University Hospitals of Leicester
NHS Trust

Annual Report

2025/26

University Hospitals of Leicester NHS Trust

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

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Overview

Welcome statements from the Chair and Chief Executive

Chair's statement

It is my privilege to present this year's annual report for University Hospitals of Leicester NHS Trust. As Chair, I remain deeply proud of the extraordinary commitment, resilience, and professionalism demonstrated by our colleagues across what has been another demanding year for the NHS.

Throughout the past year, our organisation has continued to operate in a complex and evolving healthcare landscape. Pressures on urgent and emergency care, workforce challenges, and increasing demand for services have tested our systems. Yet time and again, our teams have risen to these challenges with determination, compassion, and an unwavering focus on patient care.

We have made meaningful progress against our strategic priorities. Improvements in patient access, investment in digital infrastructure, and the strengthening of our clinical services are helping to create a more responsive and sustainable organisation. Our elective recovery programme has enabled us to treat more patients, while maintaining safety and quality as our foremost priorities.

Quality of care remains at the heart of everything we do. This year, we have continued to embed a culture of continuous improvement, learning from incidents, and listening closely to patient feedback. While we acknowledge that there is more to do to consistently meet all performance standards, we are encouraged by the progress made and remain firmly committed to delivering safe, effective, and compassionate care for all.

Our workforce is our greatest asset. I would like to extend my sincere thanks to every colleague, volunteer, and partner who contributes to our Trust. We have taken steps this year to improve colleague. wellbeing, support recruitment, and foster a more inclusive and supportive working environment. These efforts are essential not only for our people but also for the patients and communities we serve.

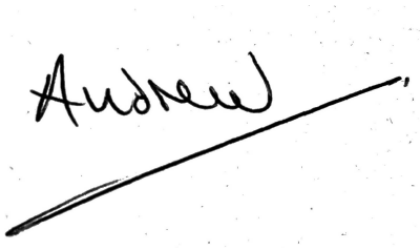
This year also saw periods of industrial action by Resident Doctors, which presented additional challenges across our services. Our priority throughout was to minimise disruption to patients and ensure that safety and urgent care remained protected. I would like to express my sincere gratitude to colleagues across all professional groups who went above and beyond during these periods—adapting rotas, covering additional duties, and supporting one another to maintain continuity of care under considerable pressure. Their professionalism and collective effort ensured that we were able to continue delivering safe services to our patients during these challenging times.

Collaboration has been a defining theme of the year. Working closely with partners across the Leicester, Leicestershire and Rutland system, we are strengthening integrated care pathways and improving outcomes for our population. In particular, our growing partnership with University Hospitals of Northamptonshire has demonstrated the tangible benefits of closer collaboration between neighbouring trusts. By starting work on aligning clinical pathways, sharing expertise, and coordinating services across organisational boundaries, we are improving access to specialist care, reducing variation, and making better use of our collective resources. This collaborative approach not only enhances patient outcomes but also strengthens our ability to respond to system-wide challenges with greater resilience and flexibility.

Financial sustainability continues to be a significant challenge across the NHS. We have worked diligently to manage our resources responsibly, identifying efficiencies while protecting frontline services. Maintaining this balance will remain a key focus in the coming year.

Looking ahead, we are clear about the work still required. Reducing waiting times, improving access to services, and enhancing patient experience will remain central to our priorities. At the same time, we will continue to invest in innovation, infrastructure, and our workforce to ensure the long-term resilience of our organisation.

In closing, I would like to thank our patients and communities for their trust and support, and our colleagues for their dedication and compassion. Together, we will continue to build a stronger, more sustainable healthcare service for the future.



Andrew Moore
Trust Chair
22 June 2026

Chief Executive's statement

The last year in the NHS and at UHL and UHN has been a period of transformation. For me, four themes stand out: a gradual return of public confidence, the continuing strain on colleague experience, stronger financial discipline, and the rapid rise of digital and artificial intelligence (AI) transformation.

Public confidence in the health service is beginning to improve for the first time since before the pandemic. The annual British Social Attitudes poll has tracked attitudes towards the

NHS since 1983 and has found that faith in the health service remains low but is slowly recovering, though Gen Z are less happy with the NHS than older people. Overall, 26 per cent of people said they were satisfied with the NHS last year, up from a record low of 21 per cent in 2024. Here at UHL and UHN, we have improved quality, safety and access and early verbal feedback from recent CQC visits is promising. Our Group Clinical Strategy developed with involvement and insight from colleagues, partners, and communities across Leicester, Leicestershire, Rutland, and Northamptonshire, sets out how we will improve care, access, and outcomes for our population over the next decade, including reducing unwarranted variation and making better use of our collective expertise and capacity. Delivering this strategy requires us to work together more consistently across our hospitals and teams.

At the same time, this has been a difficult year for many colleagues across the NHS. The NHS Staff Survey results nationally show engagement and motivation have fallen due to operational pressures, burnout and dissatisfaction with pay. Within the high-level metrics, we know colleagues with protected characteristics, including race and disability, experience higher levels of discrimination, harassment, and reduced opportunities for career progression. The proportion of NHS colleagues who would recommend their organisation as a place to work fell to 56.9% in 2025, down from 59.9% in 2024 and close to its 2022 low. Scores at UHL and UHN deteriorated, and I know this is partly connected to the difficult decisions we have had to take. Some of those decisions have prompted criticism and this is both expected and accepted. We do not always get everything right, and constructive challenge, ideas and solutions help us improve. Over the next year, we also have important choices to make, and we are committed to listening, to improving experience of work and ensuring colleagues with protected characteristics see real change for the better.

Financially, this has been a year of greater grip across the NHS: workforce growth has levelled out and there have been notable reductions in agency use and increases in productivity. Locally, both UHL and UHN are delivering the revised control total we agreed with NHS England, and at UHL we have reduced the deficit compared to last year. Both UHL and UHN are forecasting a further reduction in deficit next year. Of course, none of this removes the reality of inflation, rising demand and service resilience pressures, all of which mean significant financial challenge, and which contribute to the need for difficult choices. Our focus remains on protecting high-quality care, improving productivity and working closely with partners to reduce duplication and make best use of our collective resources. By planning early and acting decisively, I am confident we will navigate the year ahead.

In a modern NHS, digital technology and AI are essential for enhancing patient outcomes, increasing operational efficiency, and enabling proactive care management. They help improve communication, remote monitoring, and personalised treatments, shifting the focus from reactive to preventative care while boosting efficiency. Key tools with increasing influence over the last year include telehealth, wearable devices, and AI-driven diagnostics. At UHL and UHN we are investing heavily in digital technology and AI and I

believe this is the biggest opportunity we have to improve patient care, colleague experience and our finances over the next 10 years. Digital innovation, including ambient voice technology, is still at an early stage but being piloted thoughtfully across sites, spreading both cost and risk. UHL's Patient Administration System (PAS) could not have gone live without UHN colleagues stepping in to support and we are now able to share skills and knowledge across organisations in ways that simply were not possible before. At UHL and UHN, AI will create jobs, change jobs and mean some jobs will no longer be needed. We need to support colleagues as we respond to these changes, and no decisions about roles will be made without engagement and support.

I am grateful to the many colleagues who have contributed to the transformation over the last year. In the last 12 months, the conversations that stay with me are the simplest ones. When I ask colleagues why they work in the NHS, the answer is almost always the same: *because I want to make a difference*. And UHL colleagues have done exactly that over the last 12 months.

Richard Mitchell
Chief Executive, UHL NHS Trust
22 June 2026

Overview: *About us*

Welcome to our 2025/26 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: https://www.uhleicester.nhs.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.**

Below are the elements of our strategy that we progressed over the past year:

- Delivery of year two of the Quality Strategy (2025/28), embedding PSIRF (Patient Safety Incident Response Framework), advancing the Perinatal Safety Improvement Programme, and strengthening quality governance and assurance.
- Measurable progress in access and flow, including transformation of planned care and urgent and emergency care pathways, aligned with national access standards.
- Sustained delivery of the Medium Term Financial Plan, maintaining financial control while progressing major transformation programmes and productivity improvements.
- Continuation of the Group 'One Digital' journey, reducing fragmentation across digital and data systems and progressing toward a more data-driven, digitally-enabled Trust.
- Strengthened people and culture outcomes, delivering year two of the People and EDI strategies and acting on staff survey feedback with a focus on compassionate and inclusive leadership.
- Progress toward a mature continuous improvement culture, advancing NHS IMPACT Continuous Improvement ambitions and embedding "Improving Together" methodologies across services.
- Advancement of the Group Model (UHL–UHN), implementing joint pathways

through the Group Clinical Strategy to improve safety, outcomes and system resilience.
- Enhanced partnership working with system partners, shaping clear plans for proactive Neighbourhood and community based care across Leicester, Leicestershire, Rutland and Northamptonshire.
- Increased participation in research and clinical trials, improving research delivery, commercial trial timeliness and staff engagement in innovation activity.
- Strong strategic leadership and assurance, with regular Board reporting on delivery of annual priorities, quality performance and progress against the organisational strategy.

You can read our full strategy on our website:
https://www.uhleicester.nhs.uk/about/trust/mission-vision-values/

Our Future Hospitals and Transformation

As part of the on-going delivery of our wider Group Clinical Strategy this ambitious programme will reconfigure acute and maternity services for the people of the Leicester, Leicestershire 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.

UHL's Transformation agenda as described above 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.

New Hospital Programme Developments
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 early 2032. 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.

Enabling Works
To enable the construction of new buildings at both the LRI and 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. In addition, Education and Training centres will be created in the historic Victoria building, providing our medical students and staff with modern learning environments.
This work has commenced with the final works due to complete in early 2028. Work at the GH is not as progressed but will be part of the next phase of development with NHP in 2026/27.

NHSE Funding (Return to Constitutional Standards)
Additionally national funding opportunities have been successfully secured for the capital development of facilities to support urgent care pathways which will improve access to services for patients across LLR:

- **Urgent Treatment Centre**
  The development of a new build Urgent Treatment Centre (UTC) at the LRI co-located with the existing Emergency Department will provide an improved clinical pathway to ensure patients are seen in the right environment in a timely fashion. The development is in construction with a completion date of Summer 2027. It creates the first step in standardising the Urgent Care offer across LLR and will support future developments as additional funding becomes available.

- **Community Diagnostic Centre**
  To support local population needs, there is a requirement for additional diagnostic capacity within LLR. Specific funding has been made available subject to business case approval to build a new Community Diagnostic Centre (CDC) at the Leicester General Hospital (LGH) with an associated refurbishment development within the City - location yet to be confirmed. They will be designed to accommodate the facilities in order to meet the core national requirements of a CDC. The business case is currently in development with the intent to start construction in 2027.

East Midlands Planned Care Centre and Endoscopy Unit at the LGH
Both facilities have now been operating fully since 2025, successfully delivering care in fit-for-purpose facilities. Both have and continue to introduce digitally enabled processes to support patient access and clinical pathways improving outcomes through better access to patient information and decision making.

UHL and UHN Group Clinical Strategy

In 2025/26 UHL and UHN finalised our joint Group Clinical Strategy (2025-30).

This strategy, and its 6 pillars of focus, involves bringing together clinical services across the UHL/UHN group and within the community (with neighbourhood health) to develop joint care models and pathways to reduce variation, share knowledge/ resources, and enhance efficiency such as via economies of scale.

Group Clinical Strategy Framework (2025-30)

In October 2025, programme governance was mobilised to coordinate and drive the strategy's delivery. Six workstreams, each of which is chaired by an executive leader from across the two trusts, manage the planning and day-to-day delivery of the focus areas - reporting progress, issues and risks to the Operational Group. The Operational Group, comprising colleagues from UHL and UHN Strategy and Partnerships teams, undertakes overall programme management including coordinating, monitoring and supporting the workstreams.

In 25/26 there has been progress on the development of enhanced Group collaboration arrangements across key specialties such as Plastic Surgery, Haematology, Spinal Surgery and Nuclear Medicine, with target operating models' development and being implemented. There has been a movement of patients between the Trusts within the group to offer patients lower waiting times.

In 26/27, target operating models will be developed for frailty, long terms conditions and neighbourhood health, in partnership with LPT/NHFT, general practice, local authorities and the integrated care board (ICB). Further specialties will develop and implement target operating models across the group as part of the safe and sustainable workstream and we will continue to define the models of care for maternity, neonates, CYP and cancer care.

Year in review – news highlights
April – June

23 April 2025: Miracle girl, Vanellope, returned for groundbreaking UK-first surgery
https://www.uhleicester.nhs.uk/news/miracle-girl-vanellope-returns-to-the-university-hospitals-of-leicester-nhs-trust-for-groundbreaking-uk-first-surgery/
Seven years after Vanellope Hope Wilkins was born with her heart outside her body, she returned to UHL for a second groundbreaking operation. An expert team came together during the eight-hour operation at the East Midlands Congenital Heart Centre (EMCHC), at the Leicester Royal Infirmary, to reconstruct Vanellope's chest. The surgery was essential to protect her heart as she continues to grow.

15 May 2025: Hundreds have life-saving heart screening at pop-up clinic in Leicester
https://www.uhleicester.nhs.uk/news/hundreds-have-life-saving-heart-screening-at-pop-up-clinic-in-leicester/
Hundreds of people benefited from a free heart health check in Leicester city centre on 13 May as part of an initiative to improve early detection. The event was organised by our cardiology team in partnership with Valve for Life UK to raise awareness of heart valve disease. Throughout the day, more than 500 people were screened – with around 50 being referred for further investigation after signs of potential heart issues were detected.

27 June 2025 - Hinckley's state-of-the-art Community Diagnostic Centre opened
https://www.uhleicester.nhs.uk/news/hinckleys-state-of-the-art-community-diagnostic-centre-formally-opens/

A £24.6 million state-of-the-art Community Diagnostic Centre (CDC) was officially opened in Hinckley. The first of its kind in Leicestershire, the brand-new purpose-built facility offers patients a wide range of diagnostic tests closer to home, giving greater choice on where they are undertaken and easing pressure on our busy hospitals. Located next to the site of the former Hinckley and District Community Hospital on Mount Road, the CDC provides a range of

diagnostic tests such as CT, MRI, X-ray, ultrasound, phlebotomy, dermatology, audiology assessments and endoscopy.

30 June 2025: UHL team scooped HSJ award for multilingual digital check-in kiosks
https://www.uhleicester.nhs.uk/news/uhl-team-scoops-hsj-award-for-multilingual-digital-check-in-kiosks/

UHL picked up an HSJ award for its work to improve access to healthcare through digital innovation. The Trust won the Digital Equality, Diversity and Inclusion Award for the introduction of multilingual self-check-in kiosks at the East Midlands Planned Care Centre (EMPCC) at the Leicester General Hospital. The kiosks, which offer six language options including Gujarati, Punjabi, Polish, Bengali, Hindi and English, are designed to support patients when they attend their appointments.

July-September

2 July 2025: UHL named as UK's first EAACI Centre of Excellence
https://www.uhleicester.nhs.uk/news/uhl-named-as-uks-first-eaaci-centre-of-excellence/
UHL achieved a UK first, after being named as a Centre of Excellence by the European Academy of Allergy and Clinical Immunology (EAACI). This prestigious international designation – which recognises the work of our allergy, immunology, asthma and severe asthma services, in collaboration with partners at the University of Leicester's Department of Respiratory Sciences – has been earned by just 12 centres worldwide.

30 July 2025: UHL-UHN Group signed AI agreement with Microsoft
https://www.uhleicester.nhs.uk/news/uhl-uhn-group-signs-ai-agreement-with-microsoft/
UHL and University Hospitals of Northamptonshire NHS Group signed a Memorandum of Understanding with Microsoft to formalise a partnership to develop AI healthcare solutions. The agreement builds on existing relationships and successes to benefit patient care and includes incorporating AI into how we deliver clinical care, administer care and transform support services across our organisations.

12 August 2025: First patients received 'groundbreaking' blood cancer treatment at UHL
https://www.uhleicester.nhs.uk/news/first-patients-receive-groundbreaking-blood-cancer-treatment-at-uhl/
A ground-breaking blood cancer treatment that involves transforming cells in the immune system so they can attack and destroy cancer cells was delivered at UHL for the first time. Chimeric antigen receptor T-cell therapy – known as CAR T-cell therapy – is a personalised treatment, which uses the patient's own genetically modified immune system cells (T-cells) to target and kill cancer cells. The specialist treatment is only available in a few centres nationally for patients with specific cancers, including B-cell lymphomas and acute lymphoblastic leukaemia, where other treatments have not worked.

21 August 2025: Leicester General Hospital celebrated Pathway to Excellence® accreditation

https://www.uhleicester.nhs.uk/news/university-hospitals-of-leicester-nhs-trust-becomes-first-to-gain-double-accredited-status/

Leicester General Hospital achieved its Pathway to Excellence® accreditation, making UHL the only NHS trust in the UK to have two inpatient sites with Pathway accreditation. It came just over a year after the Glenfield Hospital became the seventh hospital in the UK to achieve this prestigious status. The two hospitals are now recognised as outstanding places to work for nurses, registered nursing associates, and midwives.

29 August 2025: UHL recognised as one of the UK's top apprenticeship employers

https://www.uhleicester.nhs.uk/news/uhl-recognised-as-one-of-the-uks-top-apprenticeship-employers/

UHL was named one of the UK's best apprenticeship employers by the Sunday Times, recognising the Trust's long-term investment in staff development and creating career opportunities.

1 September 2025: Anaesthetics teams reach ACSA accreditation goal

https://www.uhleicester.nhs.uk/news/anaesthetic-teams-reach-acsa-accreditation-goal/

Plaques were presented to the Trust to honour its success in earning Anaesthesia Clinical Services Accreditation (ASCA) from the Royal College of Anaesthetists. ACSA is a comprehensive process for quality improvement through peer review, covering all aspects of anaesthetics services. Achieving the accreditation shows that the departments have been assessed as providing services of a high and consistent quality.

5 September 2025: HRH The Duke of Edinburgh officially opened Thornton Suite at the Leicester Royal Infirmary

https://www.uhleicester.nhs.uk/news/hrh-the-duke-of-edinburgh-officially-opens-thornton-suite-at-the-leicester-royal-infirmary/

The state-of-the-art Thornton Suite at the Leicester Royal Infirmary was officially opened by His Royal Highness The Duke of Edinburgh. Based in the Osborne building, the Thornton Suite is a specialist facility designed to support the treatment of gynaecological cancers with a specialised form of radiotherapy called brachytherapy.

October- December

1 October 2025: UHL began first UK trial to assess AI effectiveness across all patient groups

https://www.uhleicester.nhs.uk/news/uhl-undertaking-first-uk-trial-to-assess-ai-effectiveness-across-all-patient-groups/

Colleagues began the first UK evaluation of the safety and effectiveness of using AI software across different patient groups. Working with specialist AI evaluation company Aival, the Trust is evaluating the performance of a system which currently supports clinicians when viewing chest X-rays.

9 October 2025: UHL – UHN Group Clinical Strategy 2025 – 2035 is launched

https://www.uhleicester.nhs.uk/news/our-uhl-uhn-group-clinical-strategy-2025-2035/
In October, UHL and the University Hospitals of Northamptonshire launched their joint Group Clinical Strategy which outlined how they plan to work together over the next 10 years. The strategy's aims are to deliver more consistent, higher-quality care for the people we serve, better support colleagues and tackle shared challenges – improvements neither organisation could achieve alone. Our Group Clinical Strategy, which is grounded in data, insight and patient voice, has been created through conversations with our clinicians alongside healthcare and wider system partners.

17 October 2025: UHL selected to host new research collaboration initiative
https://www.uhleicester.nhs.uk/news/uhl-nihr-arc-eastmidlands-hosting-announcement/
The National Institute for Health and Care Research (NIHR) announced a £157 million investment over the next five years to support 10 NIHR Applied Research Collaborations (ARCs) across England, including the NIHR ARC East Midlands hosted by UHL. The new NIHR ARCs will support the transformation set out in the NHS 10 Year Plan, the Life Sciences Sector Plan and the Government's Health and Growth Missions by tackling some of the UK's most pressing health and social care challenges through high-quality applied research.

24 October 2025: UHL perinatal services awarded gold for excellence in LGBTQ+ healthcare
https://www.uhleicester.nhs.uk/news/uhl-perinatal-services-awarded-gold-for-excellence-in-lgbtq-healthcare/
UHL's perinatal services were awarded the Gold Pride in Practice Award from the LGBT Foundation, recognising excellence in LGBTQ+ healthcare for the department's ongoing commitment to inclusive, person-centred care. Pride in Practice is a national quality assurance programme delivered by the LGBT Foundation to help healthcare providers strengthen their services for LGBTQ+ patients. The Gold
Award represents the highest level of achievement, placing UHL among a small number of maternity and neonatal units nationally to be recognised at this level.

4 November 2025: UHL benefitted from £700,000 investment in NHS solar schemes across Leicester and Leicestershire
https://www.uhleicester.nhs.uk/news/uhl-benefits-from-700000-investment-in-nhs-solar-schemes-across-leicester-and-leicestershire/
More than £700,000 was invested in green energy projects for NHS buildings in Leicester and Leicestershire, with over £300,000 going to a solar scheme at UHL's Preston Lodge rehabilitation unit. Great British Energy provide the cash for roof mounted solar arrays as part of the drive to meet the country's net zero targets. These investments will reduce the NHS's carbon emissions and reduce energy bills.

5 November: State-of-the-art endoscopy unit welcomed first patients
https://www.uhleicester.nhs.uk/news/state-of-the-art-endoscopy-unit-welcomes-first-patients/
A new endoscopy unit at the Leicester General Hospital welcomed its first patients. The unit has the capacity to see an extra 9,000 patients every year and will play an important part in reducing waiting lists. The purpose-built unit includes six procedure

rooms, and 20 private pods for patients before and after their procedures, each with an en-suite.

6 November: Badger babies welcomed as UHL launches new maternity notes app
https://www.uhleicester.nhs.uk/news/badger-babies-welcomed-as-uhl-launches-new-maternity-notes-app/
Expectant parents across Leicester, Leicestershire and Rutland can access maternity records and tailored pregnancy information at the touch of a button following the launch of a new app called Badger Notes. Badger Notes replaces the traditional hand-held paper file with an app to view a week-by-week timeline, scheduled appointments and maternity records as well as access to information leaflets and the ability to submit thoughts and questions about antenatal care, birth plan and postnatal care to midwives and doctors.

11 November 2025: Ground-breaking new centre turbocharges research and treatment for patients with artery disease
https://www.uhleicester.nhs.uk/news/award-for-global-vascular-research-centre/
NIHR Leicester Biomedical Research Centre experts at the Glenfield Hospital were awarded nearly £2 million to set up a global vascular research centre. The funding, from the National Institute for Health and Care Research (NIHR) Research Professorships scheme, supported the creation of a ground-breaking new programme called CIRCULIFE, giving patients with artery problems in the legs or main body artery the right medicines, lifestyle advice and care at the right time.

11 December 2025: BBC went behind the scenes at UHL's emergency department
https://www.uhleicester.nhs.uk/news/bbc-goes-behind-the-scenes-at-uhls-emergency-department-this-winter/
The BBC went behind the scenes at UHL's emergency department and saw first-hand how our teams were working to provide patients with compassionate care in the face of unprecedented winter pressures. The news feature, presented by the BBC's national health editor, Hugh Pym, highlighted some of the initiatives which UHL have put in place to manage high levels of demand for care.

15 December 2025: UHL completes refurbishment of Preston Lodge to boost winter care capacity
https://www.uhleicester.nhs.uk/news/uhl-completes-refurbishment-of-preston-lodge-in-a-boost-to-winter-care-capacity/
UHL completed the refurbishment of its new 53 bed community rehabilitation facility, Preston Lodge, marking a major step in improving patient recovery and discharge support. The new standalone unit, based in North Evington just 1.6 miles from the Leicester Royal Infirmary, helps patients recover from their hospital stay while getting specialist care such as physiotherapy, occupational therapy, speech and language support, and rehabilitation.

