	1,616,842	1,437,043
Related to discontinued operations	-	-

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

	2024/25	2023/24
	£000	£000
Income recognised this year	2,642	2,903
Cash payments received in-year	1,007	817
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	1,978	1,462

Note 4 Other operating income (Group)

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	55,603	-	**55,603**	47,736	-	**47,736**
Education and training	64,467	-	**64,467**	55,555	-	**55,555**
Non-patient care services to other bodies	7,862		**7,862**	11,176		**11,176**
Income in respect of employee benefits accounted on a gross basis	5,677		**5,677**	8,302		**8,302**
Receipt of capital grants and donations and peppercorn leases		5,549	**5,549**		834	**834**
Charitable and other contributions to expenditure		-	**-**		566	**566**
Revenue from operating leases		251	**251**		413	**413**
Charitable fund incoming resources		2,184	**2,184**		2,168	**2,168**
Other income	27,397	-	**27,397**	23,097	-	**23,097**
Total other operating income	**161,006**	**7,984**	**168,990**	**145,866**	**3,981**	**149,847**
Of which:						
Related to continuing operations			168,990			149,847
Related to discontinued operations			-			-

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 (2023/24 - £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.

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.

	2024/25	2023/24
	£000	£000
Income	5,020	4,263
Full cost	(3,342)	(3,079)
Surplus / (deficit)	**1,678**	**1,184**

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)

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	251	413
Total in-year operating lease income	**251**	**413**

Note 6.2 Future lease receipts (Group)

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	284	279
- 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	**284**	**279**

Note 7.1 Operating expenses (Group)

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,361	2,878
Purchase of healthcare from non-NHS and non-DHSC bodies	17,203	20,704
Purchase of social care	-	-
Staff and executive directors costs	1,120,031	1,006,325
Remuneration of non-executive directors	188	257
Supplies and services - clinical (excluding drugs costs)	184,758	166,488
Supplies and services - general	19,699	17,592
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	169,323	152,807
Inventories written down	32	7
Consultancy costs	4,613	1,267
Establishment	10,614	8,439
Premises	66,306	64,556
Transport (including patient travel)	8,153	9,039
Depreciation on property, plant and equipment	51,222	49,468
Amortisation on intangible assets	6,662	5,113
Net impairments	45,308	12,225
Movement in credit loss allowance: contract receivables / contract assets	2,109	282
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	1,881	(4,164)
Change in provisions discount rate(s)	8	(117)
Fees payable to the external auditor		
audit services- statutory audit	316	335
other auditor remuneration (external auditor only)	-	-
Internal audit costs	153	134
Clinical negligence	49,610	42,488
Legal fees	1,097	711
Insurance	735	751
Research and development	54,762	48,031
Education and training	4,770	3,713
Expenditure on short term leases	8,096	7,761
Car parking & security	742	334
Hospitality	-	-
Losses, ex gratia & special payments	50	35
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other NHS charitable fund resources expended	1,692	1,727
Other	6,481	13,097
Total	**1,840,975**	**1,632,283**
Of which:		
Related to continuing operations	1,840,975	1,632,283
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 (2023-24 - £Nil).

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1,000k (2023/24: £1,000k).

Note 8 Impairment of assets (Group)

	2024/25	2023/24
	£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	24,472	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	20,836	5,883
Impairments of charitable fund assets	-	-
Other	-	6,342
Total net impairments charged to operating surplus / deficit	**45,308**	**12,225**
Impairments charged to the revaluation reserve	6,769	12,537
Total net impairments	**52,077**	**24,762**

There was a sharp increase in impairments costs which increased by £33.1m year on year, largely driven by the impairment of NHP assets under construction (£24.3m) following the announcement of a pause in the programme. There was an overall reduction reflects and overall 1.9% reduction in the valuation of Trust properties pre-capex additions and some significant downward valuations on completed projects like EMPCC.