23 December 2025: More than £50 million funding announced for two major schemes at UHL
https://www.uhleicester.nhs.uk/news/more-than-50-million-funding-announced-for-two-major-schemes-at-uhl/
In December, UHL had over £50million of funding approved to deliver exciting new projects set to shape the way patient care is delivered. NHS England gave the green light for a new £12.8m Urgent Treatment Centre (UTC) at the Leicester Royal Infirmary (LRI), which is due to open in 2027. The national New Hospital Programme (NHP) approved £39m of funding for UHL to begin essential enabling works on its three

hospital sites. The work is expected to finish in early 2028, paving the way for the main construction phase of the NHP in 2032.

January – March 2026

6 February 2026: UHL wins national award for transformative Electronic Patient Record rollout

https://www.uhleicester.nhs.uk/news/uhl-wins-national-award-for-transformative-electronic-patient-record-rollout/

The Patient Administration System (PAS) project team at UHL won a prestigious HTN Now Awards 2025/26 in the Healthcare Improvement and Operations Transformation category. The recognition marks a major digital milestone for the Trust and celebrates its largest electronic patient record (EPR) project to date.

12 February 2026: Doctors at Glenfield Hospital became the first in England to use new technique to treat irregular heart rhythms

https://www.uhleicester.nhs.uk/news/doctors-at-glenfield-hospital-are-first-in-england-to-use-new-technique-to-treat-irregular-heart-rhythms/

Consultant Cardiologists at the Glenfield Hospital became the first in England to treat atrial fibrillation using a new pulsed field ablation (PFA) procedure. Consultant Cardiologists, Dr Riyaz Somani and Dr Zakariyya Vali, completed the Trust's first successful treatment using the new Volt™ PFA System, developed by healthcare company, Abbott.

20 February 2026: UHL Consultant Cardiologist received City of Leicester Award for decades of life-changing work

https://www.uhleicester.nhs.uk/news/uhl-consultant-cardiologist-honoured-with-city-of-leicester-award-for-decades-of-life%e2%80%91changing-work/

Professor Sir Nilesh Samani, Consultant Cardiologist, was presented with a City of Leicester Civic Award by the Deputy Lord Mayor of Leicester, Councillor Bhupen Dave. The award celebrates individuals whose work has made a profound and lasting difference to people in Leicester and beyond. Professor Samani, who has spent more than five decades living and working in Leicester, said he was deeply touched by the honour.

10 March 2026: Patient praises 'amazing' team who helped her walk again after horse riding accident

https://www.uhleicester.nhs.uk/news/patient-praises-amazing-team-who-helped-her-walk-again-after-horse-riding-accident/

The high-quality care provided to Leicester Royal Infirmary patient, Nicola Turner, saw her make remarkable progress in her recovery following a complex leg fracture. UHL surgeons fitted an external fixation frame to stabilise the fracture and support the healing process. As part of her rehabilitation, Nicola attended a specialist monthly physiotherapy exercise class offering personalised exercise plans, one-to-one physiotherapy support, and a chance to connect with others recovering from traumatic injuries.

12 March 2026: Leicester General Hospital celebrated official opening of new state-of-the-art MRI scanner
https://www.uhleicester.nhs.uk/news/leicester-general-hospital-celebrates-official-opening-of-new-state-of-the-art-mri-scanner/
UHL unveiled the UK's first Canon Vantage Galan 3T / Supreme Edition MRI in March. The state-of-the-art MRI scanner, at the Leicester General Hospital, marked a significant investment in modern diagnostic technology for patients. The Canon Vantage Galan 3T / Supreme Edition MRI is expected to deliver around 6,500 MRI scans every year and will help clinicians take clearer, more detailed pictures of the inside of the body, supporting improved patient care and enhanced clinical outcomes.

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	2025/26	2024/25	2023/24	Trend
A&E (UHL) – Total Time in A&E (4hr Wait)	61%	62.4%	60.1%	57.1%	↑
A&E (UHL+ LLR UCC) – Total Time in A&E (4hr Wait)	78%	77.0%	75.0%	72.5%	↑
% 12 Hour Trolley Waits In A&E	10.3%	3.2%	3.7%	5.0%	↑
MRSA (All)	0	8	4	5	↓
Clostridium Difficile	92	147	212	165	↑
% Of All Adults Who Have Had VTE Risk Assessment On Admission To Hospital	95%	97.3%	98.2%	96.9%	↓
Never Events	0	4	6	4	↑
SHMI Mortality	<=100	99	100	102	↑
Urgent Operations Cancelled Twice	0	No Data	No Data	18	

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

Whilst UEC has been challenged during 2025/26, we are proud that by working in partnership within UHL and across the wider Leicester, Leicestershire and Rutland area, we have seen improvements across the patient's pathway.

In 2025/26 we have:

- Expanded our Same Day Emergency Care pathways and seen an increase of 10% from 2024/25
- Completed the business case for a new co-located Urgent Treatment Centre at the Leicester Royal Infirmary with building commencing in March 2026
- Developed direct admission pathways with our Ambulance provider to ensure patients can be taken directly to the place they need care avoiding attendance at the Emergency Department
- Developed our medical daycase services into one location at the Leicester General Hospital freeing up ward capacity to support winter.
- Expanded specialist input into the Emergency Department at the Leicester Royal Infirmary
- Opened a new Frailty Same Day Emergency care unit at the Leicester Royal Infirmary
- Increased Cardiorespiratory Same Day Emergency care at the Glenfield Hospital
- Improved our discharge processes to get people home, or to the right place for their onward care, discharging c. 10,900 more patients than in 2024/25.
- Reduced Length of Stay for our Emergency patients from 7.32 days to 7.22 days resulting in patients being able to go home quicker.
- Improved our 4-hour access performance from 59% in 2024/25 to 66.4% in March 2026

During 2025/26 we were challenged with ambulance handover times affecting our ability to take patients from ambulances and into our emergency department, however this improved from December to March with an improvement of 26 minutes for average handover time. Our ambulance performance across the year showed an improvement in the number of hours lost to ambulance delays particularly through winter. Our 12-hour performance was 10.61% in March 2026 compared to 7.68% in March 2025. This demonstrates the need to further improve our UEC performance. Our demand increased by 5,000 attendances to our Emergency Department, and we admitted 4,893 more patients to our hospitals compared with 2025/26. 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 2026/27 we will:

Improve the quality of our services through: -

- Implement the Modern Service Frameworks for Cardiovascular, SEPSIS, Dementia and Frailty
- Implement the Paediatric Early Warning System in the Emergency Department by April 2027
- Implement new ways of working at the Glenfield Hospital with specialty medical input to improve waiting times.

Digitally Enabled through: -

- E-Triage in the Emergency Department
- Develop our IT system to improve flow through the hospital
- Develop our IT system to reduce the reliance on paper through the whole emergency pathway
- Expand our electronic referring system to support timely access to specialist support when needed
    -

Be more Productive by: -

- Reduce Inpatient Length of Stay for Adults and Children
- Develop our Same Day Emergency Care services further with the implementation of appointment slots
- Implement the National Clinical Operational standards for first 72 hrs
- Implement the National Model Emergency Department framework
- Improve our Discharge Process
- Complete the build of the co-located Urgent Treatment Centre in August 2027.

Work in partnership on: -

- The establishment of a Mental Health emergency centres co-located with the Emergency Department
- The development of Neighbourhood models and Primary care same day access for urgent appointments
- The development of our frailty services in the community and in our hospitals

This will enable us to deliver our local strategy of transforming patient care, strengthening our culture and supporting delivery of our financial plan

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

Planned Care

Our performance

There are many achievements to be proud of across Elective Care, Cancer Care, and Diagnostics for 2025/26. Although progress on key access metrics has not met our

expectations, several challenges have made this year particularly demanding. These include ongoing industrial action, emergency and cancer care pressures, and most notably, a major hospital transformation when in June 2025 we introduced the new electronic patient administration system (NerveCentre).

Elective

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

- The elimination of 78-week waiters this year, with exceptions only in particularly complex cases or to accommodate patient choice. In March 2026 our final reported 78-week waiter position was 1, due to significant clinical complexity.
- Continued reduction in 65-week waits, in March 2026 this was 47.
- Improved productivity metrics by 6%, placing UHL in the upper quartile of all Trusts.
- Capped theatre productivity improved by 3.75% to 81.5%.

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.

- Patients waiting over a year for treatment (52 plus weeks) unfortunately increased across the year, ending 2026 with 2,239 patients. This represents 2% of the total waiting list.
- Our total waiting list increased between April 2025 and March 2026 and now stands at 113,973. Much of this reflects a change in referral recording following the introduction of NerveCentre: e-RS referrals are now registered on the electronic patient record on receipt, rather than after clinical triage, this also now includes any referrals later returned to primary care.

As we move into 2026/27, 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.

The key tenets of the operational plan for planned care in 2025/26 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 this year 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
- Standardising outpatient clinic templates across specialities
- Scoping and procuring ambient voice technology to improve time patients receive consultation correspondence
- Developing a case to automate calling and booking of appointments
- Launching advice and guidance in all specialties to support primary care and offer patients the right test, first time.
- Identification of specialities that will move to an advice and refer model to support primary care, which will avoid duplicate referrals where other management may be more appropriate.
- Moving to electronic referrals for all specialties
- Centralised procurement of orthopaedic kit to reduce variation and ensure best value
- Standardisation of pathway outcome data capture in the new Patient Administration System to improve reporting and understand areas of opportunity
- Moving gynaecology, surgery and urology to a centralised pre-operative assessment model to improve clinic utilisation, reduce variation and improve workforce efficiency
- Re-named community sites to UHL in the Community (UHLiC) to improve public awareness that these clinics and theatres are ran by UHL clinicians, in a community setting.
- Continued to roll out single waiting lists between community and acute sites to offer patients the first available appointment, which may be at another location.
- Repatriating cataracts and hernias to UHL from the Independent Sector
- Ran a series of training events to outline the key components of planned care redesign, with a focus on reducing low value follow ups in line with national guidance. This will support focused work in 2026/27 to deliver our planning assumption of a 5% reduction in outpatient follow-up activity.
- We have enhanced our digital innovation initiatives. Including; Ambient Dictate for specific services, introduced ‘Isla’ for additional support, implemented Federated Data Platform which is used across the NHS to optimise the booking and scheduling of theatre lists, and encouraged the use of the NHS App to enable patients to manage their appointments more efficiently.

This work supports progression of our operational plan to reduce the length of time patients are waiting for their diagnosis and treatment.

Plans for 2026/27

For 2026/27, our focus remains on building on the foundations we have set over the last 4 years to continue to deliver improvement.

By April 2027 we aim to improve by 12% 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 2026/27 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 2027
- Improve Daycase and theatre session utilisation rates to 85% by March 2027
- 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.
- Continue to focus on reducing waits for diagnostic tests
- Complete a full musculoskeletal pathway review with a specific focus on back pain, community physiotherapy and rheumatology by January 2027
- Introduce Advice and Refer (A&G) across 5 specialties across the year, starting with Gastroenterology and HPB in April 2026.

Cancer 2025/26

In March 2026, **63.8%** of patients with a confirmed cancer diagnosis began treatment within 62 days, compared with 60.3% in the previous year. The number of patients treated on a 62 day pathway increased by 3.1% this year, and with a small reduction in waiting times, there were less patients waiting beyond 62-days than the start of the year. Despite some progress, we still need to do better and performance against the 62-day standard remains under pressure.

Gynaecology, Head & Neck, Skin and Urology services have all demonstrated improvements, with fewer patients waiting over 62 days than in 2024/25.

Referrals to Urgent Suspected Cancer pathways have continued to increase, rising by 3.9% compared to last year.

During 2025/26, some specialties experienced an unexpected reduction in capacity due to staffing levels falling below those required to meet demand. As a result, the proportion of patients diagnosed within 28 days of referral fell from an average performance of 80% in Q4 last year to 67.6% in March 2026.

Against the 31-day standard; Radiotherapy performance has improved by 27.7% to 86.6%, drug treatment has maintained delivery above the National target of 96%. Access to surgical treatment within 31-days delivered an improvement of 6.1% compared to March last year, however monthly performance remains variable and work to improve this will be a priority into 2026/27.

What we are proud of in 2025/26

- Improved waiting times for patients with prostate and breast cancer receiving hormone therapy prior to radiotherapy.
- With £3.9m investment and support from the East Midlands Cancer Alliance and NHSE, commenced an improvement programme to streamline MDT processes and secured additional capacity to strengthen resilience and reduce operational risk.
- Extensive diagnostic audits in Cancer pathways to understand delays and plan staging investigations earlier in the pathway
- Secured funding to continue with the Non-Specific-Symptoms pathway. So far this has supported 158 patients receiving an earlier cancer diagnosis.
- FIT tests are now distributed and processed by UHL providing quicker results
- The liver surveillance programme has been extended secured for a further year to support earlier identification of cancer.
- Expanded our robotic surgical programme in line with the National NHS and Cancer plans – this means offering patients less invasive surgery, reduced length of stay, reduced complications, less pain and faster return to normal activities.
- Continued to work collaboratively with University Hospitals of Northamptonshire to provide mutual aid support for Oncology patients across both counties.
- Reduced the time patients are waiting on the day for oncology treatments though improved scheduling.
- An additional 3,211 patients have been remotely monitored as part of their personalised stratified cancer follow up or cancer monitoring, bringing the current total number of patients being monitored to 9,000.

- In preparation for the commencement of Lung Cancer Screening to commence in 2026/27, outlined the requirements to meet the needs of people who receive an earlier diagnosis through this programme.
- Through our digital programme, commenced the work to integrate our patient administration system with cancer database and introduced paperless planning in Radiotherapy.
- Upgraded our Brachytherapy equipment with state-of-the-art. The unit also received a visit from HRH Prince Edward.
- Continued to improve cancer outcomes and services dataset (COSD) compliance improved, which is used to influence the requirements for cancer diagnosis and treatment Nationally.

Our Plan for 2026/27

- Embed "Days Matter" and reduce the number of steps in a pathway to improve time to treatment
- Increase the number of straight to test pathways to enable earlier diagnosis
- Expand active surveillance and opportunities to monitor patients remotely, reducing the need for patients to attend hospital
- Roll out MDT streamlining programme
- Strive to improve patient experience including pre-diagnosis accessibility and information
- As part of the digital programme advance the interfaces between databases to improve efficiency in patient tracking and timeliness of data transfer between providers
- Reduce time to 1st appointment in Breast by increasing triple assessment clinic capacity

Diagnostics

Waiting times to receive a diagnostic test have reduced for the second year running. The number of patients waiting over 6 weeks reduced by 6.4% since the start of the year to 2,902 with 87.7% of patients receiving a test within 6 weeks. The new Endoscopy unit at the Leicester General Hospital which opened in November 2025, is a major investment in new capacity, enhancing patient experience and supporting a meaningful reduction in waits for a test in the year ahead.

Additional capacity has supported a significant improvement in waits for MRI, Sleep and Echocardiography services.

There has been a reduction in DNA (did not attends) in both MRI and CT and high utilisation of our capacity in cystoscopy, urodynamics and Paediatric sleep studies supporting improvements in productivity, although there is more to do across services to align with peer benchmarking.

What we are proud of in 2025/26

- The Hinckley Community Diagnostic Centre officially opened in June 2025, expanding access to a wide range of diagnostics and contributing to reduced MRI waits.
- We opened the new Endoscopy unit at the Leicester General Hospital, with all sites now JAG accredited.
- Invested £1.4m into new and replacement diagnostic equipment and digital technology, including a second DEXA scanner.
- With our managed equipment service partners, installed a state-of-the-art 3T Supreme MRI scanner, expanding capacity and offering 3T-level imaging across all three of our main hospital sites.
- Expanded the range of tests primary care can request directly for women's and children's health, with more to be introduced this year.

Our plans for 2026/27

- To increase the number of straight to test pathways to get patients to right test, first time.
- We have bid for capital investment to expand into a 3rd community diagnostic centre access in the city.
- Improve endoscopy session utilisation and reduce waits to less than 6 weeks.
- Deliver a minimum of 93% of patients waiting less than 6 weeks and zero 13+ week waits for the 15 key tests by the end of the year.

Quality Excellence

Harm Free Care, LEAF & Fundamentals

UHL remains committed to delivering **safe, outstanding, individualised care**, free from avoidable harm. Acknowledging sustained operational pressures across the Trust, our teams have continued to demonstrate resilience, innovation, and a strong improvement culture. This year, we strengthened our approach to quality through clearer performance measures, enhanced clinical practice, and targeted harm reduction initiatives.

Tissue Viability

During 2025/26, the Tissue Viability Service continued to strengthen its approach to skin integrity and complex wound care, despite increasing patient acuity, higher referral volumes and a rise in pressure damage present on admission. The introduction of a new Patient Activity Dashboard marked a major step forward, replacing the previous online diary and providing real-time visibility of activity, demand and performance. With a fully established set of KPIs now in place, the team have consistently met or exceeded response time standards, demonstrating improved prioritisation, responsiveness and clinical oversight. High numbers of Tissue Viability care plans were

implemented across inpatient areas, supporting earlier intervention and contributing to sustained Deep Tissue Injury resolution. Advanced clinical skills, including the management of complex wounds and Negative Pressure Wound Therapy, are now firmly embedded in routine practice, helping to improve outcomes for some of the Trust's most vulnerable patients.

Demand for the service has risen, with referrals frequently exceeding 150 per month and patient reviews peaking at more than 660. Alongside clinical activity, the team delivered extensive education across wards and Link Nurse networks, strengthening ward level ownership of skin integrity and care plan compliance. Quality improvement remained central to the service's work, including refinement of the HAPU validation process, improved access to advanced pressure relieving equipment, and development of enhanced dashboards to better reflect clinical complexity. A cost efficiency trial of an alternative Clinicept wipe showed promising financial and clinical benefits, with plans for a Trust wide rollout.

The team also played a key role in the Trust's Fundamentals of Care programme, supporting wards to improve skin care, nutrition, continence, mobility and overall patient experience. National recognition continued to grow, with a member of the Tissue Viability Team invited as a keynote speaker at the Wounds UK Conference and the Specialist Lead Nurse delivering a webinar with international reach. A published clinical case study further showcased UHL's innovation and partnership working.

Looking ahead to 2026/27, priorities include expanding digital wound care technology, strengthening DTI prevention pathways, increasing ward-based education, reducing variation across CMGs and sustaining reductions in hospital acquired pressure ulcers. The service will also continue contributing to national learning through research, conference involvement and sector wide collaboration.

Falls Prevention

Over the past year, the Trust has continued to make strong progress in reducing inpatient falls and improving the safety and wellbeing of patients at risk. Falls across our hospitals have remained below the national average, demonstrating the impact of our ongoing prevention strategy and the commitment of staff to recognising risks early and responding quickly. A major focus this year has been strengthening staff skills and confidence. Regular training has been delivered on lying and standing blood pressure assessments, helping teams identify postural hypotension—a common cause of falls. New head injury training has also been introduced to improve the quality of neurological observations and ensure any signs of deterioration are recognised without delay. Falls Recovery Training has been refreshed and is now delivered jointly with the Manual Handling Team, giving staff practical and clinical skills to safely support patients after a fall.

We have also invested in new technology to enhance patient safety. Falls sensor devices have now been implemented across clinical areas, offering an additional layer of protection for patients at highest risk by alerting staff to movement earlier and helping reduce unwitnessed falls. Staff have received training and clear guidance to support safe and consistent use, and work is underway to strengthen how we record and review falls that occur while a sensor is in place. This will help us understand how well the devices are working and where further improvements may be needed. Alongside this, the Trust is contributing to research exploring the wider impact of falls technology on patient outcomes. An additional development has been the Vision Assessment Project, which will assist staff to identify vision problems in patients aged 65 and over.

Looking ahead, the focus for 2026/27 includes fully embedding falls sensor devices across the Trust, strengthening post fall reviews and using established KPIs to identify early signs of escalation. Together, these efforts reflect our continued commitment to delivering safer care and reducing avoidable harm for our patients.

Continence Care

Over the past year, UHL's Continence Team has continued to make a meaningful difference to the comfort, dignity, and safety of the people we care for. Their work has

focused on practical improvements that help staff deliver the right care at the right time, while also shaping national thinking on continence management.

A key achievement this year was the introduction of new digital urinary device assessment. This simple but powerful change means staff can more easily monitor catheters, recognise early signs of infection, and act quickly when patients need support. It is already helping to reduce avoidable harm and improve the consistency of care across our hospitals.

The team's influence has reached far beyond UHL. Our decaffeinated drinks initiative—designed to help reduce the impact of incontinence—has gained national attention, featuring in parliamentary discussions, national safety reviews, and specialist conferences. Alongside this, the team has continued to champion dignity focused initiatives such as *Bins for Blokes*, ensuring men have appropriate facilities for disposing of continence products.

Innovation has been a strong theme throughout the year. A major evaluation of the PureWick female external catheter showed impressive results, preventing skin damage, reducing bed days, and saving the Trust more than £70,000. This work has been recognised nationally through award shortlisting and coverage in leading nursing publications. A separate trial of continence wipes also delivered striking improvements, significantly reducing moisture associated skin damage and receiving overwhelmingly positive feedback from staff.

As we look ahead to 2026/27, the focus remains firmly on reducing harm, improving patient experience, and supporting staff. The team will continue exploring alternatives to indwelling catheters, strengthening early identification of infection risks, and embedding digital tools that support safer, responsive care. UHL will also continue to build strong partnerships across clinical teams and the wider health sector, sharing learning and contributing to national improvement efforts.

Through all of this, the Continence Team remains committed to delivering compassionate, evidence-based care—and to continually finding new ways to improve the lives of the patients and families we serve.

Leicester Excellence Accreditation Framework (LEAF)

Building on the successful launch of the Leicester Excellence Accreditation Framework (LEAF) in 2024/25, the Trust has made significant progress in embedding LEAF as its core approach to ward-level quality assurance, improvement and accreditation.

During 2025/26, LEAF has moved from pilot into large-scale delivery, with the framework now established as a central mechanism for supporting wards to deliver safe, high-quality, person-centred care. LEAF continues to provide a consistent, data-driven approach to understanding performance, celebrating excellence and targeting improvement where required.


Phase 1 of LEAF, focusing on adult inpatient wards, progressed at pace during the year. Wards across all Clinical Management Groups engaged with the LEAF dashboard, Quality Assurance visits and Quality Improvement (QI) processes. The framework has supported ward teams to use data more confidently, triangulating dashboard intelligence with lived experience from patients and colleagues to drive meaningful change at ward level.

Quality Assurance visits remain a key component of LEAF, providing assurance to the Trust Board that standards of care are being met while also offering constructive, supportive feedback to teams. The visits have strengthened visibility of good practice, improved consistency and enabled earlier identification of risk, with targeted support offered where needed.

A key milestone during the year was the Trust's first ward achieving LEAF accreditation. Ward 16 at Leicester General Hospital, one of the original LEAF pilot wards, successfully achieved Good accreditation, demonstrating sustained improvement, strong multidisciplinary engagement and effective use of data to support quality and safety. This achievement provides early assurance that the LEAF framework is delivering meaningful and measurable improvements in care at ward level.

In parallel, LEAF has continued to strengthen the Trust's quality improvement capability. Ward teams have been supported to develop and deliver Quality Improvement Initiatives aligned to Trust priorities, with a clear focus on sustainability and measurable impact. This has contributed to improved ownership of improvement work and greater multidisciplinary engagement.
Colleague voice remains a core component of the LEAF framework. During 2025/26, the LEAF staff survey has seen a significant increase in participation, reflecting improved engagement and confidence in the process. To further strengthen this, LEAF staff survey coverage has been embedded as a metric within the LEAF dashboard, ensuring wards actively encourage colleagues to share their views three times a year. Survey results are fed back to ward teams in a timely and structured way, with feedback provided within a two-week timeframe, enabling teams to respond promptly to themes raised and incorporate learning into local improvement activity.