Note 9 Employee benefits (Group)

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	878,896	786,887
Social security costs	93,270	85,144
Apprenticeship levy	4,316	3,966
Employer's contributions to NHS pensions	157,877	120,775
Pension cost - other	72	100
Temporary staff (including agency)	12,603	33,192
Total gross staff costs	**1,147,034**	**1,030,064**
Recoveries in respect of seconded staff	-	-
Total staff costs	**1,147,034**	**1,030,064**
Of which		
Costs capitalised as part of assets	4,298	3,564

Note 9.1 Retirements due to ill-health (Group)

During 2024/25 there were 4 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £70k (£1,746k in 2023/24).

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

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensionsBoth 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by of the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

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

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

Note 11 Finance income (Group)

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	2,846	4,017
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
NHS charitable fund investment income	214	216
Other finance income	-	-
Total finance income	**3,060**	**4,233**

Note 12.1 Finance expenditure (Group)

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on lease obligations	3,451	2,933
Interest on late payment of commercial debt	29	6
Total interest expense	**3,480**	**2,939**
Unwinding of discount on provisions	55	41
Total finance costs	**3,535**	**2,980**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2024/25	2023/24
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	29	6

Note 13 Other gains / (losses) (Group)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	54	1,171
Losses on disposal of assets	(220)	(1,657)
Gains / losses on disposal of charitable fund assets	-	-
Total gains / (losses) on disposal of assets	**(166)**	**(486)**

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was £76 million (2023/24: deficit £63million). The trust's total comprehensive expense for the period was £68 million (2023/24: expense £50 million).

Note 15 Discontinued operations (Group)

The Group and Trust had no discontinued operations in 24/25 (Nil 2023/24).

Note 16.1 Intangible assets - 2024/25

Group	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**57,148**	**12**	**5,679**	**62,839**
Transfers by absorption	-	-	-	**-**
Additions	14,302	-	1,201	**15,503**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	(5,679)	**(5,679)**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2025	**71,450**	**12**	**1,201**	**72,663**
Amortisation at 1 April 2024 - brought forward	**33,709**	**-**	**-**	**33,709**
Transfers by absorption	-	-	-	**-**
Provided during the year	6,662	-	-	**6,662**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2025	**40,371**	**-**	**-**	**40,371**
Net book value at 31 March 2025	**31,079**	**12**	**1,201**	**32,292**
Net book value at 1 April 2024	**23,439**	**12**	**5,679**	**29,130**

Note 16.2 Intangible assets - 2023/24

Group	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**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 - as previously stated	**25,884**	**-**	**-**	**25,884**
Prior period adjustments	-	-	-	**-**
Amortisation at 1 April 2023 - restated	**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 17 Property, plant and equipment - 2024/25

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 2024 - brought forward	**52,956**	**537,916**	**6,635**	**64,053**	**140,776**	**338**	**49,460**	**4,122**	**856,256**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	31,605	-	23,069	11,003	-	3,796	214	**69,687**
Impairments	-	(30,925)	(11)	(24,472)	-	-	-	-	**(55,408)**
Reversals of impairments	-	3,320	11	-	-	-	-	-	**3,331**
Revaluations	50	12,336	334	-	-	-	-	-	**12,720**
Reclassifications	-	29,554	(84)	(39,634)	4,179	-	9,919	1,745	**5,679**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,541)	-	-	-	**(1,541)**
Valuation/gross cost at 31 March 2025	**53,006**	**583,806**	**6,885**	**23,016**	**154,417**	**338**	**63,175**	**6,081**	**890,724**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**20,856**	**431**	**-**	**82,285**	**189**	**31,254**	**2,311**	**137,326**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	18,531	390	-	9,071	12	5,557	402	**33,963**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,328)	-	-	-	**(1,328)**
Accumulated depreciation at 31 March 2025	**-**	**39,387**	**821**	**-**	**90,028**	**201**	**36,811**	**2,713**	**169,961**
Net book value at 31 March 2025	**53,006**	**544,419**	**6,064**	**23,016**	**64,389**	**137**	**26,364**	**3,368**	**720,763**
Net book value at 1 April 2024	**52,956**	**517,060**	**6,204**	**64,053**	**58,491**	**149**	**18,206**	**1,811**	**718,930**

Note 17.1 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 - as previously stated	**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	(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 - as previously stated	**-**	**-**	**-**	**-**	**79,181**	**183**	**32,075**	**2,237**	**113,676**
Depreciation at start of period as FT	-	-	-	-	-	-	-	-	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	19,300	431	-	8,901	6	4,538	74	**33,250**
Impairments	-	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 17.2 Property, plant and equipment financing - 31 March 2025

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	53,006	529,869	6,064	23,016	54,511	124	26,343	3,208	-	**696,141**
Owned - donated/granted	-	14,550	-	-	9,878	13	21	160	-	**24,622**
NBV total at 31 March 2025	**53,006**	**544,419**	**6,064**	**23,016**	**64,389**	**137**	**26,364**	**3,368**	**-**	**720,763**

Note 17.3 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	505,104	6,204	64,053	50,828	137	18,202	1,746	-	**699,230**
Owned - donated/granted	-	11,956	-	-	7,663	12	4	65	-	**19,700**
NBV total at 31 March 2024	**52,956**	**517,060**	**6,204**	**64,053**	**58,491**	**149**	**18,206**	**1,811**	**-**	**718,930**

Note 17.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

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 2025	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Note 17.5 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 18 Donations of property, plant and equipment

	Group and Trust	
	2024/25	2023/24
	£000	£000
Assets purchased with donations from the Trust's charitable fund	2,564	2,768
Assets received from DHSC relating to Covid treatment	-	-
Other	-	804
	2,564	**3,572**

Note 19 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 20 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 20.1 Right of use assets - 2024/25

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 2024 - brought forward	**24,583**	**84,644**	**58**	**17,917**	**127,202**	**8,432**
Transfers by absorption	-	-	-	-	**-**	-
Additions	13,472	4,458	-	-	**17,930**	8,838
Remeasurements of the lease liability	(893)	2,494	-	-	**1,601**	159
Reclassifications	-	-	-	-	**-**	(3,704)
Valuation/gross cost at 31 March 2025	**37,162**	**91,596**	**58**	**17,917**	**146,733**	**13,725**
Accumulated depreciation at 1 April 2024 - brought forward	**8,012**	**56,410**	**58**	**10,978**	**75,458**	**2,246**
Transfers by absorption	-	-	-	-	**-**	-
Provided during the year	5,353	8,530	-	3,376	**17,259**	1,228
Reclassifications	-	-	-	-	**-**	(1,513)
Accumulated depreciation at 31 March 2025	**13,365**	**64,940**	**58**	**14,354**	**92,717**	**1,961**
Net book value at 31 March 2025	**23,797**	**26,656**	**-**	**3,563**	**54,016**	**11,764**
Net book value at 1 April 2024	**16,571**	**28,234**	**-**	**6,939**	**51,744**	**6,186**
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						11,764

Note 20.2 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**
Additions	1,488	9,398	-	3,660	**14,546**	-
Remeasurements of the lease liability	1,229	979	-	-	**2,208**	-
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
Reclassifications	1	-	-	-	**1**	(97)
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 20.3 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 30.1.

	Group & Trust	
	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**43,807**	**41,745**
Carrying value at 1 April - restated	**43,807**	**41,745**
Transfers by absorption	-	-
Lease additions	17,930	14,546
Lease liability remeasurements	1,601	2,208
Interest charge arising in year	3,451	2,933
Early terminations	(47)	(497)
Lease payments (cash outflows)	(14,516)	(17,128)
Other changes	-	-
Carrying value at 31 March	**52,226**	**43,807**

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 20.4 Maturity analysis of future lease payments at 31 March 2025

	Group & Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	9,125	140
- later than one year and not later than five years;	42,163	11,806
- later than five years.	938	-
Total gross future lease payments	**52,226**	**11,946**
Finance charges allocated to future periods	-	-
Net lease liabilities at 31 March 2025	**52,226**	**11,946**
Of which:		
Leased from other NHS providers		159
Leased from other DHSC group bodies		11,787

Note 20.5 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 finance 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 23 Other investments / financial assets (non-current)

	Group & Trust	
	2024/25	**2023/24**
	£000	**£000**
Carrying value at 1 April - brought forward	**5,347**	**4,964**
Acquisitions in year	764	891
Movement in fair value through OCI	61	393
Disposals	(780)	(901)
Carrying value at 31 March	**5,392**	**5,347**

Note 24 Analysis of charitable fund reserves

	31 March 2025	31 March 2024
	£000	£000
Unrestricted funds:		
Unrestricted income funds	4,913	5,909
Restricted funds:		
Other restricted income funds	1,254	2,071
	6,167	**7,980**

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 25 Inventories

	Group & Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Drugs	9,199	9,231	6,338	7,314
Work In progress	-	-		
Consumables	19,151	18,258	19,151	18,258
Energy	217	308	217	308
Other	-	-		
Charitable fund inventory	-	-		
Total inventories	**28,567**	**27,797**	**25,706**	**25,880**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £91k (2023/24: £866k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £7k).