The impact and innovation of LEAF has also been recognised externally and internally. During the year, LEAF was shortlisted for the Nursing Times *Technology and Data in Nursing Award*, reflecting national recognition of the programme's use of digital insight and data to drive improvement in nursing practice and patient care. In addition, the Trust's LEAF Data Leads were shortlisted for the UHL *Outstanding Contribution Award (Team) – Non-Clinical*, acknowledging their collective contribution to

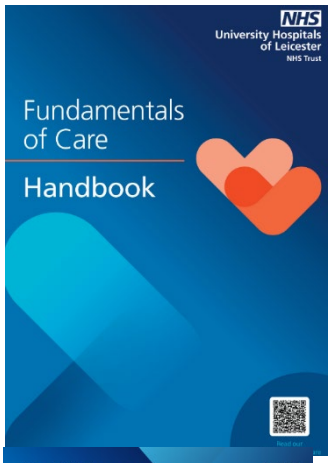
developing, maintaining and enabling meaningful use of data to support ward-level quality improvement and assurance.

Phase 2 of LEAF is now underway, extending the framework into specialist clinical areas including Emergency Departments, Intensive Care Units and Theatres. This phase has been deliberately designed in partnership with frontline clinical teams to ensure that LEAF remains clinically meaningful, proportionate and relevant to the complexities of specialist care environments. Work is currently focused on collaborating with clinical leaders and multidisciplinary teams within each area to shape metrics informed directly by frontline experience and professional judgement.
As part of Phase 2, bespoke digital dashboards will be developed for each specialist area, enabling teams to access timely, relevant performance insight aligned to their unique operational and clinical context.

Fundamentals of Care

Throughout 2025/26, FoC visits expanded rapidly across wards and departments. These visits are intentionally supportive and grounded in real patient experience, enabling staff to see care through the eyes of patients and families. By focusing on how care feels—not just what is documented—teams have been able to recognise excellent practice, reflect openly and make meaningful improvements. This has contributed to a visible shift away from task driven routines towards truly person-centred care, where communication, kindness and human connection are central.

The first full year of the Fundamentals of Care (FoC) programme has brought a clear and measurable strengthening of compassionate, person-centred care across University Hospitals of Leicester. Now firmly embedded across all three hospital sites, the programme has helped staff focus on what matters most to patients: dignity, communication, emotional connection and consistently -high quality care at the bedside. Guided by the UHL Fundamentals of Care Promise and its twelve commitments, teams have developed a shared understanding of how respectful, safe- and compassionate care should be delivered every day.



Leadership visibility has been a defining feature of the programme's success. Senior nurses, matrons and ward leaders have taken an active role in FoC visits, modelling curiosity, compassion and supportive challenge. Staff consistently describe the approach as reassuring and developmental, helping to build confidence and strengthen psychological safety. This has supported more open conversations about care quality and encouraged teams to take ownership of improvement.

The programme has also helped bring coherence to wider quality and safety priorities, including nutrition and hydration,

falls prevention, tissue viability, deconditioning and infection prevention. By aligning these workstreams under a single, patient centred framework, FoC has reduced duplication and reinforced a clear narrative about what good care looks like in practice.

A major milestone this year was the launch of the Fundamentals of Care Handbook. Designed as a practical, accessible guide, it translates the FoC Promise into clear expectations around dignity, communication, personal care, mobility, nutrition, infection prevention and safety. Early feedback shows that the handbook is strengthening staff confidence, supporting consistency and acting as a valuable companion to FoC visits and coaching conversations.

By encouraging small, achievable improvements grounded in observation and patient feedback, the programme has helped teams embed improvement into everyday practice rather than viewing it as additional work. This has supported long-term cultural change and strengthened multidisciplinary engagement.

As the programme continues to mature, the focus will be on deeper integration with LEAF and the wider Quality Excellence agenda, continued leadership visibility and sustained attention to the lived experience of patients and families.

During 2025/26, LEAF formally aligned with the Pathway to Excellence® Team as part of the newly established UHL Quality Excellence Team. This integrated model brings together accreditation, quality improvement, shared decision making and professional practice excellence into a single, coordinated offer for clinical teams. As part of this approach, colleagues from the Pathway to Excellence® Team support LEAF Quality Assurance visits, strengthening collaboration, promoting excellence and ensuring a consistent, supportive approach to assurance, improvement across clinical areas.

Celebrating Excellence Across Our Workforce

In 2025, University Hospitals of Leicester became the first NHS Trust in the UK to achieve designation through the Pathway to Excellence® programme across 2 hospital sites. This achievement reflects sustained investment in colleague wellbeing, professional leadership and shared decision making, supporting high-quality, safe patient care.

This recognition celebrates what our colleagues demonstrate every day: outstanding teamwork, compassionate leadership, and a strong commitment to professional development and wellbeing. The ANCC highlighted high levels of colleague satisfaction, robust recognition practices, and positive workplace culture at Leicester General Hospital (LGH).

Photo: LGH nursing and midwifery colleagues celebrating Pathway to Excellence® accreditation.

American Nurses Credentialing Centre (ANCC) Interim Monitoring is a mandatory mid-cycle review for organisations with Pathway to Excellence® designation, ensuring continued compliance with required standards between accreditation cycles. This document outlines key workforce trends from the Organisational Demographic Form (ODF) submitted by Glenfield Hospital for the 2026 review

A review of workforce trends within the Organisational Demographic Form (ODF) and analysis of the data demonstrates marked improvements in staffing stability, a strengthened and more effective skill mix, and increased levels of educational preparation across the nursing workforce. These positive developments align closely with the organisation’s workforce strategy and reflect continued adherence to ANCC Pathway to Excellence® standards. Collectively, these outcomes support and justify the submission of the 2026 ODF as evidence of sustained progress and organisational commitment to excellence in nursing practice.

Our Pathway journey continued to gain momentum through shared learning and celebration. A Pathway to Excellence® mini conference, held jointly with University Hospitals of Northamptonshire (UHN), brought colleagues together to showcase innovation, exchange ideas, and strengthen a culture of excellence that puts people and patients first.

Photo: Colleagues at the Pathway to Excellence® mini conference.

Shared Decision Making (SDM): Strengthening Voice and Recognition

Shared Decision Making (SDM) Councils continue to play a vital role in empowering colleagues and strengthening a culture where every voice matters. Throughout 2025, SDM Councils actively supported colleague engagement, promoted local recognition, and championed improvements that enhance both staff experience and patient care.

SDM Councils worked closely with the Pathway to Excellence® programme, reinforcing the principles of professional autonomy, shared leadership and meaningful recognition. Council members consistently celebrated colleagues within their clinical areas, contributing to the sustained increase in in recognition of colleagues across the Trust through implementing local recognition schemes.

Looking ahead to 2026/27, UHL will host 2 joint SDM Celebration and Learning Events bringing together SDM Councils from UHL and UHN to share achievements, learning and best practice, and to celebrate the positive impact of SDM across our organisations.

Recognition That Makes a Difference

Recognition initiatives expanded further in 2025 with the introduction of Team BEE and Student DAISY awards. A total of 226 BEE and 361 DAISY nominations were received, demonstrating growing engagement and appreciation across clinical and non-clinical teams. The first Team BEE Award was presented to the Estates and Facilities Team at Leicester Royal Infirmary following their exceptional response to a major fire. Their bravery, compassion and professionalism exemplified UHL’s values and commitment to patient and colleague safety.

These awards highlight the everyday compassion, professionalism and dedication shown by our teams across UHL.

Photo: Estates and Facilities Team at LRI receiving the first Team BEE Award.

Embedding Research and Innovation 2025/26

Across the 2025/26 financial year, the Trust's Department of Research and Innovation (R&I) continued to evolve, despite operating under sustained national pressures characterised by changing regulatory expectations and increased system-wide demand for research performance. Notwithstanding these increased expectations, the Department has continued to generate high-impact research. Activity has reached broader and more diverse participant groups, and research outputs have attracted greater visibility and press attention, reinforcing UHL's position as a leading centre for research excellence. In 2025/26, a total of 23,487 participants were recruited to research projects. Of these participants, 21,887 took part in portfolio projects, and 481 were recruited into commercially-sponsored studies, demonstrating a more than 5% uplift in commercial recruitment. In 2025/26, the Department also generated £30.8m of income, of which £5m has been produced by commercial research projects.

Alongside this continued growth, R&I at UHL also experienced significant investment on a national scale. In September 2025, the National Institute for Health and Care Research (NIHR) announced UHL as the host of the UK-wide Commercial Research Delivery Centre (CRDC) Network, a £6.5 million public-private partnership established in collaboration with the pharmaceutical industry. With UHL delivering the strategic coordination of 21 CRDCs across the four nations, the Network aims to build research capacity, modernise clinical trial infrastructure, and offer more patients the opportunity to receive the latest innovative treatments, in line with the Government's ambition to streamline study set-up in the UK. Alongside Leicester's position as host of the CRDC Network, the Leicestershire and Northamptonshire CRDC also received significant investment, totalling £4.7 million over 7 years.

In addition, the NIHR announced a £157 million investment to support ten Applied Research Collaborations (ARCs) across England over the next five years, with UHL operating as the host ARC East Midlands and securing a total of £9.7 million in localised funding. From April 2026, the new ARCs will support the transformations set out in the NHS 10 Year Plan, the Life Sciences Sector Plan and the Government's Health and Growth Missions, tackling some of the UK's most pressing health and social care challenges through high-quality applied research, driving effective interventions and models of care into practice at pace. The Department also committed to PA funding for an additional 20 UHL Consultants, representing a more than 10% increase in the number of Consultants who offered this support.

Highlights from across the R&I Department for 2025/26 include:

- Professor Gerry McCann being awarded the role of British Heart Foundation (BHF) Professor of Cardiology. This prestigious recognition has been accompanied by a five-year award of £1.265 million, underscoring both the significance of Professor McCann's work and UHL's ongoing commitment to advancing world-class cardiovascular research.
- The successful launch of two new digital research newsletters, delivered via the internal UHL Connect platform and externally through LinkedIn. Published on a monthly basis, these newsletters have quickly become an effective channel for showcasing research activity, opportunities and achievements across the organisation. Engagement has grown rapidly, with each subscriber base now exceeding 1,000 users and spanning local and international audiences.
- Cardiology expert Professor Sir Nilesh Samani being honoured with a City of Leicester Civic Award in recognition of his outstanding and far-reaching contributions to improving lives in Leicester and beyond. At a ceremony attended by Councillors, family and dignitaries, Professor Samani was given a special medal by the Deputy Lord Mayor, Councillor Bhupen Dave. The award was particularly poignant as the nomination was made by the late Councillor and former Lord Mayor Manjula Sood, reflecting the deep impact of Professor Samani's work across the community.
- The launch of a new Diabetes Model of Care Toolkit, developed through more than a decade of collaboration between the NHS Leicester, Leicestershire and Rutland (LLR), UHL, the NIHR Applied Research Collaboration (ARC) East Midlands, and the EDEN team at the Leicester Diabetes Centre. This resource sets out a clear and practical approach to improving diabetes care at scale, bringing together the expertise of clinicians, educators, commissioners and community partners to support more effective and sustainable diabetes care.
- The launch of the British Heart Foundation Leicester Centre of Research Excellence, which aims to accelerate medical innovation and bring cutting-edge cardiovascular research closer to patient care. Opened by Professor André Ng on the 8th September 2025, the Centre represents a major investment in advancing heart health, and is backed by £3 million in funding from the British Heart Foundation's competitive Research Excellence Award scheme, alongside match funding from the University and additional support from UHL, bringing the total investment amount to around £7 million.
- The achievements of Professor Melanie Davies CBE, Director of the NIHR Leicester BRC, who received a 2025 National Scientific and Health Care Achievement Award at the American Diabetes Association (ADA)'s 85th Scientific Sessions Conference in Chicago on 23rd June 2025. Professor Davies is only the second woman to receive this prestigious award, and is the first woman outside of the USA to do so.

Health inequalities:

The Trust's 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. Further in October 2025, the trust launched its Group Clinical Strategy in close collaboration and partnership with University Hospitals for Northamptonshire with a commitment to equity being key to successful delivery and implementation for patients experiencing our services.

UHL continues to work proactively to identify, understand and address health inequalities in access to our services, the experiences of those services and outcomes for the population we serve.

Improving health and reducing inequality is a non-scoring domain in the NHS Oversight Framework, with sub-domains in improving population health, primary prevention and inequalities. Specific metrics that UHL is required to measure and monitor are shown below.

- Percentage of inpatients referred to in-house tobacco treatment services who make a supported attempt to quit stop smoking (primary prevention)
- Percentage of people waiting over 6 weeks for a diagnostic procedure or test (primary prevention)
- Under 18s elective waiting list growth (inequalities)

Although UHL is only expected to measure in-house tobacco treatment service referrals, a comprehensive overview of the trust's activity relating to prevention is undertaken through the trust's annual Prevention Report, now in its third year. The report is published one year in retrospect to allow data collection and analysis. The 2025-26 report can be found here, and describes activity relating to 2024-2025. Inequalities improvement work continues across most of the scoring domains of the NHS Oversight Framework (Access to services, Effectiveness and experience of care, Patient Safety and People and workforce).

The Trust recognises continuous improvement as a key enabler of delivering its strategic goals. The 'HEALTH-E' Pro-Equity Framework (figure 1) was developed and embedded into the Trust's Quality Improvement (QI) registration process; at the point of registration, colleagues are prompted to identify the health equity component of their project and work through the framework to build patient engagement. This framework prompts and supports colleagues to build equity into their QI initiatives, building on the premise of 'improvement through the lens of equity'.

While only in its first year of use, the Pro-Equity approach is recognised as key to improving health inequalities and iteration is needed to further improve and the embed the framework.

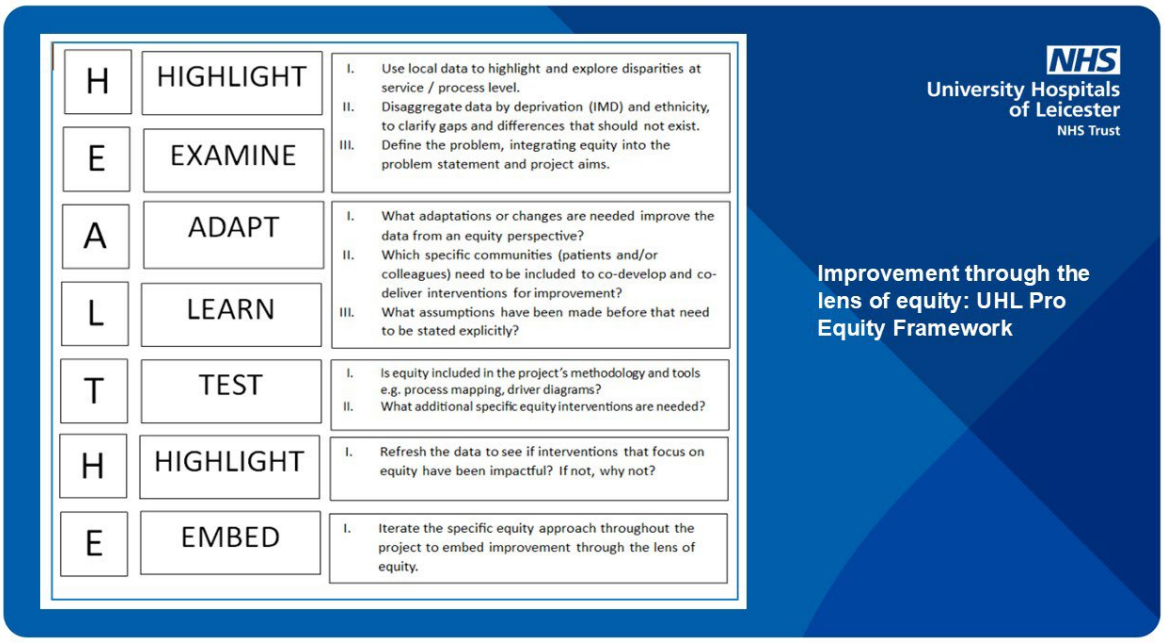


Figure 1

The patient safety healthcare inequalities reduction framework further provides a structures approach to health inequalities improvement across five principles. The principle and associated work relating to each is outlined below:

Principle 1: All staff, patients, service users, families and carers have access to information, translation and interpretation services when needed. UHL offers 24/7 access to interpretation and translation services for patients and staff are actively encouraged and supported to utilise this service.

Principle 2: All healthcare staff receive undergraduate patient safety training, ongoing training, and accessible resources that improve their awareness and understanding of healthcare inequalities related to patient safety risks. UHL works closely with academic partners to support the education and development of undergraduate students across the full breadth of healthcare professions.

Principle 3: Accurate and complete diversity data are collected for protected characteristics and inclusion health groups on digital platforms. This work includes making disaggregated data available so evaluation can drive improvements in patient safety and healthcare inequalities. Protected characteristics are captured through the Trust's PAS and a Health Equity EPR group with core colleagues from digital and health equity teams meets regularly to ensure that additional requirements are developed into the PAS to meet equity standards. This includes capturing additional needs and communication preferences for patients and highlighting different, sometimes vulnerable groups, such as veterans. A recent review of ethnicity coding showed high completion rates. All service data is available disaggregated by recorded characteristics on request by clinical and operational teams from Business Intelligence.

Principle 4: Representatives of diverse communities are involved in the design and delivery of improvements aimed at reducing patient safety healthcare inequalities. This co-production involves drawing on the knowledge and experience of patients, service

users, carers, families, communities and staff. UHL's Health Equality Partnership (UHEP) is a collaborative formed of over forty community organisations and key colleagues from across the health equity, patient experience and patient engagement infrastructure at UHL. Quarterly meetings enable community representatives to raise issues directly with the trust as well as provide opportunities for UHL to share information with communities directly. Additionally, UHEP has been proactively involved in trialling AI interpretation technology as part of an innovation project, testing the use of WhatsApp channels as a means of information sharing and the establishment of the trust's Patient Digital Reference group, a forum through which communities are actively involved in shaping how the trust uses technology and digital to deliver services.

Principle 5: Improve the understanding of patient safety healthcare inequalities and drive improvement through identifying priority areas for research. The Trust continues to work towards ensuring research quality data on health inequalities is accessible. Key avenues through which research priorities are established include the trust's Biomedical Research Centre, as well as through individual academic clinicians.

NHS England's Statement of Information on Health Inequalities supports Trusts to fulfil their legal duties, take an evidence-led improvement approach to tackling health inequalities, and provides guidance on how health inequalities information should be used to inform local action. While the Trust does not routinely publish in public all the data, it is available to colleagues within UHL and can be disaggregated by protected characteristics and deprivation. Health inequalities data is reported to Board through the Integrated Performance Report for outpatient non-attendances, focusing on deprivation. Maternity measures are also available through the local maternal health inequalities dashboard. In addition, a quarterly health inequalities report is presented to Quality Committee and Board which details focused areas of work and improvement, including accounting for legal and statutory requirements such as the Accessible Information Standard and Equality Delivery System.

Education Excellence – Nursing and Midwifery Workforce

Continuous Professional Development (CPD) for our nursing and midwifery workforce is central to enhancing both patient safety and experience. Our commitment is to ensure that every learner, including students, trainees, or apprentices, have equitable access to opportunities for personal development, lifelong learning, and professional growth.

Our Trust continues to offer clinical apprenticeships to support career pathways from healthcare assistant to registered nurse and advanced clinical practitioners. 44 healthcare support workers commenced their student nursing associate training at the UHL School of Nursing Associates in 2025 including individuals from other health and social care organisations across Leicestershire. Eleven nursing associates completed a Nursing Degree apprenticeship with eight graduating with First-Class Honours and securing a registered nurse post within UHL. In 2025, we also had 54 Trainee ACPs commencing or continuing their ACP Masters programme who were from a wide range of healthcare professionals, nursing, midwifery, AHP or paramedicine.

UHL continues to work in partnership with our local universities supporting pre and post-registration student nurses and midwives. As a large placement provider and host

Trust for higher education institutions across the Midlands, we supported approximately 700 student nurses, nursing associates, and midwives at various stages of their academic and professional programmes. In 2025 UHL supported the 'national graduate guarantee' initiative, recruiting all locally trained, newly qualified Registered Nurses and Midwives who chose to commence their healthcare career in our hospitals and community services.

We increased our commitment to widening access to nursing and midwifery training and inclusion, and participation from local communities working in close partnership with our local colleges of further education to promote healthcare careers. We provided 'industry placements' for over 80 T-level students on our inpatient wards and maternity services throughout the year inspiring a future generation of nurses and midwives.

Our School of Nursing and Midwifery Practice based at the Glenfield Hospital managed the annual allocation of ringfenced CPD funding meeting the training needs of our nursing and midwifery workforce via internal education and training, accredited university modules, and specialised leadership and coaching programmes. With increasing numbers of pre and post registration learners coming through our school and a focus on digital innovation, research and advanced clinical practice, the school are meeting the requirements of the national Educator Workforce Strategy increasing the capacity and quality of our educators and ensuring career pathways in these specialised areas.

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.

The 2025 Medical Educator Awards were presented at an Education Update event in November 2025. 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 120 nominations for the awards and winners were from across a number of professions and specialties. Over 100 UHL educators attended the 2025 event which included updates from UHL, NHSE-WTE, and Leicester Medical School. The event showcased high-quality project work from across the Trust and was particularly valued by educators for the opportunity to take part in round-table discussions with peers, focusing on shared challenges in medical education

The Trust has continued to make progress against its ten-point plan to improve resident doctors' working lives, with a focus on addressing practical issues that have a direct impact on day-to-day experience. This includes redesigning the study leave process to enable course fees to be paid in advance, reducing financial burden and uncertainty for resident doctors. There has also been targeted work with payroll and medical workforce teams to reduce payroll errors and improve the timeliness and accuracy of pay, particularly for rotation changes and new starters. In parallel, governance and representation have been strengthened through the Resident Doctor Lead role, providing a direct and established route for resident doctor concerns and priorities to be escalated to the Trust Leadership Team. It is recognised that the current financial environment requires the Trust to make a number of difficult decisions; some of these, such as changes to on-site facilities, are in tension with the aims of the ten-point plan and have generated feedback from resident doctors. Collectively, these actions reflect a continued commitment to improving core systems, communication and accountability that underpin resident doctors' working lives, while recognising the challenges that remain.

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 421 evidence summaries in the year April 2024-March 2025, an increase of 13% from the previous year. Of these, 35% were for UHL authored research publications.
The Midlands Evidence Repository (MIDER) was launched in March 2026 (https://mider.openrepository.com/home) as a Midlands-wide NHS research repository, and is adding UHL authored publications regularly.

In the past year 2651 documents and books were supplied to library users to assist their work, research and professional development. 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 70% 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 517 new and updated leaflets added in the last year.

In 2025, the Trust was approved to commence its wider reconfiguration programme, with enabling works forming a critical first phase of this activity. These enabling works are essential to delivering the broader reconfiguration, within which medical education

is an important component. As part of this programme, the Department of Clinical Education vacated the Jarvis Building at the beginning of February 2026, enabling refurbishment of the space to commence. In line with the wider reconfiguration timeline, the department is scheduled to relocate to Rogers Ward in February 2027. The refurbished accommodation will provide flexible, high-quality space for teaching and training, supporting the Trust's long-term commitment to providing appropriate environments for medical education as part of the wider estate transformation.

Undergraduate Medical Education

University Hospitals of Leicester NHS Trust remains the largest provider of clinical education for students from the University of Leicester Medical School. In 2025, the Medical School celebrated its 50th anniversary, marking an important milestone and recognising five decades of achievement in medical education, research and clinical partnership. Hospitals in Leicester have played a central role in that history, providing the clinical environments, educators and supervision that support students in developing the knowledge, skills and professional values required for modern medical practice. The strength of this partnership continues to make Leicester Medical School an attractive choice for high-achieving applicants; A-level entry requirements are now A*AA, and in 2025 the programme did not enter the clearing process.