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. Distribution of inventory by the Department ceased in March 2024.

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

Note 26.1 Receivables

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Current				
Contract receivables	22,659	32,693	22,659	32,691
Allowance for impaired contract receivables / assets	(3,863)	(4,623)	(3,863)	(4,623)
Prepayments (non-PFI)	8,058	6,535	8,036	6,519
PDC dividend receivable	1,285	87	1,285	87
VAT receivable	8,315	3,788	7,572	3,142
Corporation and other taxes receivable	-	-	-	28
Other receivables	1,015	769	1,131	779
NHS charitable funds receivables	80	317	-	-
Total current receivables	**37,549**	**39,566**	**36,820**	**38,623**
Non-current				
Contract receivables	3,944	2,155	3,944	2,155
Allowance for impaired contract receivables / assets	(894)	(481)	(894)	(481)
Prepayments (non-PFI)	-	-	-	-
PFI prepayments - capital contributions	-	-	-	-
PFI lifecycle prepayments	-	-	-	-
Interest receivable	-	-	-	-
Other receivables	1,367	1,345	1,367	1,345
NHS charitable funds receivables	-	-	-	-
Total non-current receivables	**4,417**	**3,019**	**4,417**	**3,019**
Of which receivable from NHS and DHSC group bodies:				
Current	15,492	20,637	15,179	20,637
Non-current	1,367	1,345	1,367	1,345

Note 26.2 Allowances for credit losses - 2024/25

	Group & Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2024 - brought forward	**5,104**	**-**
Allowances at start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
New allowances arising	2,676	-
Changes in existing allowances	-	-
Reversals of allowances	(567)	-
Utilisation of allowances (write offs)	(2,456)	-
Changes arising following modification of contractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2025	**4,757**	**-**

Note 26.3 Allowances for credit losses - 2023/24

	Group & Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2023 - as previously stated	**4,822**	**-**
Prior period adjustments	-	-
Allowances as at 1 Apr 2023 - restated	**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 27.1 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	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	**42,391**	**107,980**	**37,347**	**101,080**
Net change in year	(640)	(65,589)	1,655	(63,733)
At 31 March	**41,751**	**42,391**	**39,002**	**37,347**
Broken down into:				
Cash at commercial banks and in hand	2,780	5,081	30	37
Cash with the Government Banking Service	38,971	37,310	38,972	37,310
Total cash and cash equivalents as in SoFP	**41,751**	**42,391**	**39,002**	**37,347**
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**41,751**	**42,391**	**39,002**	**37,347**

Note 27.2 Third party assets held by the trust

University Hospitals of Leicester NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Bank balances	4	9
Total third party assets	**4**	**9**

Note 28.1 Trade and other payables

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Current				
Trade payables	58,903	47,171	59,210	48,035
Capital payables	10,533	16,590	10,533	16,590
Accruals	57,031	66,697	56,303	65,689
Receipts in advance and payments on account	-	-	-	-
PFI lifecycle replacement received in advance	-	-	-	-
Social security costs	10,972	10,602	10,955	10,577
VAT payables	-	-		
Other taxes payable	12,636	11,198	12,617	11,188
PDC dividend payable	-	-		
Pension contributions payable	13,589	12,125	13,589	12,125
Other payables	413	1,106	309	1,002
NHS charitable funds: trade and other payables	219	240	-	-
Total current trade and other payables	**164,296**	**165,728**	**163,516**	**165,206**
Of which payables from NHS and DHSC group bodies:				
Current	10,462	5,530	10,462	9757
Non-current	-	-		