This strength is reflected in both student feedback and workforce outcomes. In the 2025 National Student Survey, final-year medical students ranked Leicester first in subjects aligned to medicine for overall positivity. There has also been a notable increase in the proportion of final-year students choosing to remain locally for Foundation Year 1 training, rising from 30% to 41%. Together, these measures reflect the quality of the student experience in Leicester and the contribution of UHL to developing and retaining the future medical workforce.

Postgraduate Medical Education

An additional number of trainees were allocated to UHL in 2025 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. Ongoing challenges in providing supervision for increasing trainee numbers are recognised; however, during the past year the Trust successfully piloted an Educational Supervisor model to increase supervisory capacity. The findings were positive, and the model has therefore been extended for a second year.

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.

Building on developments reported last year, the Trust has continued to strengthen trust-level engagement with Resident Doctors through the Doctors' In Training Committee, supported by a dedicated Engagement Officer. This combined approach

has helped improve how trainees connect with, and understand the importance of engaging with, the Trust around education and workplace experience. The impact of this work is demonstrated by a sustained increase in engagement with formal feedback mechanisms, most notably a rise in NETS survey completion for Postgraduate Medicine from 507 responses in 2024 to 676 in 2025 (an increase of 33%). This improvement suggests greater confidence among trainees that their feedback is valued and used to inform change.

The Trust continues to use intelligence from a range of local and national surveys to review and assure the quality of medical education provision at UHL. The 2025 GMC National Training Survey identified no red flags for UHL, representing an improvement on the single pink flag reported in 2024. UHL was ranked highest in the East Midlands for overall satisfaction, clinical supervision, adequate experience and feedback. Where concerns are identified through the NHSE-WTE process, the Trust undertakes formal investigation and provides a structured response, including action plans where required. The Department of Clinical Education works closely with services and Resident Doctor representatives to monitor progress, support improvement and ensure feedback is communicated back to trainees, reinforcing the value of continued engagement.

Over the past year, further progress has been made in improving the experience of Locally Employed Doctors and Clinical Fellows working at UHL. A structured, high-quality induction programme is now delivered regularly throughout the year, tailored specifically to the needs of LED/CFP doctors. In addition, a protected teaching programme has been established, running twice monthly on Thursdays and covering a broad range of relevant topics. Alongside this, continued development of the Trust's education websites, Educational Supervision resources and supporting materials has strengthened the support available to this workforce. These resources are brought together and made easily accessible through a dedicated Padlet platform.

The three Clinical Education Centres have continued to benefit from recent technology upgrades, improving both the learning environment and the range of educational activity supported across the Trust. Alongside this, there has been increasing focus on the use of digital technology to enhance educational delivery and support. This includes early exploration of how artificial intelligence can be used responsibly to support educators and learners, for example by improving access to educational resources, supporting feedback, and streamlining administrative processes. Building on this work, the Department of Clinical Education plans to develop a departmental digital strategy, setting out how technology can best support high-quality education, educator development and learner wellbeing. Future work will also explore the use of immersive technologies, such as simulation and virtual environments, to enhance learning and contribute to staff health and wellbeing.

Although Corporate Induction is primarily an HR function, the Department of Clinical Education continues to work collaboratively with HR to deliver this for over 700 Resident Doctors, spread over 5 rotation dates every year. We continue to review, update and refresh the induction material in the form of recordings available on HELM and respond to feedback provided from Resident doctors and key Stake holders. One of the challenges has been the migration to nhs.net email accounts as well as training

for new doctors on the utility of NerveCentre and we continue to work with the Digital and Data team to finesse this.

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

Strengthening the voice of patients and families

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

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

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

(a) Marthas Rule:

Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.

It has been developed in response to the death of Martha Mills and other cases related to the management of deterioration. Central to Martha's Rule is the right for patients, families and carers to request a rapid review if they are worried that a patient's condition is getting worse and their concerns are not being responded to.

There are 3 components to Martha's rule:-

1. 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.
2. 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.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

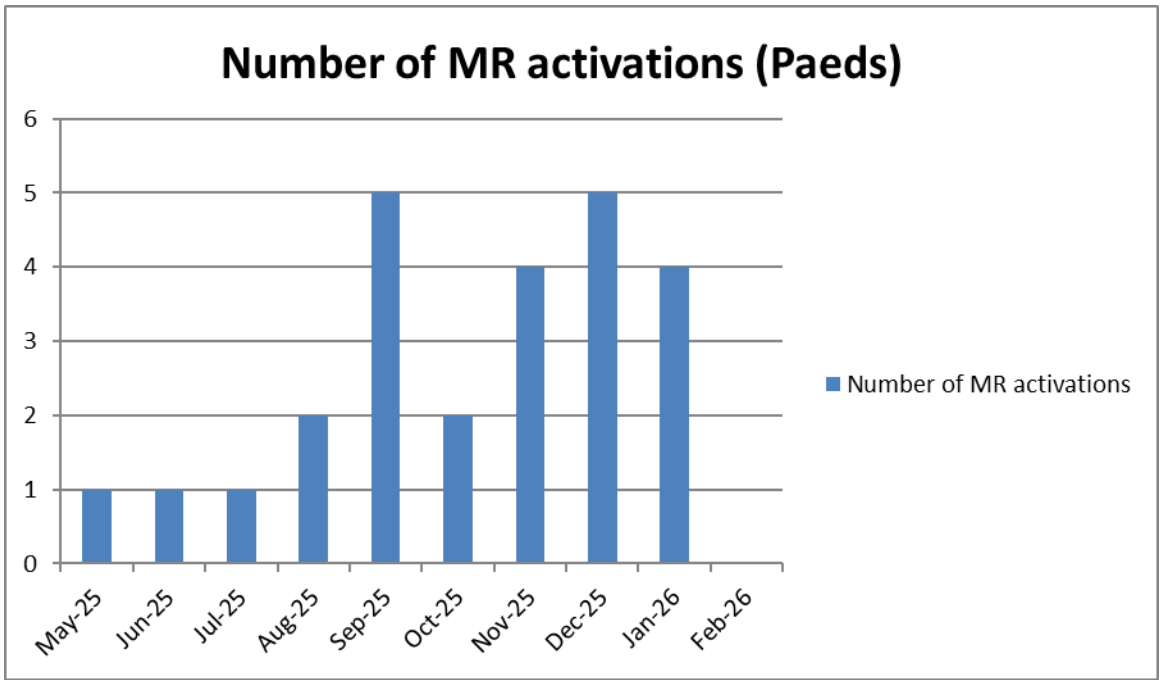
Where we are now

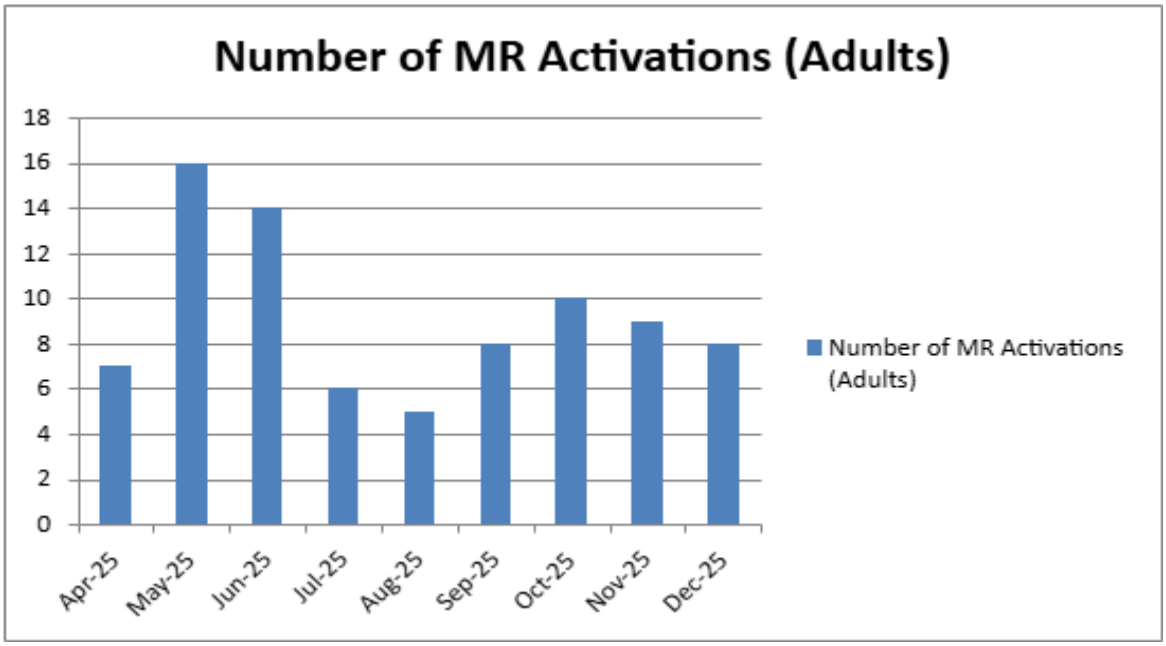
For UHL we have implemented Component 2 and 3 across adult, children's and neonatal services and we are aiming to roll out into Maternity in 2026/2027.

Component 1 will be rolled out in adults and children's services by end of April 2026.

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

The implementation of Martha's rule in adults and children's has been successful,





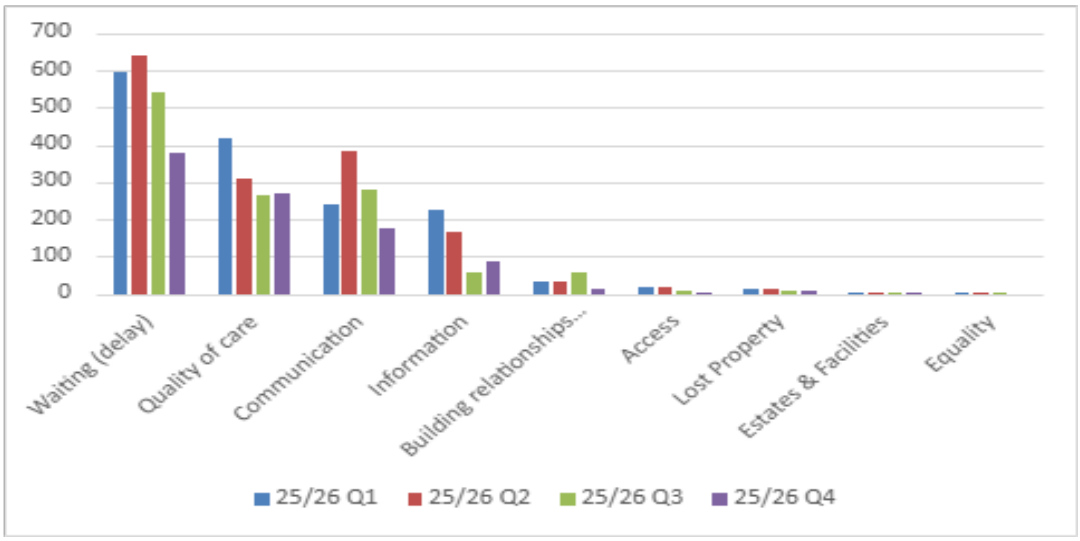
Adult Martha's Rule Activations were made up of 29 Males with an average age of 67 and 54 females with an average age of 51 during 2025-26.

(b) The PALS service (Patient Advice and Liaison Service)

During 2025-26 the Trust continued to strengthen the role of PALS as a key access point for patients, families and carers seeking advice, reassurance or early resolution of concerns. The service continues to focus in listening carefully, responding promptly and working collaboratively with clinical and administrative teams to resolve issues wherever possible without escalation

Where we are now (Our current performance strengths and weaknesses)
The table below show the themes of PALS contacts to date. The service received 5259 contacts for 2025-26.

The overall aim is to respond to patient and families' concerns raised through the PALS service within five working days.



What success will look like

Building on the 2024-25 expansion plans, we envisage PALS becoming further embedded across all sites, with improved visibility and extended availability. This will support consistency in access to advice and early resolution

Key priorities for 2026 –27 include:

- Strengthening early resolution to prevent escalation to formal complaints
- Improving timeliness and quality of responses
- Enhancing data insight from PALS themes to inform service improvement
- Continuing to work closely with clinical teams to support learning and compassionate responses
- Utilising technology to support early resolution and timeliness of responses

(c) Implementation of Carers passport:

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

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

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

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

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

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

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

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

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

Our current performance strengths and weaknesses
Our ward patient experience surveys show that Noise at Night is a significant concern for patients. Noise meters are currently monitoring noise levels to establish a baseline. Considering the last six months performance (Oct-25 to Mar-26), patient satisfaction with Noise at Night from staff has improved to 78.7 compared to a score of 77.7 for the same period in 2024-25. Similarly, satisfaction with Noise at night from other patients has also improved from 61.8 to 62.2 when the same time periods are considered.

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	TARGET	RESULT	TARGET
FFT Area	**2024-25**	**2024-25**	**2025-26**	**2025-26**	**2026-27**
Inpatients	**95.0%**	**97.1%**	95.0%	**95.5%**	**95.5%**
Outpatients	**95.0%**	**94.8%**	95.5%	**94.6%**	**96.0%**
Emergency Department	**80.0%**	**81.2%**	81.0%	**85.6%**	**82.0%**
Maternity	**95%**	**93.1%**	95.5%	**92.7%**	**96.0%**

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

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

Our current performance strengths and weaknesses

Sixty six 15 step assessments that took place during 2025/26 have been considered to arrive at these top 3 areas of strength:

1. Outstanding kindness, compassion and human connection
A universally praised aspect of UHL's culture.

2. Strong hydration, regular drink rounds and attention to patient comfort
Demonstrating commitment to fundamental care.

3. Clean, calm environments in many areas, showing pride and safety

Reassuring first impressions and consistent IPC awareness.

These strengths form a solid foundation for improvement work, support positive CQC narratives, and demonstrate the Trust's deep commitment to delivering safe, personalised, compassionate care.

Areas for improvement identified included:

1. **Medicines and Records Security**
   Inconsistent adherence to requirements for ensuring that drug trolleys and notes trolleys are locked when not in use.
2. **Environment and Estates**
   Ward environments were cluttered with equipment, with variation noted in cleanliness standards. AIS signage required improvement to support wayfinding and clarity.
3. **Branding and Patient Information**
   Key patient-facing information was missing or outdated, including PALS and Veterans posters, Friends and Family Test materials, and some incorrect or inconsistent messaging.

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

As 15 steps is undertaken on multiple occasions there is an expectation that we would see continuous improvements. Additionally, this year we have been working with NHSE to further develop the 15 steps proforma, which will include accessible information standards, patient feedback in regard to sleep, and nutrition and hydration.

D. Improving Patient Nutrition: Ensure patients receive meals in a timely manner, which are nutritionally correct to meet their needs and provide a choice of meals. Enact improvement actions through the multi-disciplinary group overseeing this workstream. Good nutritional intake is an integral component of patient care, poor nutrition and hydration affects patients' overall health and wellbeing and reduces their ability to recover from illness.

Where we are now.
Baseline feedback from PLACE visits, patient catering surveys and patient feedback was triangulated and process mapped. Patients have fed back we still need to do more with regard to timely access to meals, preparation for mealtimes, and access to menu's.

Our current performance strengths and weaknesses

The catering satisfaction survey launched in September 2025 and to date there have been 2,054 responses. Analysis of the top questions/themes that contribute to the overall rating for the Catering Service at UHL identified these questions as the top three:

- Was the food quality good?
- Did the food taste good?

- Was the food presentation/appearance good?

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

Patients will receive a meal that is their choice and meets all their nutritional requirements, within a timely fashion, and that they are adequately prepared to commence their meal.

The focus for the next year will be:

1. Reduce Waste
2. Nursing/MDT mealtime processes
3. Drinks service (including flask pilot) – ensure all wards deliver regular hydration opportunities.

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

(a) Patient information

Where we are now

We are modernising patient information across UHL and partner organisations to improve quality, consistency and accessibility, and as commissioned an external review into how we provide patients with appropriate information. Feedback from colleagues has highlighted that developing, publishing, and reviewing of patient information needs to be simplified and more widely available in different formats.

A systematic review and archiving process is in place to ensure that outdated or inaccurate patient information is removed. Leaflets are now being actively reviewed, with numbers reducing awaiting update and author feedback. This has reduced the risk of patients receiving misleading or clinically outdated information

Our current performance strengths and weaknesses

We currently have patient information sitting within multiple platforms, access to these platforms for patient is part of the external review.

There has been some progress regarding this, and we are working towards putting all our patient information leaflets onto our website which the overarching aim to move to patient portal app.

In terms of interpretation and translation services, a new tender is in progress.

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

Patients will have the information they need to support their decision making and their recovery. Information will be provided in the most appropriate format, including written, audio and video and in languages to meet each patients need.

Translation and Interpretating services will be widely available and used 24/7 and the key performance indicators will be met.

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

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

Resolving complaints, and patient feedback

During 2026-27, the Trust will continue to strengthen its approach to complaint handling, with a clear focus on timeliness on quality, compassion, and learning. Complaints will continue to be managed through a more integrated and consistent model, aligning with PALS and triangulating with other data such as claims information to ensure a full picture of emerging and persistent issues is recognised and described. Many of the themes and actions identified from complaints form part of wider programmes of work such as improving the fundamentals of care.

Complaints are an essential source of information on the quality of our services and standards of care from the perspective of our patients, families, and carers.

We are keen to listen, learn and improve using feedback from the public, HealthWatch, local GPs and other providers as well as from national reports published by the Parliamentary Health Service Ombudsman.

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

Improving complaint handling

The Independent Complaint Review Panel review a random sample of recently closed complaints and advise what was handled well and what could have been done better. This feedback is used for reflection and learning with the Patient Experience and CMG teams and reported through our TLT (Trust leadership Team).

The Complaints team will continue to work closely with the CMG's, providing advice, guidance and practical support to improve quality and reduce delays.

Key priorities for 2026-27 include:

- Improving compliance with response timescales
- Strengthening empathetic communication
- Improving the clarity and accessibility of complaint responses
- Supporting the embedding of learning from complaints into quality improvement activity
- Triangulating complaints with other patient feedback to identify key areas of

positive and negative patient experience

Complaints activity: (formal complaints, verbal complaints, requests for information and concerns) by financial year – 1 April 2016-13 March 2026

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2025/26
Formal complaints	1,467	1,886	2,260	2,534	1,476	2,264	2,165	1,717	1329
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	21
Total	4,228	4,031	4,040	4,382	2,808	4,297	4,616	2,200	1356
Trend	0.2 % increase	4.7 % decrease	0.2 % increase	8.6 % increase	35.9 % decrease	53.02 % increase	7.42 % increase	52% decrease	38% decrease

48% of complaints were closed within the 25 working days timeframes and 77% for the 60 working days timeframes in 2025-26.

Top 10 complaint themes for 2025-26:

Primary Subjects for formal complaints	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	Total
Medical Care	118	157	170	114	559
Nursing care	35	53	52	44	184
Communication	34	50	53	34	171
Appointments including delays and cancellations	10	29	17	16	72
Waiting times	14	23	23	12	72
Staff attitude	17	19	18	13	67
Integrated Care/Discharge	6	8	9	9	32
Medication	6	6	5	6	23
Confidentiality	0	10	3	1	14
Complications	6	0	3	1	10
Total	246	355	353	250	1204

Reopened complaints

Number of formal complaints received and reopened by quarter April 2023 to March 2026:

23/24 Q1	23/24	23/24	23/24	24/25	24/25	24/25	24/25	25/26	25/26	25/26	25/26

		Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Complaint	418	494	450	321	342	366	289	332	261	370	366	277
Reopened	16	16	23	18	9	17	16	26	22	35	26	4
% Closed first time	96%	97%	95%	94%	97%	95%	94%	92%	92%	91%	93%	99%

Reopened complaints indicate whether the initial Trust response provided good quality, compassionate and comprehensive responses – **Getting It Right First Time.** As indicated in the table above, the Trust closed 99% of complaints in the final quarter of 2025-26

Parliamentary Health Ombudsman Service

This is the final stage in NHS complaints. All complainants have a right to approach the PHSO if they are dissatisfied with the way their complaint has been addressed and / or handled by the Trust.

The Trust will continue to engage openly and constructively with the PHSO during 2026-27. Learning from PHSO decisions and feedback will be shared with the services to strengthen local complaint handling, investigation quality and patient communications

Of the 18 open cases in 2025-26:

- 3 were upheld / partly upheld, requiring an apology/action plan/financial compensation
- 11 remain open
- 4 were enquiries and closed without an investigation

Looking ahead: Complaints and PALS in 2026-27

In 2026-27, the Trust will continue to prioritise patient voice as the driver for improvement. Complaints and PALS data will be triangulated with safety, quality and experience data to identify emerging risks and improvement opportunities.

Patient Feedback

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

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

We are delighted to say that during 2025-26 circa 255,003 feedback forms / surveys were received from patients. These surveys included the Friends and Family Test question and of the 255,003 responses, 239,724 contained a positive response, 8,274 included suggestions for improvement and 7,005 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.
- In Maternity services SMS/texts 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 and to inpatients/day case patients the day after discharge. A survey option for Family, carers and friends is also included.
- 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 2025-26 there have been 9,200 completed FFT responses from Family, Carers and Friends across the Trust and this feedback has been shared with the clinical teams.

Volunteer Services

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

Our teams of volunteers have grown and developed with around 66 volunteers helping in a Meet and Greet role in public areas of the sites helping patients and visitors find their way to their destination and providing support for those preferring help to or needing assistance to make the journey. In order to maximise both the satisfaction for volunteers and the impact their role has, six of our more experienced volunteers have taken on the role Shift Leader. This enables them to train and guide new volunteers and help direct valuable volunteer resources to the areas of greatest need during any shift. This enables a better quality of customer service for our patients, visitors and staff. Our patient Visiting Service has developed to offer visits from volunteers across all three sites to those patients who may not have many relatives or friends available to visit or who are just feeling lonely and isolated in hospital and enjoy a chat.

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

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

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

Working with partners

In 2025/26 we have continued to work with system partners, NHS acute Trusts and non-NHS organisations including the VCSE sector to embed the 3 key aims of the NHS 10 – Year Health Plan. A key area of focus has been Neighbourhood Health Models which supports the goal of the NHS 10 Year plan-hospital to community care and delivering more services locally.

The NHS 10-year plan focuses on three key changes to develop a new care model:

- Hospital to community
- Analogue to digital
- Sickness to prevention

Partnership Tenders

The Partnership Team submitted eight tenders throughout the 2025/26 year. We have successfully secured a new service for treating cancer within adults: Tumour Infiltrating Lymphocyte Therapy, specifically for Melanoma. We have been re-appointed as a spoke service to Cambridge University Hospitals for the provision of a genomics service across the East of England. This is vital as genomic provision is a central pillar within the 10-year plan. A final success in 2025/26 was the enabling of the infected blood inquiry support service, by partnering with citizens advice and LPT UHL currently supports all patients in the East Midlands that require psychological and social support.

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 those experiencing emotional or spiritual distress relating to questions of life, death, illness, change, relationships, identity and meaning.

The rich diversity of Leicester, Leicestershire and Rutland's religions and beliefs is reflected within the Chaplaincy team which includes Christian, Hindu, Jewish, Jain, Muslim, Non-religious and Sikh. The service strives to reflect the communities served by the Trust. Leicester's hospitals was the first in the UK to employ non-religious chaplains, and the Trust continues to contribute through involvement with the Non-Religious Pastoral Support Network, helping to support training for the next generation of non-religious chaplains.

Over the past year chaplains have served more than 200 wards, departments and locations across both UHL and LPT sites. There have been over 12,000 patient visits, representing the fourth consecutive year of growth and the highest activity levels since the pandemic. The service also received over 1,200 referrals from patients, families and staff seeking chaplaincy support. Our volunteer team continues to expand and now includes 33 chaplaincy volunteers, who play an important role in extending the reach of pastoral care across hospital sites.

Chaplains continue to provide a 24/7 on-call service for urgent pastoral and spiritual care needs. On average the service receives around 30 out-of-hours calls each month, equating to approximately one call every day, highlighting the critical role chaplaincy plays in supporting patients, families and staff during times of crisis.

Supporting families experiencing bereavement remains a central part of the service. The team has continued to develop an inclusive approach to baby funerals, ensuring families receive sensitive and personalised support at a profoundly difficult time. During the year chaplains supported over 60 baby funerals and more than 30 adult funerals, alongside baptisms and other belief-specific rituals. Chaplaincy also assists with hospital weddings and other significant rites, reflecting the continued importance of spiritual care at key moments in people's lives.

Demand for prayer, worship and spiritual practice across the hospital community continues to grow. Chaplains facilitate over 300 religious services each year across

hospital sites, providing opportunities for reflection and worship for both patients and staff.

Supporting the wellbeing of staff is an important element of the service. Over the past year chaplains provided over 1,800 instances of staff support and contributed to the training of over 500 staff members on topics including spiritual care, cultural awareness and compassionate practice. To reach staff working overnight shifts, the team introduced “Chaplaincy at Night”, engaging with colleagues who may otherwise have limited access to wellbeing support with excellent feedback.

Chaplains also contribute to the life of the hospital community through the recognition of major religious and cultural festivals, including Chanukah, Christmas, Diwali, Easter, Eid and Ramadan, Remembrance, VE Day, Guru Nanak Sahib’s Gurpurab and Vaisakhi, alongside initiatives such as South Asian Heritage Month, Black History Month and Baby Loss Awareness Week and Dying Matters week,. Through events across hospital sites, chaplains engage with hundreds of staff and visitors, celebrating the diversity of the Trust’s community.

Chaplains also contribute to wider Trust activity, including EDI initiatives, wellbeing events, memorial services, charity events and commemorations, demonstrating the breadth of chaplaincy’s role within the organisation.

The service continues to act as a bridge between the hospital and wider faith and belief communities. Chaplaincy provision is also delivered to Leicestershire Partnership NHS Trust, supporting patients and families across mental health units and community hospitals throughout Leicester, Leicestershire and Rutland. Chaplaincy continues to contribute to discussions and initiatives supporting health equality and community engagement, including participation in the UHL Health Equality Partnership.

Chaplains from Leicester also contribute nationally to the profession through involvement with the College of Healthcare Chaplains, the National Chaplaincy Forum and the Network for Pastoral, Spiritual and Religious Care in Health, helping to shape the continued development of chaplaincy across the NHS.

Aims for 2026/27

• To further strengthen Chaplaincy’s contribution to end-of-life and palliative care across the Trust, working closely with clinical teams to ensure spiritual, pastoral and cultural needs are recognised and supported as part of holistic care for patients and families approaching the end of life.

• To further develop the offer and awareness of Chaplaincy as a support option for staff, establishing stronger links with Staff Wellbeing services and Staff Networks to support the Trust’s commitment to be a great employer and ensure staff know how to access compassionate pastoral support.

• To respond to the NHS’s strategic direction towards greater digitalisation by developing the Chaplaincy service’s digital capability, improving the recording of spiritual care within electronic patient records, enhancing data collection and insight, and strengthening the online presence of the service so that chaplaincy support is more visible, accessible and integrated within modern healthcare systems.

Digital and Data

2025/26 has been a landmark year for digital and data at UHL. We have delivered foundational capability that will underpin our transformation for years to come, whilst continuing to improve the day-to-day experience of technology for our colleagues. The future of sustainable healthcare is digital and data-driven, and the progress made this year positions UHL to realise that ambition.

Strategy and Direction

The Trust formally approved its group-wide digital and data strategy for 2025–2028, uniting University Hospitals of Leicester and University Hospitals of Northamptonshire under a single collaborative vision – ***one digital***. This strategy sets out seven priorities: getting the basics right, putting users' needs first, using digital as a tool for transformation, embracing emerging technology, bringing our data together, harnessing strategic partnerships, and creating and embedding one digital across both organisations. Alongside this, we approved a dedicated data strategy setting out how we will use data for insight, research, and operational improvement. These strategies provide a clear framework for investment, prioritisation, and delivery.

Electronic Patient Record

The most significant milestone of the year was the successful go-live of our new Patient Administration System (PAS) in June 2025, delivered in partnership with Nervecentre. This is the first entirely new PAS to be developed and deployed within the NHS this century. The deployment included migrating more than 50 million data points with zero data loss across some of the busiest hospitals in the country. The new PAS replaces decades-old technology and provides a modern, integrated foundation for managing referrals, appointments, theatres, and patient records. Clinical and administrative staff rapidly adopted the new digital workflows, which are already saving time and reducing administrative burden.

We also completed the go-live of BadgerNet, our new maternity and neonatal electronic patient record, replacing paper records with fully digital documentation for neonatal care teams and maternity services. This ensures safer, more joined-up care for mothers and babies across our hospitals.

Our work continues to gain regional and national recognition, with multiple NHS peers visiting UHL to learn from our mobile-first EPR approach. The Trust leads the East Midlands Acute Provider Digital Design Collaborative, working with nine acute trusts and covering 14,000 beds across the region on the deployment of Nervecentre.

Data and the Federated Data Platform

UHL became the first NHS Trust in the country to produce key national returns – including the Commissioning Data Set (CDS) and Emergency Care Set (ECS) – from source system through to submission entirely on the NHS Federated Data Platform (FDP). This pioneering work is defining the canonical data model for acute trusts nationally, meaning that the integration work done at UHL will benefit trusts across England as they adopt FDP. We continue to develop FDP as our core data warehouse,

replacing fragmented local systems with a unified, modern platform that enables better insight, faster reporting, and reduced reliance on specialist resource.

Artificial Intelligence and Emerging Technology

We have made considerable strides in the responsible adoption of artificial intelligence. UHL completed the largest NHS procurement of ambient voice technology, which is now live in its early phase with full roll-out planned for 2026/27. This technology enables clinicians to automatically generate clinical documentation from patient consultations, reducing time spent on administrative tasks and allowing more time for direct patient care.

Our commitment to safe and transparent AI is reflected in our role as the only UK organisation signed up to the European Trustworthy and Responsible AI Network (TRAIN) initiative. We are undertaking the first UK trial to assess AI effectiveness across all patient groups, ensuring that AI tools work equitably and safely for the diverse communities we serve. Our AI Governance Oversight Group (AIGO) provides structured oversight of all AI deployments, ensuring safe and effective implementation across the organisation. We continue to advance AI use in imaging, dermatology, stroke, pathology, and cardiology.

We have established a strategic partnership with Microsoft, including the roll-out of Co-pilot to support colleagues with everyday productivity tasks, and are working together on use cases including discharge summary generation, clinical coding support, and digitisation of health records.

Automation and Corporate Services Transformation

Our automation programme has progressed through two waves of delivery. Wave 1, which piloted automation in finance and people services, delivered £480,000 in benefits in its first quarter and tracked ahead of forecast throughout the year. Building on this success, Wave 2 scaled automation across both UHL and UHN, targeting corporate services including people services, clinical coding, and medical workforce management. The programme is delivering a net benefit of approximately £6 million per annum across both trusts, releasing capacity, reducing temporary staffing spend, and moving corporate services away from paper-based processes. This makes it easier for colleagues to interact with corporate services, whether that is recruitment, payroll, or occupational health, and ensures we look after our people more effectively.

Cyber Security and Infrastructure

We have delivered additional cyber security capability in line with the evolving threat landscape and the requirements of the NHS Data Security and Protection Toolkit, which now incorporates the Cyber Assessment Framework. Our cyber security team continues to work proactively to protect the Trust’s systems and data, and we have developed a strategy to achieve full compliance across all five domains by 2029 as required by NHS England.

Improving the Experience of Technology

We have continued to invest in improving the day-to-day experience of digital services for our colleagues. Response times to problems have improved, with more issues resolved at first contact through the helpdesk and faster access to devices. These improvements reflect our commitment to getting the basics right – ensuring that when colleagues log in, things work, and when they need support, they get it quickly.

Looking Ahead to 2026/27

2025/26 was about delivering foundational capability. The programme for 2026/27 allows us to realise the potential of the solutions we have built. Our priorities include:

Delivering the strategy through a detailed roadmap, including digitising all outpatient services, removing paper from core clinical processes, and delivering the Nervecentre theatres and intensive care modules – meaning that all core clinical processes will run digitally.

Expanding the use of AI in clinical operations, including AI-powered booking and calling systems and further advances in clinical AI to support diagnosis and care delivery.

Establishing FDP as our core data warehouse, enabling faster, better insight and reducing local costs.

Full roll-out of ambient voice technology, freeing clinicians from administrative documentation and enabling them to spend more time with patients.

By bringing together leadership, infrastructure, and innovation across both organisations, we are 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 Resilience & Response (EPRR)

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 2025, where following reviews from the Leicester, Leicestershire and Rutland 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 significantly strengthened its working relationships with Digital & Data to support the Trust during the upgrade to the Trust's Electronic Patient Record system, through the development of the Nervecentre Downtime Framework, and supporting the delivery of associated workshops, dress rehearsals and briefing sessions.

The EPRR Team has been working closely with internal and external stakeholders, to deliver exercises to support improving the Trust's Evacuation & Shelter arrangements, as well as provide opportunities to exercise the organisations arrangements in response to Hazardous Materials and events involving Chemical, Biological, Radiological and Nuclear materials.

In the forthcoming year, alongside reviewing, updating, training and exercising the Trust's plans, the EPRR Team will specifically be exploring a number of opportunities alongside the Local Resilience Forum to create regional exercises, as well as collaborating with UHL's Security Specialists to implement the Terrorism (Protection of Premises) Act 2025 (known as Martyn's Law). This is a UK legislation designed to improve public safety by making certain premises legally responsible for taking proportionate, practical steps to prepare for and mitigate the risk of terrorist acts.

Sustainability

Sustainability is embedded within UHL's strategic direction and is delivered through established governance and operational arrangements. As a large multi-site acute Trust in the NHS, UHL recognises both its responsibility and opportunity to reduce environmental impact while improving health outcomes, operational resilience, and financial sustainability.

UHL's sustainability programme is providing the framework for the Trust's contribution, public health protection, and long-term service transformation. Sustainability considerations are embedded across estates, clinical pathways, workforce development, procurement, digital transformation, and emergency preparedness, ensuring a whole-organisation approach rather than isolated initiatives.

What we've accomplished

Since the publication of UHL's first Green Plan in 2022, the Trust has made measurable progress across multiple sustainability domains.

1. Reduced total carbon emissions by 16.7% between the 2021/22 baseline and 2024/25.
2. Embedded sustainability reporting into formal governance structures, including monthly Sustainability Working Group oversight, quarterly Finance and Investment Committee reporting, and annual Trust Board assurance.
3. Expanded the sustainability workforce, including dedicated leadership for energy, waste, travel, and sustainability delivery.
4. Achieved significant improvements in waste segregation and compliance, supporting a 9.07% year-on-year reduction in waste-related carbon emissions.
5. Delivered large-scale energy efficiency programmes, including Trust-wide LED lighting upgrades and Building Management System improvements.
6. Transitioned the Hospital Hopper service to zero-emission vehicles as the operational fleet, supporting staff, patient, and visitor travel between sites while improving local air quality.
7. Embedded sustainability into clinical practice through anaesthetic gas reduction, inhaler optimisation, and digital care pathways.
8. Elimination of desflurane anaesthetic gas and targeted nitrous oxide waste reduction has significantly reduced emissions contributing to a 59% reduction in anaesthetic gas emissions since 2021/22.
9. Investment in digital pathways, virtual clinics, and Care at Home models has reduced unnecessary travel while improving patient access and experience.

10. Biodiversity enhancements, including large-scale tree planting at Leicester General Hospital, have improved green space, wellbeing, and local environmental quality.

These achievements demonstrate that sustainability is now operationalised across UHL, moving beyond planning into delivery.

Green Plan 2025 – 2028
UHL's Green Plan 2025–2028 is the Trust's current strategic sustainability framework. It covers a three-year delivery period and aligns with NHS England guidance, national Net Zero commitments, and local Integrated Care System priorities.

The Green Plan sets out a structured programme of actions across defined Areas of Focus, each with executive sponsorship, operational leadership, clear objectives, and measurable milestones. It addresses mitigation and adaptation, ensuring that carbon reduction, climate resilience, and public health protection are progressed in parallel.

The plan builds on earlier achievements and shifts the Trust from foundational delivery to embedded, system-wide sustainability integration.

Areas of Focus and Accountability

Area of Focus	Executive Sponsor	Total Actions	Completed
Workforce and System Leadership	Chief People Officer	15	13
Food and Nutrition	Group Chief Nurse	5	3
Climate Change Adaptation	Director of Corporate and Legal Affairs	6	3
Medicines	Medical Director	8	1
Estates and Facilities	Group Chief Nurse	16	3
Net Zero Clinical Transformation	Director of Health Equality & Inclusion	7	4
Digital Transformation	Group Chief Digital Information Officer	8	2
Travel and Transport	Group Chief Nurse	8	2
Procurement and Supply Chain	Chief Financial Officer	6	0
Carbon Footprint	Chief Operating Officer	1	1

Table 1: Green Plan Areas of Focus and Accountability

Delivery of the Green Plan
Delivery of UHL's Green Plan is organised through themed Areas of Focus that provide structured management oversight of climate-related risks and opportunities across the organisation. Each Area of Focus has a named executive sponsor and operational lead, ensuring clear accountability for delivery. Performance, risks, and interdependencies are monitored through the Sustainability Working Group and escalated through established Trust governance, supporting Board oversight and integration into strategic and financial decision-making. Detailed actions and milestones are published in the Green Plan 2025–2028; the summaries below describe how climate-related responsibilities are governed and managed in practice.

Workforce and System Leadership
The Workforce and System Leadership Area of Focus establishes the governance, capability and accountability arrangements required to manage climate-related risks and opportunities across the Trust. Executive oversight by the Chief People Officer ensures that sustainability responsibilities are embedded within leadership structures, workforce planning and organisational development. This Area of Focus supports effective management oversight by strengthening climate literacy, role clarity and escalation routes, enabling consistent delivery across all other sustainability domains.

Net Zero Clinical Transformation
Net Zero Clinical Transformation ensures that climate considerations are integrated into clinical strategy, pathway redesign and service transformation. Executive oversight is provided by the Director of Health Equality & Inclusion, with operational support to ensure that carbon, quality and equity impacts are considered together. This Area of Focus provides assurance that climate-related opportunities, such as digital and preventative care models, are embedded within clinical governance rather than addressed separately.

Travel and Transport
The Travel and Transport Area of Focus manages climate-related risks and opportunities associated with staff commuting, patient access, business travel and fleet operations. Executive sponsorship by the Group Chief Nurse ensures oversight at senior level, reflecting the links between travel, workforce resilience, access to care and air quality. This Area of Focus supports coordinated management of emissions and operational dependencies through engagement with system partners and local transport authorities.

Estates and Facilities
Estates and Facilities is a core Area of Focus for managing climate-related physical and transition risks arising from the Trust's estate and infrastructure. Executive oversight by the Group Chief Nurse ensures that sustainability considerations are integrated into decisions relating to patient safety, service continuity and capital investment. This Area of Focus provides structured management of energy use, infrastructure resilience and decarbonisation planning, supporting long-term risk mitigation and value-for-money decision-making.

Procurement and Supply Chain
The Procurement and Supply Chain Area of Focus addresses climate-related transition risks associated with indirect emissions and supplier dependency. Executive sponsorship by the Chief Financial Officer ensures alignment between sustainability requirements, financial control and contract management. This Area of Focus supports governance oversight of Scope 3 emissions and ensures that climate considerations are embedded into procurement processes and value-based decision-making.

Medicines
The Medicines Area of Focus manages climate-related risks and opportunities associated with high-impact medicines, including anaesthetic gases and inhalers. Executive oversight by the Medical Director ensures that sustainability considerations are integrated into clinical governance and prescribing practice. This Area of Focus provides assurance that emissions reduction initiatives are clinically led, evidence-based and aligned with patient safety and quality standards.

Climate Change Adaptation
Climate Change Adaptation focuses on the management of physical climate risks, including extreme weather and temperature-related impacts on services and infrastructure. Executive oversight by the Director of Corporate and Legal Affairs ensures alignment with the Trust's risk management framework, emergency preparedness and business continuity arrangements. This Area of Focus supports identification, assessment and mitigation of climate-related risks through integration with EPRR governance and the Trust Risk Register.

Digital Transformation
Digital Transformation supports management of climate-related risks and opportunities through reduced resource use, remote working and digitally enabled care. Executive oversight by the Group Chief Digital Information Officer ensures that digital sustainability considerations are integrated into information governance, system resilience and service design. This Area of Focus enables lower-carbon service delivery while supporting operational efficiency and access.

Carbon Footprint
The Carbon Footprint Area of Focus provides the metrics and evidence required to monitor climate-related performance and inform decision-making. Executive oversight by the Chief Operating Officer ensures that emissions data is used to identify risks, target interventions and support strategic prioritisation. This Area of Focus underpins the Trust's approach to monitoring progress against net zero commitments and supports transparent reporting in line with NHS and TCFD expectations.
Actions delivered through the Green Plan provide the primary mechanism for addressing the climate-related risks, opportunities, and targets described within the TCFD disclosure.

Reporting
Sustainability performance is reported through established governance structures:

1. Monthly reporting to the Sustainability Working Group
2. Quarterly reporting to the Finance and Investment Committee
3. Annual reporting to the Trust Board

This structure ensures executive oversight, financial scrutiny, and strategic accountability. Sustainability metrics also inform risk management, capital planning, and business case development. Reporting covers Green Plan delivery status, key metrics (including emissions where available), material risks, and investment pipeline updates.

Financial Profile of Green Plan Actions
To support effective financial planning and oversight, all actions within the Green Plan have been assessed and categorised by cost. This provides clarity on how much of the programme can be delivered through existing resources, where policy or process change is required, and where additional investment may be needed. Costs reflect indicative order-of-magnitude estimates at time of plan refresh and are subject to business case development and approvals.

Actions deliverable within existing budgets
A significant proportion of Green Plan actions (46 actions) are deliverable within existing budgets. These actions focus on governance, leadership, clinical practice change,

service redesign, reporting, engagement, and improved use of existing systems and resources. This demonstrates that much of the Trust's sustainability delivery is about embedding sustainability into day-to-day operations and decision-making, rather than relying on new funding.

Actions requiring policy or process change
A total of 11 actions require policy or process change rather than direct financial investment. These actions focus on updating standards, guidance, governance arrangements, procurement approaches, and ways of working to better integrate sustainability and resilience into existing Trust processes. This reflects the importance of organisational change and leadership, alongside financial investment, in delivering the Green Plan.

Low investment actions (under £50,000)
Five actions require low levels of investment, typically under £50,000. These actions are targeted, discrete interventions that support delivery of wider sustainability objectives, such as enabling tools, small-scale infrastructure, or pilot initiatives. These costs are generally manageable within revenue planning or small capital allocations and offer high value relative to spend.

Medium investment actions (under £500,000)
Seven actions fall into the medium investment category, requiring funding of under £500,000. These actions are more substantial and typically relate to enabling infrastructure, service enhancements, or system improvements that support decarbonisation, resilience, and operational efficiency. These actions are suitable for prioritisation through existing capital planning processes, business cases, or external funding opportunities where available.

High investment actions (over £500,000)
Seven actions require high levels of investment, exceeding £500,000. These actions are concentrated in areas where sustainability and resilience are inherently capital-intensive, particularly estates, infrastructure, and major system upgrades. These investments are long-term in nature and closely aligned with backlog maintenance, safety, resilience, and net zero delivery. They are expected to be considered through formal capital planning, phased delivery, and where appropriate, external funding or "invest to save" approaches.

Subgroups	Within Existing Budget	Policy Change	Low Investment Under £ 50,000	Medium Investment Under £ 500,000	High Investment Over £ 500,000
Carbon Footprint	1	0	0	0	0
Climate Change Adaptation	5	1	0	0	0
Digital Transformation	3	1	2	1	1
Estates and Facilities	5	1	1	3	6
Food and Nutrition	2	1	0	2	0
UHL Green Plan	1	0	0	0	0

Medicines	5	0	2	1	0
Net Zero Clinical Transformation	5	1	0	1	0
Procurement and Supply Chain	3	3	0	0	0
Travel and transport	5	2	0	1	0
Workforce and System Leadership	13	2	0	0	0
Total	**48**	**12**	**5**	**9**	**7**

Table 2: Financial Profile of Green Plan Actions

This profile demonstrates that UHL's sustainability programme is financially proportionate, with most progress driven by integration and smarter ways of working, supported by targeted investment where it delivers resilience, safety, and long-term value.

Carbon Impact

UHL continues to make sustained progress in reducing its carbon footprint, demonstrating a clear downward trajectory in total emissions across the reporting period. This reflects a combination of targeted estates interventions, energy efficiency programmes, clinical pathway changes, waste reduction initiatives, and behavioural change activity, aligned to NHS England's Net Zero ambitions.

Between 2021/22 and 2024/25, UHL reduced its total carbon emissions by 8,547 tCO_2e, representing a 16.7% reduction over four years. This reduction has been achieved despite ongoing operational pressures, estate complexity, and increasing clinical demand.

UHL's emissions profile is reported across Scope 1, Scope 2, and Scope 3 emissions in line with NHS carbon footprint reporting conventions. UHL monitors and reports its carbon footprint emissions in line with NHS and national reporting requirements. Carbon data is used to:

1. Track progress against Net Zero trajectories.
2. Identify priority interventions.
3. Inform investment decisions.
4. Support compliance with statutory and NHS reporting frameworks.

Total Carbon Emissions (Scopes 1, 2, and 3)

UHL's total emissions have reduced year on year over the reporting period, as set out below.

Year	Scope 1	Scope 2	Scope 3	Total
2021–2022	27,485	7,710	15,887	51,082
2022–2023	24,677	6,532	15,279	46,488
2023–2024	22,085	7,685	14,940	44,710
2024–2025	20,600	8,228	13,706	42,535

Table 3: Total Carbon Emissions (Scopes 1, 2, and 3) in tCO_2e

Key observations

1. Scope 1 emissions reduced by 6,885 tCO_2e (25%) since 2021/22.
2. Scope 3 emissions reduced by 2,181 tCO_2e (13.7%) since 2021/22.
3. Scope 2 emissions increased in 2024/25, reflecting electricity-related factors rather than increased demand.
4. Overall trajectory remains downward and aligned with Net Zero pathways.

Scope 1 Emissions (Direct Emissions)

Scope 1 emissions represent direct emissions from sources owned or controlled by the Trust, including gas combustion, oil use, fleet fuel, anaesthetic gases, and refrigerants.

Scope 1 emissions by source

Year	Gas	Oil	Fleet	Stationary Combustion	Anaesthetic Gases	Refrigerants	Total Scope 1
2021–2022	21,080	82	236	5	5,508	573	27,485
2022–2023	20,750	51	208	4	3,092	573	24,677
2023–2024	18,622	61	158	5	2,666	573	22,085
2024–2025	17,384	223	166	6	2,249	573	20,600

Table 4:Total Scope 1 Emissions in tCO_2e

Key drivers of Scope 1 reduction

1. Gas emissions reduced by 3,696 tCO_2e (17.5%) since 2021/22 through energy efficiency measures, operational optimisation, and infrastructure upgrades.
2. Anaesthetic gas emissions reduced by 59%, reflecting changes in clinical practice and increased adoption of lower-carbon alternatives.
3. Oil use remains minimal but increased slightly in 2024/25 due to contingency and resilience requirements.

Scope 1 remains UHL's largest emissions category, and continued focus on heat decarbonisation, energy optimisation, and clinical engagement will be critical to delivering further reductions.