Note 28.2 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 2025 £000	31 March 2025 Number	31 March 2024 £000	31 March 2024 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 29 Other liabilities

	Group & Trust	
	31 March 2025	31 March 2024
	£000	£000
Current		
Deferred income: contract liabilities	4,650	4,812
Deferred grants	-	-
Deferred PFI credits / income	-	-
Other deferred income	-	-
NHS charitable funds: other liabilities	-	-
Total other current liabilities	**4,650**	**4,812**

Note 30.1 Borrowings

	Group & Trust	
	31 March 2025	31 March 2024
	£000	£000
Current		
Other loans	-	-
Lease liabilities	9,125	9,434
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	-	-
NHS charitable funds: other current borrowings	-	-
Total current borrowings	**9,125**	**9,434**
Non-current		
Lease liabilities	43,101	34,373
Total non-current borrowings	**43,101**	**34,373**

Note 30.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2024/25	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2024	**43,807**	**43,807**
Cash movements:		
Financing cash flows - payments and receipts of principal	(11,065)	**(11,065)**
Financing cash flows - payments of interest	(3,451)	**(3,451)**
Non-cash movements:		
Additions	17,930	**17,930**
Lease liability remeasurements	1,601	**1,601**
Remeasurement of PFI / other service concession liability resulting from change in index or rate		**-**
Application of effective interest rate	3,451	**3,451**
Change in effective interest rate	-	**-**
Changes in fair value	-	**-**
Early terminations	(47)	**(47)**
Other changes	-	**-**
Carrying value at 31 March 2025	**52,226**	**52,226**

Group - 2023/24	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2023	**41,745**	**41,745**
Prior period adjustment	-	**-**
Carrying value at 1 April 2023 - restated	**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**

Note 31 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**1,635**	**898**	**-**	**13,149**	**15,682**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	4	4	-	(13)	**(5)**
Arising during the year	192	84	1,247	2,842	**4,365**
Utilised during the year	(233)	(72)	-	(4,428)	**(4,733)**
Reversed unused	-	-	-	(2,494)	**(2,494)**
Unwinding of discount	35	20	-	69	**124**
Movement in charitable fund provisions	-	-	-	-	**-**
At 31 March 2025	**1,633**	**934**	**1,247**	**9,125**	**12,939**
Expected timing of cash flows:					
- not later than one year;	229	71	1,247	7,758	**9,305**
- later than one year and not later than five years;	1,404	863	-	1,367	**3,634**
- later than five years.	-	-	-	-	**-**
Total	**1,633**	**934**	**1,247**	**9,125**	**12,939**

Note 31.1 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Pensions: injury benefits	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**1,635**	**898**	**-**	**13,104**	**15,637**
At start of period for new FTs					**-**
Transfers by absorption	-	-	-	-	-
Change in the discount rate	4	4	-	(13)	**(5)**
Arising during the year	192	84	1,247	2,792	**4,315**
Utilised during the year	(233)	(72)	-	(4,383)	**(4,688)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	-	-	-	(2,494)	**(2,494)**
Unwinding of discount	35	20	-	69	**124**
At 31 March 2025	**1,633**	**934**	**1,247**	**9,075**	**12,889**
Expected timing of cash flows:					
- not later than one year;	229	70	1,247	7,708	**9,254**
- later than one year and not later than five years;	1,404	864	-	1,367	**3,635**
- later than five years.					**-**
Total	**1,633**	**934**	**1,247**	**9,075**	**12,889**

Note 31.2 Clinical negligence liabilities

At 31 March 2025, £492,905k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals of Leicester NHS Trust (31 March 2024: £275,039k).

Note 32 Contingent assets and liabilities

There Group and Trust had no contingent assets or liabilities at 31.3.25 or 31.3.24

Note 33 Contractual capital commitments

	Group & Trust	
	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	16,012	16,235
Intangible assets	1,925	426
Total	**17,937**	**16,661**

Note 34 Other financial commitments

The group / trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

The Group and Trust have no other financial commitments.