Scope 2 Emissions (Indirect Electricity Emissions)

Scope 2 emissions relate to purchased electricity consumed by the Trust.

Year	Electricity Emissions
2021–2022	7,710
2022–2023	6,532
2023–2024	7,685
2024–2025	8,228

Table 5: Total Scope 2 Emissions in tCO2e

The increase in Scope 2 emissions in 2024/25 reflects:

1. DEFRA Grid emissions factor have changed
2. New builds being added to the estate
3. Estate operational demands within ageing infrastructure

This reinforces the importance of:

1. On-site generation
2. Demand reduction
3. Building Management System optimisation
4. Sub-metering and real-time energy monitoring

These actions are already being progressed through NEEF-funded projects and the refreshed Green Plan pipeline.

Scope 3 Emissions (Indirect Value Chain Emissions)
Scope 3 emissions capture indirect emissions arising from the Trust's activities but occurring from sources not owned or controlled by UHL.

Scope 3 emissions by category

Year	Inhalers	Travel (WTT)	Business Travel	Waste	Water	Energy Transmission & WTT	Total Scope 3
2021–2022	7,950	59	32	1,248	105	6,493	15,887
2022–2023	7,771	51	26	1,407	174	5,850	15,279
2023–2024	7,700	40	98	1,362	135	5,605	14,940
2024–2025	7,185	42	127	543	180	5,630	13,706

Table 6: Total Scope 3 Emissions in tCO2e

Key trends

1. Inhalers remain the largest Scope 3 category, accounting for over 50% of Scope 3 emissions
2. Waste emissions reduced by 60% in 2024/25, reflecting improved segregation, contract changes, and behavioural programmes
3. Business travel emissions increased in 2024/25 as activity levels normalised post-pandemic
4. Water-related emissions increased slightly, highlighting growing demand, resilience and efficiency considerations

Scope 3 emissions remain the most complex area for decarbonisation and require system-wide action across procurement, clinical pathways, travel, and supplier engagement.

Carbon Reduction Trajectory and Net Zero Alignment
UHL's emissions reduction trajectory aligns with NHS England's targets of:

1. Net Zero Scope 1 and 2 by 2040
2. Net Zero Scope 3 by 2045

The Trust has already delivered:

1. A quarter reduction in Scope 1 emissions
2. Sustained reductions in Scope 3 emissions
3. Significant progress in waste, anaesthetics, and energy efficiency

The Refreshed Green Plan (2025–2028) will support this trajectory through:

1. Heat decarbonisation planning
2. Further LED and BMS optimisation
3. Low-carbon clinical practice initiatives
4. Expanded Scope 3 engagement and measurement
5. Invest-to-save programmes that deliver both carbon and financial benefits

Data quality and limitations

Emissions data is derived from NHS-approved methodologies and national reporting frameworks. Scope 1 and 2 emissions are directly monitored through utilities data and energy management systems. Scope 3 emissions are based on nationally defined factors and categories provided through NHS reporting.

As recognised nationally, Scope 3 emissions estimation continues to evolve. UHL will continue to strengthen data quality, expand category coverage where appropriate, and align local monitoring with national Greener NHS reporting to ensure consistency and comparability.

UHL has demonstrated consistent and credible progress in reducing its carbon footprint across all three scopes. The Trust's emissions trajectory reflects a maturing sustainability programme that balances decarbonisation with operational resilience, patient safety, and financial sustainability.

Carbon reduction remains a core strategic priority, embedded within the Green Plan, capital planning, clinical engagement, and governance arrangements, and will continue to inform decision-making as UHL progresses toward its Net Zero commitments.

Investments (funding)

Funding	Location	Amount (£)
EV	LRI	21,700.00
EV	LGH	10,850.00
EV	GH	10,850.00
EV	Preston Lodge	21,700.00
EV	Trust Wide Funding	33,000.00
EV EMAS	LRI	325,900.00
EV Total		**424,000.00**
Solar	Preston Lodge	288,000.00
Solar Total		**288,000.00**
BMS	LRI	100,000.00
BMS	LGH	275,000.00
BMS	GH	200,000.00
BMS Total		**575,000.00**
Sub Meter	LRI	37,000.00
Sub Meter	LGH	60,000.00
Sub Meter	GH	51,000.00
Sub Meter	Trust Wide Funding	49,920.00

Sub Meter Total	197,920.00
Total Funding	1,484,920.00

Table 7: Total Funding Received for Sustainability Projects in FY 25/26

Waste management

This year, UHL carried on the journey of waste management through continuous improvement, with emphasis on strengthening its management practices, promoting correct waste segregation and targeted waste improvement projects. This journey is supported by the behavioural change programme on the acute sites, which works through regular audits of wards and departments that lead to targeted training where problems are found.

This has translated into a 2.50% reduction in overall waste volumes with a notable 4.94% reduction in clinical waste. From a climate perspective, the Trust reduced carbon emissions from waste by 9.07% year-on-year. A notable highlight was the introduction of food waste collections on all three acute sites, tied in with the introduction of 'Simpler Recycling' legislation.

The work done in the Trust was noticed and celebrated by our national colleagues at the 2025 Excellence in Waste Management Awards for the NHS in England, where the Trust won the gold award in the 'Waste management team of the year' and the 'Biggest reduction in carbon emissions from waste' categories.

Travel and access

This year, UHL continues to focus on enhancing sustainable travel options, aiming to significantly reduce commuter emissions by 50% by 2033. The Trust has achieved a landmark milestone, becoming the first NHS trust to earn 'Excellent' Modeshift STARS Accreditation status for LRI, LGH and GH. Important steps included progressing the Hopper bus tender exercise, working with the council to improve real-time bus stop information, and promoting the bus services that are available to all sites. Additional initiatives support sustainable commuting through free e-bike loans, cycle maintenance and training sessions, and promoting the BetterPoints app. The UHL continues to work closely with the city council to improve walking, cycling and bus facilities including wayfinding.

Energy

Energy management at UHL continued to strengthen during the year, despite ongoing challenges from ageing infrastructure, grid constraints, and increasing operational demand. The focus moved from foundational delivery to improved resilience, control, and long-term decarbonisation planning. Building on the previous year's completion of £1.7 million of LED lighting and Building Management System (BMS) upgrades, UHL expanded its low-energy estate and monitoring capability. Energy efficiency schemes are now fully operational across key sites, supported by wider BMS coverage and improved control of high-energy plant areas.

UHL strengthened its compliance and planning position by establishing a UK Emissions Trading Scheme (UK ETS) baseline for the next five-year period. In parallel, a major gas metering modernisation programme was delivered, with around 90% of legacy gas meters replaced with automated infrastructure, significantly improving data quality and future-proofing energy monitoring.

Task Force on Climate-Related Financial Disclosures (TCFD)

UHL prepares its climate-related financial disclosures in alignment with the Task Force on Climate-related Financial Disclosures (TCFD) framework and the Department of Health and Social Care Group Accounting Manual (GAM) requirements. This disclosure is presented on a comply-or-explain basis and reflects UHL's current level of maturity in Phase 3 implementation. It explains how climate-related risks and opportunities are governed, identified, assessed, and managed, and how these issues are increasingly integrated into operational planning, capital prioritisation, and financial decision-making.

Where quantitative scenario modelling or detailed financial sensitivity analysis has not yet been completed, UHL explains the gap, the reason for non-disclosure, and the planned improvement actions for future reporting cycles, consistent with HM Treasury's comply-or-explain principle.

Details of the Trust's position relating to the TCFD requirements are set out below.

Scope, Boundary, and Basis of Preparation

This disclosure covers activities within the Trust's Annual Report boundary. Climate-related risks and opportunities are considered across the full range of Trust functions where UHL has operational responsibility or financial exposure, including:

1. Clinical service delivery, where overheating, extreme weather and disruption to access can affect patient safety, clinical capacity, and the ability to maintain safe care pathways.
2. Estates and facilities, where climate risks may affect infrastructure resilience, plant reliability, backlog maintenance prioritisation, and the suitability of buildings for future service delivery.
3. Energy and utilities, including exposure to energy price volatility, compliance and reporting requirements, and the practical challenges of transitioning from fossil-fuelled heat to lower-carbon systems.
4. Travel and transport, including staff access to sites during disruption, fleet transition requirements, and dependency on external transport infrastructure affecting service continuity and workforce resilience.
5. Procurement and supply chain, where supplier decarbonisation expectations, availability of low-carbon products, and contractual performance create transition risks and opportunities, particularly in Scope 3 categories.
6. Waste and resource management, where regulatory change, segregation performance, and treatment routes influence both cost and emissions outcomes.
7. Emergency Preparedness, Resilience and Response (EPRR), which coordinates preparedness and response to acute climate hazards such as heatwaves, flooding and severe weather events, and ensures escalation routes are established when incidents affect service delivery.

Where services are delivered through third parties, climate-related risks are considered where UHL retains operational, financial, safety, or reputational exposure.
This disclosure draws on established Trust processes and documentation including the Green Plan, Trust Risk Register, EPRR governance structures, capital planning processes, and NHS carbon reporting. Where relevant information is reported elsewhere

in the Annual Report or external documents, cross-referencing is used to avoid duplication and to maintain a single consistent narrative.

Time Horizons
UHL assesses climate-related risks across three time horizons aligned to NHS planning cycles and asset lifecycles:

1. Short term (0–2 years): Focused on operational continuity, seasonal resilience pressures, emergency response arrangements, and immediate infrastructure vulnerabilities which could affect patient safety and service capacity.
2. Medium term (3–10 years): Focused on capital programme sequencing, major plant renewal, backlog maintenance prioritisation, fleet transition, and service transformation activity where climate considerations influence investment choices and delivery timing.
3. Long term (10+ years): Focused on long-lived asset resilience, estate redesign and repurposing, heat decarbonisation, and the structural transition required to support a net zero health system while maintaining safe, affordable healthcare provision.

These horizons ensure that both acute climate events and longer-term structural change are considered in a consistent planning framework.

TCFD Alignment Summary (Comply or Explain)

Pillar	Status	Summary
Governance	Compliant	Climate risks are overseen through established Board and committee structures, with defined escalation routes, executive accountability, and regular reporting.
Strategy	Partially compliant	Climate risks and opportunities are identified and increasingly integrated into planning. Quantitative scenario modelling and detailed financial sensitivity analysis are not yet fully developed, and a forward plan is set out to strengthen these disclosures.
Risk Management	Compliant	Climate risks are embedded within the Trust's standard risk management framework, including formal escalation, assurance mechanisms, and integration with EPRR processes.
Metrics and Targets	Partially Compliant	Emissions are reported in line with NHS requirements and actively managed. Further development is underway to improve linkage between climate risk indicators and financial planning.

Table 8: TCFD Alignment Summary

Pillar 1: Governance

Board Oversight

Climate-related risks and opportunities are embedded within UHL's formal governance structure and considered within the Trust's established approach to risk, assurance, and strategic oversight. The Trust's Risk Committee reviews strategic and high-scoring risks, including those relating to climate resilience, sustainability, and estate vulnerability. Risks rated 15 or above under the Trust's risk scoring matrix are escalated for structured executive review. These risks remain under oversight until exposure is demonstrably reduced, ensuring there is continued challenge and accountability for mitigation delivery. The Risk Committee reports to the Audit Committee, which provides independent assurance that risk management processes are effective and that material risks are appropriately identified, mitigated, and monitored. The Audit Committee reports to the Trust Board, ensuring Board-level scrutiny and oversight of how climate-related risks may affect service continuity, infrastructure resilience, and long-term affordability.

Ultimate accountability for climate-related risks and opportunities rests with the Trust Board, ensuring climate considerations remain aligned with organisational strategy, financial planning, and overall risk appetite.

Management's Role

Executive responsibility for sustainability is delegated to the Director of Estates, Facilities and Sustainability. Operational leadership is provided through the Associate Director of Sustainability and Heads of Sustainability, working with executive sponsors and operational leads across each Green Plan Area of Focus. The Sustainability Working Group, established in 2024/25, meets monthly and coordinates delivery of the Green Plan across all Areas of Focus. It provides structured oversight of delivery progress, emerging risks, interdependencies, and barriers requiring executive resolution. Key issues are escalated through established governance routes.

Climate-related considerations are embedded into day-to-day decision-making and planning activity, including:

1. Capital investment appraisal and prioritisation, where resilience, asset suitability and decarbonisation requirements are considered alongside safety, quality and value-for-money factors.
2. Procurement standards and supplier engagement, where contractual requirements and product choices increasingly reflect sustainability expectations and transition risk.
3. Clinical pathway redesign and digital transformation initiatives, where opportunities to reduce carbon, reduce travel demand and improve service efficiency are pursued alongside patient outcomes.
4. Workforce planning and travel strategy, where access, staff resilience, and sustainable travel interventions support service continuity and reduce emissions.
5. Emergency preparedness and resilience planning, where EPRR arrangements address acute climate hazards and ensure escalation, command and response routes are defined.

Reporting and Escalation

Climate-related risks are managed within the Trust's established risk management

framework and follow the same identification, assessment, escalation, and assurance processes as other strategic and operational risks. Risks are initially identified and recorded within Clinical Management Groups (CMGs) and Directorates. Where a climate-related risk is assessed at a rating of 15 or above under the Trust's risk scoring matrix, it is escalated to the Executive Risk Committee. The Risk Committee provides structured review, challenge, and assurance that appropriate controls, mitigation actions, and executive oversight are in place. Risks rated 15 and above remain under oversight until risk exposure is demonstrably reduced, enabling consistent monitoring of progress and accountability for delivery.

The Risk Committee reports to the Audit Committee, which provides independent assurance that risk management processes are operating effectively and that high-level risks, including climate-related risks, are appropriately identified, managed, and monitored. The Audit Committee supports Board-level awareness of material risks and mitigation plans and provides challenge where controls or assurance are insufficient.
The Audit Committee reports to the Trust Board. The Trust Board seeks assurance that risk management processes are robust, that principal risks are appropriately controlled, and that climate-related risks and opportunities are integrated into strategic planning, capital prioritisation, and operational decision-making.

Ultimate accountability for climate-related risks and opportunities rests with the Trust Board. Management of the risk register lies with the Director of Corporate and Legal Affairs. Individual CMG risks and responsibilities lie with each CMG head.

Pillar 2: Strategy

Strategy (a): Climate-related risks and opportunities

Climate change affects how hospitals operate, how estates perform, and how resources are allocated. UHL has reviewed how climate-related risks and opportunities may affect the Trust across short, medium, and long-term horizons, recognising that both acute events and gradual changes can influence patient safety, service resilience, and affordability.

Physical risks

Acute physical risks include heatwaves, flooding, and extreme weather events. These can affect patient safety, disrupt services, increase demand and capacity pressures, and place strain on infrastructure. Overheating in clinical environments may increase clinical risk for vulnerable patients and affects staff wellbeing and operational performance. Flooding can affect plant rooms, substations, basements, and access routes, creating potential service disruption and requiring reactive response and recovery activity.

Chronic physical risks include rising average temperatures and gradual environmental change. These increase cooling demand, accelerate asset degradation, and may affect resource resilience, including water. Over time, these risks can increase operational costs, reduce asset life, and drive additional capital requirements if not addressed through planned renewal and resilience investment.

Transition Risks

Transition risks arise as the NHS and wider economy move toward net zero. These include exposure to energy price volatility, evolving regulatory requirements, infrastructure compatibility challenges for low-carbon heating, and capital sequencing

pressures where decarbonisation competes with backlog maintenance and clinical priorities. Supplier decarbonisation expectations may also affect procurement approaches, product availability, and contract performance requirements.

Opportunities
Climate action presents opportunities to improve resilience, quality of care, and long-term value for money. Energy efficiency programmes reduce operating costs and reduce exposure to energy market volatility. Improved thermal environments support patient experience and staff wellbeing. Sustainable procurement and pathway redesign can reduce emissions while contributing to service efficiency, reduced waste, and system-wide benefits.

Strategy (b): Impact on Operations, Strategy and Financial Planning
Climate-related risks are already influencing operational and financial decision-making. Operationally, extreme weather increases reliance on EPRR arrangements to maintain safe services, including escalation routes, incident response and continuity actions. Heatwaves may increase demand and capacity pressures and can degrade the performance of clinical environments. Severe weather can disrupt workforce travel and supply chain logistics, affecting access to sites and service continuity.

From an estates perspective, ageing infrastructure is more vulnerable to overheating and extreme rainfall. Critical systems including power, heating, cooling, and water require resilience to ensure continuity of care. This influences how UHL prioritises plant renewal, invests in monitoring and control, and sequences estate improvements.

Financially, climate resilience measures require capital investment, and energy price volatility affects revenue budgets. Climate-related disruption can drive additional reactive cost through emergency response, temporary mitigations, and unplanned works.
Formal quantitative scenario modelling and detailed financial sensitivity analysis have not yet been completed. This element is therefore partially compliant under a comply-or-explain basis. UHL will strengthen this area through development of structured financial sensitivity analysis and improved linkage between climate risk indicators and investment planning, using available Trust data on estates condition, reactive maintenance trends, energy costs, and service disruption experience.

Strategy (c): Resilience Under Climate-Related Scenarios
UHL has undertaken qualitative consideration of two plausible climate scenarios consistent with public-sector guidance.

Accelerated Transition Scenario (2°C or Lower)
This scenario assumes strengthened policy action and faster decarbonisation expectations. Implications include increased pressure to decarbonise heat, potential grid capacity constraints affecting delivery timelines, tighter procurement standards and reporting requirements, and increased capital demand for infrastructure transition. This scenario informs UHL's approach to sequencing heat decarbonisation planning and assessing infrastructure readiness, including dependencies on electrical capacity and asset compatibility.

Higher Physical Risk Scenario
This scenario assumes more frequent and severe heatwaves, flooding, and extreme weather events. Implications include greater strain on clinical environments, higher

resilience requirements for critical infrastructure and utilities, and increased reliance on emergency preparedness arrangements to maintain safe service delivery during disruption. This scenario informs prioritisation of overheating risk mitigation, protection of vulnerable infrastructure, and embedding climate hazards into EPRR preparedness.

Comply-or-explain statement and improvement plan
Formal quantitative modelling and scenario-based financial quantification have not yet been undertaken. As such, this element is partially compliant under a comply-or-explain basis. The gap reflects the current stage of integrating climate scenario methods, data and estates evidence into a structured modelling approach. UHL will strengthen resilience assessment over future reporting cycles through development of scenario modelling capability and improved financial sensitivity analysis, drawing on the Green Plan, estates condition evidence, risk registers, and EPRR learning.

Across both scenarios, UHL has identified “no-regret” priorities that strengthen resilience regardless of pathway. These include strengthening energy monitoring and control, improving plant resilience and planned renewal, embedding overheating mitigation within EPRR arrangements, and integrating sustainability considerations into capital planning and procurement decisions.

Pillar 3: Risk Management
Climate-related risks are integrated into UHL’s established risk management framework and managed using the Trust’s standard processes for risk identification, assessment, escalation, mitigation and assurance. Risks are identified through estates condition evidence, incident learning, emergency planning insights, climate adaptation assessments and national NHS guidance. Identified risks are assessed using the Trust’s risk scoring methodology, considering impact and likelihood across patient safety, service continuity, compliance and financial exposure. Where thresholds are met, risks are escalated for executive oversight.

Climate risks are recorded within the Trust Risk Register and EPRR registers. Risks rated 15 or above are subject to Executive Risk Committee oversight, ensuring sustained review, challenge and accountability for mitigation delivery. Mitigation measures include infrastructure upgrades, energy optimisation programmes, plant renewal planning, adaptation actions, procurement controls, and emergency exercises. Progress is monitored through governance reporting and internal review mechanisms, enabling assurance that controls are effective and risks are being reduced over time.

Interim management targets
In addition to NHS Net Zero commitments, UHL has established interim management targets to support structured delivery and oversight. These targets focus on delivery readiness, planning completion and risk mitigation capability, enabling phased implementation and alignment to capital planning cycles.

The Trust’s interim targets include:

1. Heat decarbonisation planning: completion of site-level feasibility and sequencing plans for major sites by 2028, aligned to capital investment planning cycles.
2. Overheating risk mitigation: identification and mitigation planning for high-risk clinical areas vulnerable to overheating by 2030, with prioritised interventions embedded into estates programmes.

3. Fleet electrification: transition of Trust-owned and leased fleet vehicles to zero-emission where operationally feasible, with a minimum of 50% zero-emission fleet coverage by 2030, subject to infrastructure and clinical requirements.
4. Scope 3 emissions coverage – Expansion of Scope 3 emissions category coverage and data maturity by 2028, enabling targeted hotspot interventions across procurement, travel, and clinical pathways.

Pillar 4: Metrics and Targets

UHL aligns with NHS England targets to achieve net zero Scope 1 and 2 emissions by 2040 and net zero Scope 3 emissions by 2045.

The Trust monitors a defined set of metrics to track progress against net zero and to support management of climate-related risks:

1. Scope 1 and 2 emissions through utilities data and energy management systems, supporting identification of high-consumption areas and prioritisation of efficiency interventions.
2. Scope 3 emissions categories in line with national NHS reporting conventions, supporting identification of hotspots and informing prioritised interventions across travel, procurement, medicines and waste.
3. Delivery of energy efficiency programmes, including LED upgrades, BMS optimisation, and sub-metering expansion, providing evidence of control improvements and carbon reduction measures.
4. Waste-related emissions and compliance, including performance improvements that reduce environmental impact while supporting value-for-money and regulatory readiness.
5. Compliance with relevant schemes such as the UK Emissions Trading Scheme, supporting effective governance of carbon-related obligations.

Detailed emissions data and trends are presented in the Carbon Footprint section of this report.

Adaptation and physical risk metrics

UHL's metrics are being strengthened to better reflect physical climate risk and resilience, consistent with Annex 5 expectations.

During future reporting cycles, UHL will expand reporting of adaptation-focused indicators, which may include measures such as overheating incidents and flooding incidents, and progress measures for completion of overheating risk assessments and mitigation planning in high-risk areas.

Performance is reported annually to the Trust Board and monitored through established governance structures. Development priorities include strengthening adaptation-specific metrics and improving linkage between climate risk indicators and financial planning.

Limitations and Forward Plan

UHL's disclosures are strongest in governance and risk management. Strategy and metrics continue to mature.

Key priorities for the next reporting cycle include:

1. Development of structured climate scenario modelling capability, to move from qualitative scenario consideration to more decision-useful assessment.

2. Strengthening financial sensitivity and cost-avoidance analysis, to improve clarity on potential revenue and capital exposure and the value-for-money case for planned investment.
3. Expansion of adaptation-focused performance indicators, including resilience and incident-based metrics where data is available.
4. Enhancement of integration between climate risk assessment and capital appraisal frameworks, ensuring climate resilience and transition considerations are consistently reflected in investment decision-making.

UHL remains committed to improving transparency and embedding climate resilience and decarbonisation into core strategic and operational planning.

Richard Mitchell

Chief Executive

22 June 2026

Section 2: Accountability Report

Directors'/Members' report

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

https://www.uhleicester.nhs.uk/about/board/members/

In addition, the following were also part of the Trust Board for some or all of 2025/26:

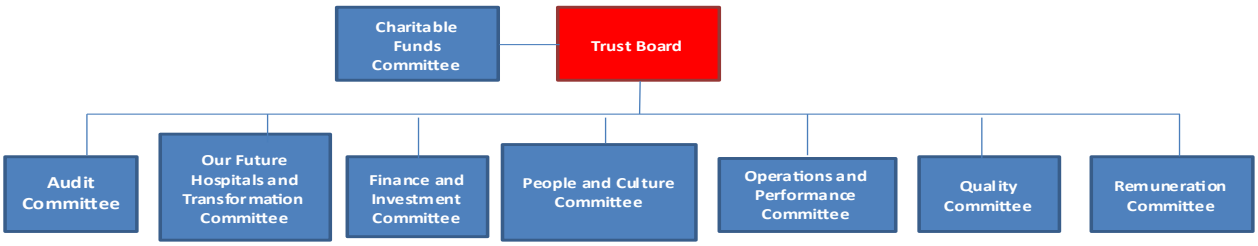
- Mr Andrew Furlong, Medical Director
- Jon Melbourne, Chief Operating Officer
- Michelle Smith, Director of Communications and Engagement
- Mark Farmer, Associate Non-Executive Director
- Dr Serbjit Kaur, Associate Non-Executive Director

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

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

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

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 regularly. 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 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 2025/26.

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 2025/26 is set out in the table below, including

Trust Board and Board Committee attendance, commencement/ending of post (if after 1 April 2025) and voting status:

Name	**Public Trust Board** (max = 8)	**Audit Committee** (max = 5)	**Finance and Investment Committee** (max = 12)	**Operations and Performance Committee** (max = 12)	**People and Culture Committee** (max = 8)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee** (max = 12)	**Remuneration Committee** (max = 7)	**Charitable Funds Committee** (max = 6)
Andrew Moore* Chairman	6/8 (75%) **(Chair)**								4/6 (67%)
Scott Adams* Non-Executive Director *(from May 2025)*	7/7 (100%)	4/4 (100%)		10/11 (91%) **(Chair from 1 May 2025)**			11/11 (100%)	N/A	
Professor Ivan Browne* Non-Executive Director	6/8 (75%)	0/5 (0%)			8/8 (100%) **(Chair)**	11/12 (92%)		7/7 (100%)	
Mark Farmer Associate Non-Executive Director *(until December 2025)*	0/0 N/A					0/0 N/A			0/0
Steve Harris Associate Non-Executive Director	1/8 13%		10/11 (83%)						
Dr Andrew Haynes* Non-Executive Director	7/8 (88%)	5/5 (100%)		11/12 (92%) **(Chair for April 2025 only)**	7/8 (88%)	11/12 (92%) **(Chair)**	11/12 (92%) **(Chair)**	7/7 (100%) **(Chair)**	
Jill Houghton* Non-Executive Director	8/8 (100%)				8/8 (100%)	11/12 (92%)			5/6 (83%)
Andrew Inchley* Non-Executive Director	8/8 (100%)	4/5 (80%)	11/11 (100%) **(Chair)**	1/1 (100%)				6/7 86%	
Dr Serbjit Kaur Associate Non-Executive Director	4/8 (50%)			9/11 (82%)		8/11 (73%)			
David Moon* Non-Executive Director	7/8 (88%)	5/5 (100%) **(Chair)**	11/12 (92%)				12/12 (100%)	7/7 (100%)	

Name	**Public Trust Board** (max = 8)	**Audit Committee** (max = 5)	**Finance and Investment Committee** (max = 12)	**Operations and Performance Committee** (max = 12)	**People and Culture Committee** (max = 8)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee** (max = 12)	**Remuneration Committee** (max = 7)	**Charitable Funds Committee** (max = 6)
Professor Thompson Robinson* Non-Executive Director	6/8 (75%)			6/11 (55%)		0/3 (0%)	5/12 (42%)		6/6 (100%) **(Chair)**
Richard Mitchell* Chief Executive	8/8 (100%)								
Dr Ruw Abeyratne Director of Health Equality and Inclusion	7/8 (88%)				5/8 (63%)	8/12 (67)			
Simon Barton Deputy Chief Executive	7/8 (88%)		10/12 (83%)				8/12 (67%)		
Lee Bond* Chief Financial Officer	8/8 (100%)		11/12 (92%)				6/12 (50%)		
Becky Cassidy Director of Corporate and Legal Affairs	8/8 (100%)		10/12 (83%)			11/12 (92%)	6/12 (50%)		5/6 (83%)
Emma Casteleijn Director of Communications and Engagement *(from 1 September 2025 to enable handover)*	4/4 (100%)						0/7 (0%)		2/2 (100%)
Mr Andrew Furlong* Medical Director *(until December 2025)*	5/6 (83%)		6/9 (67%)	6/8 (75%) (either MD or CN attended)		7/10 (70%)	5/11 (45%)		
Helen Hendley* Chief Operating Officer *(in place from 1 September 2025 to enable handover)*	3/3 (100%)		6/6 (100%)	6/6 (100%)		6/6 (100%)			

Name	**Public Trust Board** (max = 8)	**Audit Committee** (max = 5)	**Finance and Investment Committee** (max = 12)	**Operations and Performance Committee** (max = 12)	**People and Culture Committee** (max = 8)	**Quality Committee** (maximum = 12)	**Our Future Hospitals and Transformation Committee** (max = 12)	**Remuneration Committee** (max = 7)	**Charitable Funds Committee** (max = 6)
Julie Hogg* Chief Nurse	7/8 (88%)			6/12 (50%) (either MD or CN attended)		10/12 (83%)			4/6 (67%)
Jon Melbourne* Chief Operating Officer *(until 26 October 2025)*	4/5 (80%		5/6 (83%)	4/6 (67%)	4/6 (67%)	4/6 (67%)			
Will Monaghan Group Chief Digital Officer	7/8 (88%)		9/12 (75%)						
Michelle Smith Director of Communication and Engagement *(until 15 September 2025)*	4/4 (100%)						0/5 (0%)		1/4 (25%)
Clare Teeney Chief People Officer	6/8 (75%)				7/8 (88%)				
Dr Gang Xu* Medical Director *(from December 2025)*	2/2 (100%)		1/1 (100%)	0/4 (0%) (either MD or CN attended)		2/2 (100%)	0/1 (0%)		

***** voting members of the Trust Board

Corporate Governance report

The table below provides information on the declarations of interests entries made by Trust Board members and attendees for the year 2025/26:

NAME	POSITION	INTEREST(S) DECLARED
Andrew Moore	Group Chair, UHL-UHN (formerly UHL and KGH Non-Executive Director)	• Vice Chair Breast Cancer Now (charity) • Chair, University Hospitals of Northamptonshire (UHN) NHS Group • Member of the UHL Corporate Trustee Board
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

NAME	POSITION	INTEREST(S) DECLARED
		• Board Committee member, Trent College and The Elms
Scott Adams *(from 1 May 2025)*	Non-Executive Director	• Line manager of Head of Charity for Portsmouth Hospital Trust and Isle of Wight Hospital Trust charities, although no activity role in the running of either charity • Member of the UHL Corporate Trustee Board
Simon Barton	Deputy Chief Executive	• Confirmed no declarations to be made
Lee Bond	Chief Financial Officer	• Trustee of the Healthcare Financial Management Association (HFMA) (registered charity) • Member of the UHL Corporate Trustee Board
Professor Ivan Browne	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
Becky Cassidy	Director of Corporate and Legal Affairs	• Company Secretary for Trust Group Holdings Ltd
Emma Casteleijn *(from 1 September 2025 to enable handover)*	Director of Communication and Engagement	• Confirmed no declarations to be made
Mark Farmer *(until 31 December 2025)*	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 *(until 8 December 2025)*	Medical Director	• Member of the UHL Corporate Trustee Board
Steve Harris	Associate Non-Executive Director	• Director of Trust Group Holdings (TGH) • Director of Selco Builders Warehouse Ltd (from 18 August 2025)

NAME	POSITION	INTEREST(S) DECLARED
Dr Andrew Haynes	Non-Executive Director	• Registered as an expert (Principal Clinical Adviser) with Academic Health Solutions • Member of the UHL Corporate Trustee Board
Helen Hendley *(in place from 1 September 2025 to enable handover)*	Chief Operating Officer	• 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 • Chief Nurse, University Hospitals of Northamptonshire (UHN) NHS Group • Member of the UHL Corporate Trustee Board
Jill Houghton	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 • Member of the UHL Corporate Trustee Board
Andrew Inchley	Non-Executive Director	• Director – Accenture Retirement Savings Plan Trustees Limited • Director – Accenture Pension Trustees Limited • Member of the UHL Corporate Trustee Board
Dr Serbjit Kaur	Associate Non-Executive Director	• Non-Executive Director Nottingham University Hospital • Council member of the General Dental Council • Partner at Parkview Dental Practice • Family members employed at UHL
Jon Melbourne *(until 26 October 2025)*	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 • Member NHS Providers 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

NAME	POSITION	INTEREST(S) DECLARED
		• 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	Group Chief Digital Information Officer	• Lecturer with Imperial College London on the NHS Digital Academy and course content advisor. • Provides occasional ad hoc advice to technology firms based on experience gained in a previous role and not connected with suppliers at UHL • Member (CDIO and Acute Hospitals Rep) Department of Health and Social Care – AI in Health and Care Advisory Group. • Chief Digital Information Officer University Hospitals of Northamptonshire (UHN) Group
David Moon	Non-Executive Director	• Non-Executive Director, Black Country Healthcare NHS Foundation Trust *(until 31 July 2025)* • 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
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)
Michelle Smith *(until 15 Sept 2025)*	Director of Engagement and Communications	• Confirmed no declarations to be made
Clare Teeney	Chief People Officer	• Confirmed no declarations to be made
Gang Xu *(from 9 December 2025)*	Medical Director	• Member of the UHL Corporate Trustee Board

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
Andrew Moore	Trust Board
Scott Adams	Operations and Performance Committee (from 1 May 2025)
Professor Ivan Browne	People and Culture Committee
Dr Andrew Haynes	Our Future Hospitals and Transformation Committee Quality Committee Remuneration Committee Operations and Performance Committee (April 2025 only)
Andrew Inchley	Finance and Investment Committee
David Moon	Audit Committee
Professor Tom Robinson	Charitable Funds Committee

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

Role	Non-Executive Director
Senior Independent Director	Professor Tom Robinson
Board champion for Maternity Safety	David Moon
Board lead for Maintaining High Professional Standards	Allocated on a case by case basis
Vice Chair	Dr Andrew Haynes
Board champion for Health and Wellbeing and Freedom to Speak Up	Professor Ivan Browne

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

The Finance and Investment Committee 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 meets bimonthly and focuses on workforce issues, organisational culture, and organisational systems and processes. 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 meets monthly and focuses on scrutinising operational performance including planned care, urgent and emergency care, diagnostics, cancer, and elective care.

The Our Future Hospitals and Transformation Committee meets monthly and 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.

In 2025/26, following ratification at their next meeting the minutes of each Board Committee meeting above were then submitted to the next available Trust Board meeting for Board-level oversight. A written escalation report is provided to the Trust Board following each Committee meeting, with the Non-Executive Director Chair of each Committee personally presenting 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 2025/26 the UHL Remuneration Committee met on 7 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 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust recognises effective risk management as a fundamental component of good

governance, leadership, and decision-making. A Board-approved Risk Management Policy establishes a consistent, organisation-wide framework for the identification, assessment, management, monitoring, and reporting of risk in support of the delivery of the Trust's strategic priorities. The Risk Management Policy was approved by the Trust Board in December 2025.

The Director of Corporate and Legal Affairs is the Board-level Executive Director with lead responsibility for risk management, supported by the Head of Risk Assurance. Executive and Clinical Directors are accountable for ensuring that effective risk management arrangements are in place within their areas of responsibility and that risks are managed in accordance with the policy.

The Trust Board is responsible for setting the Trust's strategic priorities and ensuring robust systems are in place to identify and manage the risks to their achievement. The Board maintains oversight of the Trust's risk profile through regular reporting, horizon scanning, and structured consideration of emerging threats and opportunities to ensure that risks remain within acceptable tolerance levels.

Strategic risks are recorded on the Board Assurance Framework (BAF). The Trust Board receives assurance from its Board Committees on the effectiveness of controls, progress with mitigating actions, and the adequacy of assurance for risks within their respective remits. Each Committee has defined responsibility for scrutinising the strategic risks aligned to its portfolio and reporting its conclusions to the Board to support effective oversight and informed decision-making.

On behalf of the Trust Board, the Risk Committee chaired by the Chief Executive or Deputy oversees the operation of the Trust's risk management framework and compliance with the Risk Management Policy. The Committee meets monthly and operates an annual work plan which includes the systematic review of new and emerging significant risks. Clinical Management Groups (CMGs) attend the Risk Committee to present their significant operational risks, which are recorded on the Trust's Operational Risk Register. The Committee provides scrutiny and challenge on risk articulation, scoring, effectiveness of controls, and the credibility of mitigating actions, and provides assurance to the Audit Committee on the effectiveness of the Trust's risk management arrangements.

The Audit Committee receives regular reports on risk management and the BAF and provides the Trust Board with independent and objective assurance on the effectiveness of the Trust's risk management framework. The Committee also oversees the adequacy of assurance provided by Board Committees in relation to strategic risks.

Internal Audit considers the outcomes of its work, including reviews of the Board Assurance Framework and risk management processes, when forming the annual Head of Internal Audit Opinion.

Internal Audit issued a Substantial Assurance opinion in respect of the Trust's arrangements for risk management and the Board Assurance Framework. In forming this opinion, Internal Audit concluded that the Trust has a robust and effective framework in place for the recording, monitoring, and review of the Board Assurance Framework. Internal Audit noted that the Risk Management Committee provides effective oversight of the Trust's risk profile, including the identification, review, and

closure of significant operational risks, while maintaining clear oversight of the BAF and undertaking regular deep-dive reviews to support informed scrutiny. The review further concluded that Board sub-committees routinely consider and challenge the BAF and that strategic risks are clearly aligned to the Trust's priorities. Internal Audit recognised the Trust Board's formal review of its risk appetite and tolerance levels as an important foundation for strengthening strategic risk management and supporting effective decision-making.

At an operational level, risks recorded on the Operational Risk Register are reviewed routinely through CMG governance arrangements, with escalation to Executive Directors and the Risk Committee where appropriate. This ensures alignment between operational and strategic risk management and that risks are managed at the appropriate level in the organisation.

The risk and control framework

The Trust's risk and control framework supports the organisation to protect patients from harm, safeguard the health and wellbeing of staff, manage financial and operational risk, strengthen organisational resilience, and meet the expectations of stakeholders and regulators. The framework recognises that not all risks can be eliminated and supports the taking of well-managed risks to enable safe improvement and change. Through the application of the framework, the Trust Board has undertaken structured work to consider the mitigation, tolerance, and acceptance of risk, and has defined its risk appetite in relation to the strategic risks on the BAF.

Risks are identified through a range of sources, including forward planning; performance and quality data; incident reporting and trend analysis; clinical audit and benchmarking; complaints, claims and inquests; patient and public feedback; and assurance from internal and external stakeholders and regulators.

To support effective implementation, the Corporate Risk Team provides expert advice, guidance, and training to clinical and corporate teams, promoting consistent and proportionate application of the risk management framework. Intelligence from incidents, complaints, claims, patient feedback, and audit activity is routinely analysed to identify emerging risks and areas of potential weakness, with learning shared across the organisation to drive continuous improvement and strengthen organisational resilience.

<u>Strategic BAF Risks</u>

The Trust's strategic risks are captured within the Board Assurance Framework and are grouped under six broad themes aligned to the Trust's strategies and priorities:

1. Quality - focusing on the key goals in the Quality Strategy:
    - Embedding a Safety Culture
    - Reducing Hospital-Acquired Infections and harm
    - Patient, Family and Carer Engagement
    - Care for Patients with Additional Needs
    - Tackling Health Inequalities

2. Activity – focusing on:
    - UEC

- Elective Care and Diagnostics
- Cancer Care

3. Finance – focusing on:
   - Capital
   - Sustainability

4. Digital – focusing on the goals in the Digital Strategy:
   - Infrastructure and Reliability
   - Solutions Adoption and Usability
   - Innovation, Data and Technology Use
   - Cybersecurity and Information Protection

5. Estates & Facilities – focusing on the goals in the Estate Strategy:
   - Compliance and Suitability of Estates
   - Delivery of Net Zero Targets
   - Delivery of the New Hospitals Programme

6. People – focusing on the 3 themes in the draft People Strategy:
   - Culture - Inclusive and Supportive Staff Culture
   - Capability - Talent Development and Staff Wellbeing
   - Capacity - Workforce Productivity and Sustainability

There are no strategic risks rated 25 and the current risks as featured on the Board Assurance Framework are set out below:

ID	**Committee**	**Owner**	**Description**			**Current score**
			Risk Event	**Existing condition**	**Impact**	
01-Quality-1	QC	CN & MD	There is a risk that a positive safety culture is not consistently embedded across services	due to underreporting and variable staff confidence in raising concerns and learning from incidents	leading to patient harm, low morale, reputational damage, and non-compliance with safety standards	15
01-Quality-2	QC	CN & MD	There is a risk that hospital-acquired infections and harm do not reduce as planned	due to inconsistent delivery of fundamental care, overcrowding, and variable compliance with protocols	leading to avoidable harm, longer stays, cost pressures, and reduced confidence in care	15
01-Quality-3	QC	CN & MD	There is a risk that patients, families, and carers are not fully engaged in service development and feedback	due to limited access to and responsiveness of engagement mechanisms	leading to unmet needs, dissatisfaction, and increased complaints	15
01-Quality-4	QC	CN & MD	There is a risk that care for patients with	due to variable screening, staff	leading to poorer outcomes, readmissions, and	15

			mental health needs, learning disabilities, autism, dementia, or at end of life remains inconsistent	training, and service capability	non-compliance with national standards	
01-Quality-5	QC	CN & MD	There is a risk that patients from underserved groups continue to experience poorer access, communication, and outcomes	due to insufficient data insights, inconsistent reasonable adjustments, and language or cultural barriers	leading to continued health inequalities, dissatisfaction, missed appointments, and reputational damage	15
02-Activity (UEC)-1	OPC	COO	There is a risk of overcrowding in ED, poor patient flow, and delayed discharges across the system	due to demand exceeding UEC capacity and misaligned system resources	leading to compromised safety, extended stays, regulatory non-compliance, missed performance targets, negative effects on staff wellbeing and retention, and increased financial pressures	20
02-Activity (Elective & Diagnostics)-2	OPC	COO	There is a risk of failing to deliver timely planned care	due to the COVID-19 backlog and sustained growth in referrals exceeding capacity	leading to repeat diagnostics, patient harm, poor experience, performance below national standards, and potential financial under-recovery where activity costs exceed income	20
02-Activity (Cancer)-3	OPC	COO	There is a risk of failing to deliver timely and effective cancer care	due to sustained demand exceeding strategic capacity	leading to non-compliance with targets, reduced survival rates, and reputational harm	20
03-Finance (capital)-1	FIC	CFO	There is a risk that continuity of clinical and operational services may be compromised	due to insufficient capital availability to replace or maintain critical estates, medical equipment and digital infrastructure	leading to failure of essential assets affecting the Trust's ability to deliver safe and compliant care	16
03-Finance (Short-Term)-1	FIC	CFO	There is a risk that the Trust's financial position may further deteriorate	due to the scale of the existing in-year deficit and ongoing operational, inflationary and demand pressures	leading to increased cash requirements, reduced financial flexibility and heightened regulatory intervention	20
03-Finance (Medium to Long-Term)-2	FIC	CFO	There is a risk that the Trust may not achieve long-term financial sustainability	due to structural financial challenges across the LLR system, recurrent cost pressures, and	leading to misalignment with the MTFP, reduced capacity to invest, and adverse impacts on	20

				limited availability of capital and transformation funding	service quality and service sustainability	
04-Digital-1	OFH&TC	Group CIO	There is a risk that the Group fails to deliver a robust, consistent, and reliable digital infrastructure and operating model	due to legacy systems, fragmented platforms, and immature Group-wide governance and capability	leading to inefficiencies, staff frustration, and limited readiness for transformation	16
04-Digital-2	OFH&TC	Group CIO	There is a risk that digital solutions fail to meet clinical, operational, and patient needs and fail to address digital poverty	due to inadequate co-design, inconsistent user engagement, and fragmented integration with service improvements	leading to poor adoption, inefficient workflows, and reduced impact on care quality	16
04-Digital-3	OFH&TC	Group CIO	There is a risk that the Group does not fully harness the value of integrated data, emerging technologies, and partnerships	due to limited digital maturity, workforce capability, and commercial frameworks	leading to missed opportunities for innovation, research, income, and population health improvement	16
04-Digital-4	OFH&TC	Group CIO	There is a risk of a cybersecurity breach	due to the organisation's expanded digital footprint and evolving cyber threats	leading to service disruption, data loss, clinical safety risks, and reputational damage	20
05-Estate-01	Primary: FIC Secondary: OFH&TC	DEF	There is a risk that the estate does not support safe, compliant, and productive healthcare delivery	due to ageing infrastructure, unresolved £125m backlog maintenance (excluding VAT fees of circa £75m), and poor space utilisation	leading to safety incidents, enforcement action, service disruption, and inefficient use of resources	20
05-Estate-02	OFH&TC	DEF	There is a risk the Trust fails to meet net zero carbon targets by 2040/2045	due to reliance on outdated systems and insufficient green investment	leading to higher emissions and regulatory non-compliance	12
05-OFH-03	OFH&TC	Dep CEO & OFH Prog Director	There is a risk that reconfiguration of acute and community hospital services under the NHP is not delivered by 2034	due to delays in national capital funding and complex dependencies	leading to prolonged clinical risks and operational inefficiencies	16
06-People-1	PCC	CPO	There is a risk that UHL does not consistently embed a culture of inclusion,	due to inconsistent responses to staff feedback, variation in leadership capability, and	leading to reduced morale, engagement, and staff retention	16

			psychological safety, restorative approaches, and values-led behaviours	uneven delivery of EDI objectives		
06-People-2	PCC	CPO	There is a risk that UHL does not fully harness and develop the talents of its people	due to variation in leadership development, unclear talent pathways, and inconsistent access to wellbeing support	leading to reduced performance, staff progression and organisational resilience	16
06-People-3	Primary: PCC Secondary: FIC	CPO	There is a risk that UHL is unable to optimise workforce productivity and sustainability	due to underdeveloped workforce planning, limited digital adoption, fragmented use of partnerships, and gaps in medical recruitment and staffing controls	leading to service gaps, inefficiencies, and reliance on temporary staff	20

Operational Risk Register

The Operational Risk Register captures clinical and non-clinical risks associated with the Trust's day-to-day service delivery across Clinical Management Groups and corporate directorates. These risks are managed locally and escalated where appropriate in line with the Trust's risk management framework.

Key themes arising from the operational risk register include:

- Workforce challenges relating to recruitment, retention, and skill mix;
- Managing patient activity, demand, and flow across urgent, elective, and cancer services;
- Ageing estates, backlog maintenance, and environmental factors;
- Equipment, IM&T infrastructure, and digital risks, including cybersecurity;
- Financial risks linked to capital investment, cost pressures, and long-term sustainability.

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 Activity 2025-26

The CQC undertook an unannounced comprehensive inspection of the Medicine and Surgery core services at Glenfield Hospital in June 2025. The Surgery draft report was shared with the Trust in February 2026 and Factual Accuracy was completed and returned to the CQC. The Outcome of the Factual Accuracy Submission is not currently known. At the same time the CQC notified the Trust that they were unable to send a draft report for the Medicine Inspection as it had failed their internal Quality Assurance processes and they would be returning to reinspect the service.

In November, the Trust submitted a self-assessment questionnaire and supporting documentation as part of a thematic review of IR(ME)R compliance PET/CT Pathways. IR(ME)R did not identify any improvement actions for the Trust.

As part of the CQC 's Winter Pressures programme, the Emergency Department had an unannounced Inspection on 17 and 18 February 2026. The CQC inspection team feedback included seeing caring, compassionate staff putting patients at the centre of all they did throughout the inspection and that they saw vibrant inclusive leadership and culture in all areas. The Inspectors noted the continuous improvement in the ED performance metrics, given the high demand form such a diverse local community. They saw innovation led by clinical expertise and robust safeguarding understanding and escalation processes in all areas. The post inspection data request has been returned, and the Trust awaits the draft report.