Note 35 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 35.1 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	23,345	-	-	**23,345**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	40,699	-	-	**40,699**
Consolidated NHS Charitable fund financial assets	1,052	-	5,392	**6,444**
Total at 31 March 2025	**65,096**	**-**	**5,392**	**70,488**

	£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**

Note 35.2 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	23,345			**23,345**
Other investments / financial assets	4,000			**4,000**
Cash and cash equivalents	39,001			**39,001**
Total at 31 March 2025	**66,346**	**-**	**-**	**66,346**

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**

Note 35.3 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under leases	52,226	-	**52,226**
Obligations under PFI, LIFT and other service concessions	-	-	**-**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	122,962	-	**122,962**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Consolidated NHS charitable fund financial liabilities	219	-	**219**
Total at 31 March 2025	**175,407**	**-**	**175,407**

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**

Note 35.4 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care			**-**
Obligations under leases	52,226		**52,226**
Obligations under PFI, LIFT and other service concessions			**-**
Other borrowings			**-**
Trade and other payables excluding non financial liabilities	122,538		**122,538**
Other financial liabilities			**-**
Provisions under contract			**-**
Total at 31 March 2025	**174,764**	**-**	**174,764**

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**

Note 35.5 Fair values of financial assets and liabilities

The book value of financial liabilities is a reasonable approximation of fair value.

Note 35.6 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 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
In one year or less	132,306	130,516	131,882	134,300
In more than one year but not more than five years	42,163	32,676	42163	32,676
In more than five years	938	1,697	938	1,697
Total	**175,407**	**164,889**	**174,983**	**168,673**

	2024/25		2023/24	
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	976	2,456	835	1,698
Stores losses and damage to property	-	-	-	-
Total losses	**976**	**2,456**	**835**	**1,698**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	35
Extra-contractual payments	-	-	-	-
Ex-gratia payments	100	242	95	198
Special severance payments	1	10	2	17
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**101**	**252**	**98**	**250**
Total losses and special payments	**1,077**	**2,708**	**933**	**1,948**
Compensation payments received				

Note 37 Gifts

The Group and Trust made no gifts in 2024/25 (2023/24 - none)

Note 38 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

Kettering General Hospital NHS Foundation Trust

North West Anglia NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust

Leicestershire Partnership NHS Trust

Northampton General Hospital NHS Trust

Nottingham University Hospitals NHS Trust

United Lincolnshire Teaching 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

NHS Staffordshire and Stoke-on-Trent ICB

NHS Resolution

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 39 Better Payment Practice code

Non-NHS Payables	2024/25 Number	2024/25 £000	2023/24 Number	2023/24 £000
Total non-NHS trade invoices paid in the year	162,182	824,282	190,534	934,748
Total non-NHS trade invoices paid within target	139,024	761,834	179,597	880,562
Percentage of non-NHS trade invoices paid within target	85.7%	92.4%	94.3%	94.2%
NHS Payables				
Total NHS trade invoices paid in the year	1,801	67,693	3,433	90,622
Percentage of NHS trade invoices paid within target	94.6%	99.7%	83.4%	87.4%

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

Note 40 Capital Resource Limit

	2024/25 £000	2023/24 £000
Gross capital expenditure	104,721	122,001
Less: Disposals	(213)	(3,444)
Less: Donated, granted and peppercorn leased capital additions	(8,113)	(3,611)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	-
Charge against Capital Resource Limit	**96,395**	**114,946**
Capital Resource Limit	96,395	115,080
Under / (over) spend against CRL	**-**	**134**

Note 41 Breakeven duty financial performance

	2024/25 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(37,238)
Remove impairments scoring to Departmental Expenditure Limit	133
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**(37,105)**

Note 42 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		51	1,013	88	91	(39,655)	(40,648)	(34,051)	(27,152)
Breakeven duty cumulative position	3,910	3,961	4,974	5,062	5,153	(34,502)	(75,150)	(109,201)	(136,353)
Operating income		697,692	696,257	719,154	758,665	770,393	834,376	866,036	924,269

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(34,455)	(44,879)	(111,368)	9,715	3,778	(12,459)	(52,831)	(37,105)
Breakeven duty cumulative position	(170,808)	(215,687)	(327,055)	(317,340)	(313,562)	(326,021)	(378,852)	(415,957)
Operating income	960,790	992,246	1,086,969	1,284,222	1,318,977	1,486,225	1,587,499	1,786,212
Cumulative breakeven position as a percentage of operating income	(17.8%)	(21.7%)	(30.1%)	(24.7%)	(23.8%)	(21.9%)	(23.9%)	(23.3%)

Staff costs

	Group			
			2024/25	2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	878,896	-	**878,896**	786,887
Social security costs	93,270	-	**93,270**	85,144
Apprenticeship levy	4,316	-	**4,316**	3,966
Employer's contributions to NHS pension scheme	157,877	-	**157,877**	120,775
Pension cost - other	72	-	**72**	100
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	12,603	**12,603**	33,192
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**1,134,431**	**12,603**	**1,147,034**	**1,030,064**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**1,134,431**	**12,603**	**1,147,034**	**1,030,064**
Of which				
Costs capitalised as part of assets	4,298	-	**4,298**	3,564

Average number of employees (WTE basis)

	Group			
			2024/25	2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	2,172	220	**2,392**	2,295
Ambulance staff	14	-	**14**	-
Administration and estates	3,095	83	**3,178**	3,140
Healthcare assistants and other support staff	3,200	93	**3,293**	3,169
Nursing, midwifery and health visiting staff	5,223	309	**5,532**	5,382
Nursing, midwifery and health visiting learners	3	33	**36**	3
Scientific, therapeutic and technical staff	1,791	62	**1,853**	1,795
Healthcare science staff	970	5	**975**	943
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**16,468**	**805**	**17,273**	**16,727**
Of which:				
Number of employees (WTE) engaged on capital projects	62	62	**124**	52

Reporting of compensation schemes - exit packages 2024/25

	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	1	1	**2**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**1**	**2**
Total cost (£)	£11,000	£10,000	**£21,000**

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 resource cost (£)	£160,000	£149,840	**£309,840**

Exit packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	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	-	-	-	-
[illegible] approval	1	10	2	17
Total	**1**	**10**	**12**	**150**
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: UHL 2024/25 position (self-assessment)

* 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.
Highlighting indicates deviation from the provision, either in part or in totality

Provision	Description	Comply	Explain any deviation	Comments
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		'Our Sustainability Report' section of Annual Report 2024/25

Provision	Description	Comply	Explain any deviation	Comments
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		'About Us' section of Annual Report 2024/25
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		'Our People' section of the Annual Report 2024/25

Provision	Description	Comply	Explain any deviation	Comments
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		Monthly Integrated Performance Report Assurance role of Board Committees including FIC and Quality Committee
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*	Y		Role of Director of Health Equality and Inclusion sitting on the Trust Board. Quarterly updates provided to Board

Provision	Description	Comply	Explain any deviation	Comments
	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.			assurance Committees and public Trust Board meetings Health inequalities workstreams reported through QC. Evidence of community based engagement to address health inequalities
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 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.	Y		Quality Account Updates to Quality Committee on compliance with CQC recommendations Regular Trust Board updates on maternity clinical governance and safety.

Provision	Description	Comply	Explain any deviation	Comments
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. ~~NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.~~	Y		Patient Partner and ICB representation on Quality Committee Interaction with system partner meetings eg Trust Deputy Chief Executive attends ICB meetings, System Executive meetings etc
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	Y		Part of the 'Accountability Report' section of Annual Report 2024/25

Provision	Description	Comply	Explain any deviation	Comments
	of directors should keep engagement mechanisms under review so that they remain effective.			
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		Externally-provided FTSU function sits within an independent Directorate (Corporate and Legal Affairs). The FTSU Guardian provides regular quarterly reports to the Trust Board public session and attends for those updates Trust has a Freedom to Speak Up: Raising Concerns (whistle-blowing) Policy, and a Non-Executive Director Champion for FTSU.
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	Y		Each Trust Board agenda contains a section on declaring any interests in the specific business being discussed, which is recorded in the Minutes. In addition to the electronic system below, Trust Board members' declarations of interests are reported annually to the public session (plus any in-year updates as required) – this list is available on the Trust's external website Trust has a Managing Conflicts of Interests in the NHS Policy, and uses a publicly-accessible

Provision	Description	Comply	Explain any deviation	Comments
	for staff 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).			electronic system for capturing staff declarations of interests: https://uhl.mydeclarations.co.uk/
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)		
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		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.			
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		
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		
B2.6*	The board of directors should identify in the annual report each non-executive director it considers to be independent.	Y	The Dean of Medicine at the University of Leicester is also a UHL Non-Executive Director	Covered in the Corporate Governance element of the 'Accountability Report' section of Annual Report 2024/25 – the

Provision	Description	Comply	Explain any deviation	Comments
	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,			position at the medical school is recorded in the Trust Board declarations of interests report

Provision	Description	Comply	Explain any deviation	Comments
	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.			
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		7 NEDs excluding Chair, 5 voting Trust Board Exec Directors
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. ~~For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.~~	Y		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	by invitation of the particular committee.			
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		
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	Y		Chair meets monthly with Non-Executive Director colleagues

Provision	Description	Comply	Explain any deviation	Comments
	without the executive directors present.			
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		Covered in the Corporate Governance element of the 'Accountability Report' section of Annual Report 2024/25
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	Y		Reflected in the declarations of interests made by Trust Board members each year

Provision	Description	Comply	Explain any deviation	Comments
	chairship of such an organisation.			
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		
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		

Provision	Description	Comply	Explain any deviation	Comments
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		Trust Board currently meets monthly in public, and dates are publicised on the Trust's external website The powers reserved to itself by the Trust Board are clearly set out in the 'Standing Financial Instructions and Scheme of Delegation' UHL policy
Section C	**Composition, succession and evaluation - Provisions for NHS Trust Board appointments**			
C3.1	NHS England is responsible for appointing chairs and other non-	Y		Remuneration Committee

Provision	Description	Comply	Explain any deviation	Comments
	executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the 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	Y		Trust has a Fit and Proper Persons Policy, and relevant documentation is held centrally

Provision	Description	Comply	Explain any deviation	Comments
	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.			
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	Not included in the Annual Report 2024/25, but the information is on the Trust's external website https://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/trust-board-senior-directors/	Annual Report 2024/25 contains a hyperlink to the detailed information on the Trust's public website
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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 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. ~~For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair.~~ NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	Y		

Provision	Description	Comply	Explain any deviation	Comments
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		
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		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	their time commitment to the role, without the board first completing and approving a full risk assessment.			
	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.	Y		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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.			
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.	Y		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	individual and collective development programme.			
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)		
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. ~~Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.~~	Y		
C5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation	Y		

Provision	Description	Comply	Explain any deviation	Comments
	to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.			
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		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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.			
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	decide that external assurance is appropriate.			
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		
C5.13	Committees should be provided with sufficient resources to undertake their duties. ~~The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.~~	Y		
C5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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.			
	Insurance cover			
5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. ~~Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.~~	Y		2024/25 Annual Accounts confirm that UHL has LTPS insurance in place
Section D	**Audit, risk and internal control**			

Provision	Description	Comply	Explain any deviation	Comments
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		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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 there 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.			

Provision	Description	Comply	Explain any deviation	Comments
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		
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	Y		'Annual Accounts' section of the Annual Report 2024/25

Provision	Description	Comply	Explain any deviation	Comments
	- an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.			
D2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. ~~An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.~~	Y		
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		'Statement of Directors Responsibilities in Respect of the Accounts' section of the Annual Report 2023/24
D2.7*	The board of directors should carry out a robust assessment of the trust's emerging and	Y		

Provision	Description	Comply	Explain any deviation	Comments
	principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.			
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		'AGS' section of the Annual Report 2024/25
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	Y		'Going Concern' section of the Annual Report 2024/25

Provision	Description	Comply	Explain any deviation	Comments
	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.			
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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. ~~- For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors.~~ 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.			
E2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Y		

Provision	Description	Comply	Explain any deviation	Comments
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)		
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		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).			
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		
E2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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

Aby uzyskać informacje w innym języku, proszę zadzwonić pod podany niżej numer telefonu

જો તમને અન્ય ભાષામાં આ માહિતી જોઈતી હોય, તો નીચે આપેલ નંબર પર કૃપા કરી ટેલિફોન કરો.

All information is accurate at time of publishing (September 2025).

Leading in healthcare,
trusted in communities