The CQC returned to reinspect the medicine core service at Glenfield Hospital on 2 and 3 March 2026. The inspection team fed back that they had seen and felt a compassionate, confident, caring and highly competent medical care service, they had seen many examples of great person centred, compassionate care, they saw an experienced local leadership team supporting all staff and patients inclusively, with excellent MDT working across specialities.

The CQC completed their winter pressures inspection on the 30 and 31 March 2026 when they inspected medicine at the LRI. The CQC informed the Trust this was an unrated Inspection as they were not inspecting all key questions. The focus of the inspection was on pathways for respiratory patients, frailty and care of the older person. Feedback post inspection noted staff were caring and compassionate, committed and compassionate leadership, holistic and person centred approaches to care of older people.

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).

During 2025/26 the Trust completed a peer led self-assessment against the CQC Single Assessment Framework "Well-Led" quality statements. Twenty-eight responses from Board and senior leaders indicate that the Trust remains broadly well-led, with the majority of domains assessed as green or amber, reflecting mature leadership arrangements and effective governance systems. The review found strong evidence that leaders are visible, approachable and values-led; governance and risk management arrangements are robust; partnership working with system and external stakeholders is a significant strength; and statutory governance requirements, including data submissions and compliance frameworks, remain strong.

The assessment also identified several cross-cutting areas requiring further strengthening. These include: improving the measurability and operational translation of the Trust strategy into clearer KPIs and deliverables for staff; strengthening succession planning, leadership development and talent management and embedding a more systematic Trust-wide quality improvement methodology. The least mature domains were learning/improvement/innovation and environmental sustainability, where good practice exists but is not yet consistently embedded or supported by sufficiently systematic infrastructure, resources or impact monitoring.

The Audit Committee received the report in full and as part of a Board Development session the Board endorsed the report and oversight of actions. Progress against these actions will be monitored through appropriate Trust governance during 2026/27 as part of the Trust's governance assurance framework.

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 2025 – 2028 and TCFD

UHL's Green Plan 2025–2028 is the Trust's current strategic sustainability framework. It covers a three-year delivery period and aligns with NHS England guidance, national Net Zero commitments, and local Integrated Care System priorities.

The Green Plan sets out a structured programme of actions across defined Areas of Focus, each with executive sponsorship, operational leadership, clear objectives, and measurable milestones. It addresses mitigation and adaptation, ensuring that carbon reduction, climate resilience, and public health protection are progressed in parallel.

The plan builds on earlier achievements and shifts the Trust from foundational delivery to embedded, system-wide sustainability integration. More detail on our work on sustainability and our Green Plan is set out in Section 1 of this annual report.

UHL prepares its climate-related financial disclosures in alignment with the Task Force on Climate-related Financial Disclosures (TCFD) framework and the Department of Health and Social Care Group Accounting Manual (GAM) requirements. This disclosure is presented on a comply-or-explain basis and reflects UHL's current level of maturity in

Phase 3 implementation. It explains how climate-related risks and opportunities are governed, identified, assessed, and managed, and how these issues are increasingly integrated into operational planning, capital prioritisation, and financial decision-making.

Where quantitative scenario modelling or detailed financial sensitivity analysis has not yet been completed, UHL explains the gap, the reason for non-disclosure, and the planned improvement actions for future reporting cycles, consistent with HM Treasury's comply-or-explain principle.

TCFD Alignment Summary (Comply or Explain)

Pillar	Status	Summary
Governance	Compliant	Climate risks are overseen through established Board and committee structures, with defined escalation routes, executive accountability, and regular reporting.
Strategy	Partially compliant	Climate risks and opportunities are identified and increasingly integrated into planning. Quantitative scenario modelling and detailed financial sensitivity analysis are not yet fully developed, and a forward plan is set out to strengthen these disclosures.
Risk Management	Compliant	Climate risks are embedded within the Trust's standard risk management framework, including formal escalation, assurance mechanisms, and integration with EPRR processes.
Metrics and Targets	Partially Compliant	Emissions are reported in line with NHS requirements and actively managed. Further development is underway to improve linkage between climate risk indicators and financial planning.

Further detail on the Trust's TCFD position is set out in part 1 of this Annual Report.

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. The Trust has established robust arrangements to ensure the economy, efficiency and effectiveness in the use of its resources, supported by strong financial governance, performance management and internal control frameworks.

During 2025/26, the Trust operated within a challenging financial and operational context, including sustained demand pressures, workforce constraints and system-wide financial challenges. In response, the Trust maintained a clear focus on financial discipline, value

for money and improving productivity, while ensuring the continued delivery of safe, high-quality patient care.

The Board receives regular and comprehensive oversight of financial and operational performance through the Integrated Performance Report (IPR), which provides a consolidated view of performance against plan. This is supported by detailed scrutiny through the Finance and Investment Committee and other Board sub-committees, ensuring appropriate challenge of financial plans, efficiency programmes and resource utilisation.

The Trust had a challenging Cost Improvement Programme (CIP) to deliver during 2025/26, all schemes were subject to quality impact assessment to ensure that patient safety and care standards were maintained. The Trust was not as successful as it would have liked and we did not fully achieve our financial plans, including the cost improvement programme, such that we failed to achieve our financial plan by £20m (an £85m deficit versus a planned deficit of £65m). However, our financial performance did improve when compared to 24/25, even though we fell short of the target we set ourselves at the start of the year.

A range of transformation and productivity initiatives have progressed during the year, aligned to Trust and system priorities across the Leicester, Leicestershire and Rutland (LLR) health and care system. These include initiatives to improve patient flow, reduce unwarranted variation, optimise workforce deployment and enhance digital capability. These programmes were designed to improve both efficiency and patient outcomes.

The Trust continues to operate effective financial control mechanisms, including robust budgetary control, forecasting and financial risk management processes. Financial risks are regularly reviewed through the Board Assurance Framework and supporting risk registers, with mitigation plans in place and monitored.

The Trust has continued to strengthen its approach to procurement and contract management, ensuring compliance with regulatory requirements and maximising value from expenditure.

Through its governance structures, the Trust ensures that investment decisions are aligned to strategic priorities and supported by robust business case development and benefits realisation processes.

Notwithstanding the progress made, the Trust recognises that financial sustainability remains a key challenge. Continued focus will be required on productivity improvement and delivery of recurrent efficiencies.

Based on the review undertaken, the Trust is satisfied that appropriate arrangements are in place to secure economy, efficiency and effectiveness in the use of resources during 2025/26, with identified areas for improvement reflected in forward plans and subject to ongoing Board oversight.

Since 2023, University Hospitals of Leicester NHS Trust (UHL) and University Hospitals of Northamptonshire NHS Group (UHN) have continued to work collaboratively through a loose group arrangement. This has included the appointment of a Group Chair and

Group Chief Executive, together with a number of key executive leadership roles operating across both organisations to support the delivery of shared strategic objectives and promote greater consistency and collaboration across the Group.

During 2025/26, the Group further developed and agreed a Group Clinical Strategy, providing a shared framework for the planning and delivery of clinical services across both UHL and UHN. The strategy supports the development of sustainable, high-quality services and strengthens opportunities for collaboration and service improvement.
Towards the end of 2025/26, the Boards of UHL and UHN began meeting jointly to explore opportunities for further integration through the establishment of a Board-in-Common arrangement. This work includes consideration of the alignment of Board committees, governance structures and decision-making processes, with the aim of strengthening collaborative leadership, supporting effective oversight and enabling the Group to realise the benefits of closer organisational integration while maintaining statutory accountability.

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 47 outcomes 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. The 2025/26 DPST outcome was “approaching standards” – an action plan is in place to meet any pending outcomes in 2026/27, and progress is tracked via NHSE and the Trust’s auditors.

We can confirm for the financial year 2025/26 we logged 1 concern with the Information Commissioner’s Office (ICO) that was deemed suitable for escalating. The ICO reported 2 notified breaches to us – changes were implemented where required and the ICO advised that they were satisfied with the Trust’s responses. 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 and 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 Assistant Director of Business Intelligence and Information) 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. Our Patient Administration System matches our local patient records against the National Spine (National Summary Care Record) which ensures accurate GP attribution. We have a Data Quality dashboard that is used to support administrative leads in the specialties to identify and 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. Clinical coding audits are conducted in line with Data Protection and Security Toolkit ensuring compliance with mandatory standards. For clinical coding the Trust has an increasing number of assurance processes in place to ensure that patient complexity is accurately captured. 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.

UHL's Our Future Hospitals and Transformation Committee receives quarterly reports on the Data Quality and Clinical Coding, reinforcing a commitment for continuous improvement and excellence in data management. Updates are also submitted to the Trust's Quality Committee on a quarterly basis, for information.

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 2025/26, 10 opinion-based audits were completed and the status of those audits at the end of the year was:

Audit	Opinion
Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) Independent Assessment	Risk Rating: Very High Confidence Rating: High
Patient Safety Incident Response Framework (PSIRF)	Reasonable Assurance
Health and Safety	Partial Assurance
Medical Appraisal and Doctor Revalidation processes	Reasonable Assurance
Clinical Safety Reviews	Partial Assurance
Cash Management	Substantial Assurance
Accounts Receivable	Reasonable Assurance
Accounts Payable	Partial Assurance
Cost Improvement Programme	Minimal Assurance
Board Assurance Framework	Substantial 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

The Trust appointed new internal auditors for 2025/26. The 2025/26 Head of Internal Audit Opinion states: a *"reasonable assurance"* opinion was provided concluding that *"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective*."

The opinion provided is fair and reflects that there is adequate and effective internal control. The actions identified through the completed audits will be implemented to strengthen our internal control. Oversight of this implementation will continue via the Audit Committee with escalation as appropriate to the Trust Board. The Trust recognises that the audits identified areas for improvement in processes relating to health and safety, clinical safety reviews, and CIP – actions to address those findings have been agreed and will be implemented as a priority.

For transparency and comparison, the table below shows the overall opinion over the last four years. The Trust moved to a different Internal Audit provider in 2025/26, and although the opinion terminology/definition is therefore different in 2025/26 to previous years, the opinion of "reasonable assurance" broadly equates to the "significant assurance" opinion in 2024/25. The progress in maintaining an improved Head of Internal Audit Opinion over the last four years shows positive progress and it is now important that as an organisation we continue to embed and sustain a robust system of internal control.

Opinion 2022/23	Opinion 2023/24	Opinion 2024/25	Opinion 2025/26
Limited	Moderate	Significant	Reasonable

Financial oversight

The Trust secured a clean unqualified audit opinion in 2025/26 building on the strong financial foundations of previous years.

The Trust submitted its 2025/26 accounts in accordance with the national timetable to ensure consolidation with the National NHS accounts.

In 2025/26, the key requirements for acute providers within health systems was to maintain the increase in urgent and elective capacity, 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 2025/26 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, such that the final outturn achieved was a £46.4m 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 £72.5m of savings in 2025/26 against an exceptionally challenging efficiency target of £92m (under delivering by £19m) 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), non-pay, commercial and workforce. Each of these work programmes directly enables our operational and corporate areas to deliver their targeted financial improvement.

The Trust has agreed an operational plan for 2026/27 in conjunction with its LLR System partners which continues to include a challenging CIP requirement of £99 million, in order to deliver a breakeven position, supported by non recurrent deficit funding of £57.4m. The CIP represents 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 (without support) by 2027/28. The Trust remains committed to achieving financial sustainability and financial recovery in the longer term, but this continues to remain a weakness until this state is resolved. Key to achieving sustainable finances is delivery of a challenging but achievable cost improvement programme (CIP).

In 2024/25 and 2025/26, the target set was £92m. The Trust fell short of achieving this target in both years, achieving total CIPs across both years of £142m being £83m recurrent and £59m non-recurrent (and therefore more heavily weighted to non-recurrent savings than initially planned). Looking forward, the Trust has set itself a further challenging CIP target of £99m for 2026/27, within our planned adjusted financial performance of breakeven. High level plans totalling £95m have been identified, although at the end of Quarter 1 only 50% have been signed off by the clinical management teams as being deliverable in year. Work continues to firm up the remaining element. Oversight of the programme is managed through an Executive led Results Delivery Office (RDO) with weekly meetings to monitor progress/interrogate delivery data/and agree key decisions. The Trust also undertakes monthly CFO/COO meetings with each CMG focusing on CIP and financial delivery. The Trust remains committed to ensuring that

delivery of the CIP programme is achieved in a manner that maintains patient safety, quality of care and access to services, with appropriate governance and assurance arrangements in place to support this.

Financial Governance

Work continued throughout 2025/26 to embed the financial improvements made to the financial control environment in the preceding years. This was reflected with a significant assurance opinion 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 RSM during 2025/26. External audit is undertaken by KPMG. The implementation of recommendations made by Internal and External Audit are systematically overseen by the Audit Committee.

Conclusion

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. This includes ensuring that arrangements are in place for effective governance, risk management and internal control.

In discharging this responsibility, I have been advised by the Board and its committees, including the Audit Committee, and have drawn upon a range of assurances including internal audit, external audit, regulatory assessments and management reports.

Based on the assurances provided, including the Head of Internal Audit opinion of *reasonable assurance*, I conclude that the Trust has in place a generally effective framework of governance, risk management and internal control. While some areas for improvement have been identified, these are being addressed through agreed action plans and are subject to ongoing oversight.

No significant control issues have been identified that would fundamentally undermine the achievement of the Trust's strategic objectives.

I am therefore satisfied that appropriate actions are being taken to continuously improve the effectiveness of the system of internal control across the organisation

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
22 June 2026

Staff Report:

Staff numbers (Headcount)

	2025-26	2024/25	2023/24
Summary	Headcount		
Medical and Dental	2633	2,577	2,417
Administration and Estates	5165	5,537	5,443
Healthcare Assistants and other support staff	3556	3,723	3,755
Registered Nursing and Midwifery	5935	5,903	5,428
Scientific, Therapeutic and Technical	2193	2,169	2,093
TOTAL	**19,482**	**19,909**	**19,136**

Staff composition (by gender)

Senior Manager gender split by pay band

					Totals	
	Headcount		WTE		Headcount	WTE
	Male	Female	Male	Female		
Band 8A	140	505	133.33	453.52	**645**	**586.85**
Band 8B	75	137	71.02	129.07	**212**	**200.09**
Band 8C	30	68	29.60	63.40	**98**	**93.00**
Band 8D	15	35	15.10	33.15	**50**	**48.25**
Band 9	13	23	12.58	22.71	**36**	**35.29**
Very Senior Manager (VSM) Pay Band	7	8	7.00	7.60	**15**	**14.60**
Senior Manager Totals	**280**	**776**	**268.63**	**709.46**	**1056**	**978.08**
Overall ESR Staff Total	**4,833**	**14,649**	**4,547**	**12,685**	**19,482**	**17,232**

Sickness absence data

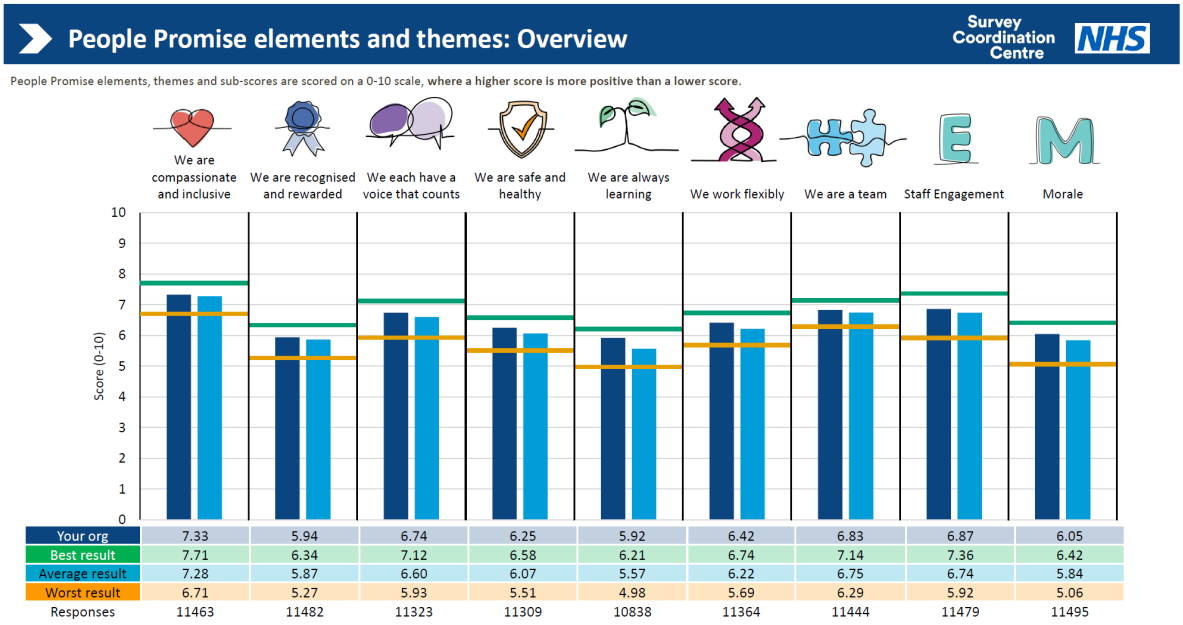
Clinical /Corporate	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Cumulative Position
358 Clinical CMGs	4.89 %	4.66 %	4.42 %	4.77 %	4.74 %	4.72 %	4.90 %	5.15 %	5.08 %	5.01 %	4.91 %	4.70 %	4.83%
358 Corporate	4.08 %	3.78 %	4.11 %	4.42 %	4.55 %	4.34 %	4.96 %	5.70 %	5.31 %	5.50 %	5.52 %	5.62 %	4.83%
UHL	4.75 %	4.51 %	4.36 %	4.71 %	4.71 %	4.66 %	4.91 %	5.24 %	5.12 %	5.09 %	5.04 %	4.85 %	4.83%
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 (7.60%)

	2025/26	2024/25	2023/24
Summary	WTE		
Medical and Dental	2,485	2,427	2,277
Administration and Estates	4,494	4,768	4,659
Healthcare Assistants and other support staff	3,041	3,172	3,220
Registered Nursing and Midwifery	5,292	5,256	4,799
Scientific, Therapeutic and Technical	1,948	1,922	1,846
TOTAL	**17,261**	**17,545**	**16,801**

Staff engagement – the NHS National Staff Survey

The Annual NHS Staff Survey was carried out between September and November 2025, using a full census approach in which all colleagues were invited to participate. The Trust continues to achieve a strong response rate, with 58.7% of colleagues (11,500 colleagues) providing feedback, remaining well above the national average for Acute and Acute & Community Trusts. The survey also generated a substantial volume of anonymous free text comments, providing rich qualitative insight into colleague experience across the organisation.



	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	Staff Engagement	Morale
Your org	7.33	5.94	6.74	6.25	5.92	6.42	6.83	6.87	6.05
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	11463	11482	11323	11309	10838	11364	11444	11479	11495

While UHL's scores across all 9 domains of the staff survey remain above benchmark average of similar NHS Trusts, our scores declined across each of these areas compared with last year. This reflects the significant pressures experienced locally and across the NHS.

Over 60% of colleagues responding to the survey said they would recommend UHL as a place to work, which is higher than the average for similar Trusts. Whilst the percentage of colleagues who would be satisfied with the quality of care has dipped slightly to 61%.

	Trust 2024	Trust 2025	Average result
q25c Would recommend the organisation as a place to work	65.50 %	60.30 %	57.80%
q25d. If a friend/relative needed treatment, they would be happy with the standard of care provided by the organisation	63.50 %	60.90 %	60.80%

We continue to score strongly for staff engagement and compassionate leadership. Our results place us as the best teaching hospital in the Midlands, and the second highest acute provider in the East Midlands region as a place to work. We are also best in the region for colleagues feeling safe and healthy.

Overall, the results demonstrate comparatively strong and stable national position in colleague experience.

One of our ten Trust deliverables underpinning the UHL priorities was to take action on feedback from the 2024 NHS Staff Survey and deliver year one of our People Strategy. During 2024/25, we implemented a coordinated Trust-wide response to staff survey feedback in relation to bullying, discrimination and harassment.

We placed particular emphasis on inclusion and respectful behaviours. We strengthened clear routes for speaking up, expanded guidance for colleagues and leaders, and progressed targeted work on sexual safety, reducing violence and aggression, and improving reporting. This work was aligned to national NHS expectations and our People Strategy priorities, and included Trust-wide campaigns, development resources, the introduction of an anti-racism statement, and focused action in areas identified through staff survey and other workforce data.

Progress and impact have been monitored through regular reporting to Trust Leadership Team and Trust Board. Our latest staff survey data indicates a reduction in colleagues experiencing discrimination from other colleagues, with UHL now scoring above the benchmark average. While there has been a slight increase in reported experiences of bullying and harassment, this mirrors the NHS average and UHL continues to score above the national average. Staff survey results also show improved willingness among colleagues to report experiences of bullying and harassment, enabling the Trust to better target interventions and tackle unacceptable behaviours. Despite these improvements, reducing instances of bullying, discrimination and harassment remain key priorities as we continue to build a stronger, more inclusive culture at UHL.

Implementing the People Strategy, including developments in Occupational Health

Our People Strategy, A great place to work, 2025-2030 is underpinned by our Trust's strategic framework, values and behaviours. Our people are our most valuable resource who play an important role in ensuring we deliver safe, effective, and high-quality care to the population we serve.

Our core aim is to be a great place to work and our People strategy describes three key themes:

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.

Amica

Amica is UHL's long-established, in-house counselling and psychological support service for colleagues. Embedded within the Trust, the team works across departments and Clinical Management Groups to support workforce wellbeing, psychological safety and healthy working environments.

For more than three decades, Amica has provided confidential psychological support to colleagues across University Hospitals of Leicester, working alongside leaders, teams and staff to sustain a healthy, compassionate and resilient workforce. The service remains accessible throughout the year, operating 24 hours

a day, 365 days a year.

A broad range of support is offered to individuals, teams and departments across the organisation. This includes psychological consultation for managers, reflective practice and supervision sessions, ward and departmental outreach clinics, workshops and wellbeing presentations, alongside access to individual support when colleagues require more focused psychological help. Staff can also access online resources and self-help materials through the Amica website.

In addition to supporting individuals, the team contributes to organisational health through facilitated conversations, mediation and team-based support where workplace pressures or interpersonal challenges arise. These interventions help maintain constructive working relationships and strengthen team functioning.

Feedback from staff and managers consistently highlights the value of having a responsive and confidential psychological support service embedded within the Trust, with satisfaction ratings remaining high at 4.8 out of 5. Outcome data and staff feedback consistently indicate meaningful reductions in distress, alongside improved wellbeing, helping colleagues remain present at work and contributing to a safe, effective and compassionate working environment.

During the year the service delivered 3,424 attended support appointments and provided 163 drop-in clinics across clinical areas, reflecting the continued demand for accessible psychological support within the organisation.

Amica activity summary 2025/26

Area of Support	Activity
Workforce support	695 sessions (supervision, coaching, reflective practice, mediation and Facilitated conversations)
Accessible frontline support *(included in above)*	163 drop-in clinics
Workshops, presentations and induction support *(included in above)*	55 sessions
Individual psychological support (counselling)	3,424 attended appointments

Occupational Health

Our Occupational Health service remains an integral part of our organisation and continues to play an important role in supporting our staff and their managers with all matters relating to health and work.

We protect the health of the workforce through vaccination against common infectious diseases, as well as those which may be specifically encountered in UHL

as a workplace.

The Occupational Health service again retained its independent accreditation as a Safe, Effective, Quality Occupational Health Service (SEQOHS) following annual review in November 2025, and remains a centre for training in Occupational Medicine, being one of only three units in the UK able to support three medical trainees.

A summary of OH activity includes:

- Over 3,500 employment checks have been undertaken for UHL staff. This has resulted in 'New Starter/EPP clearance/Pre employment screening' appointments (1,300) being provided by Occupational Health
- Approximately 3,150 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, 500 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

Health and Wellbeing

Trauma Risk Management (TRiM)

The TRiM Ambassador role was introduced to provide immediate peer support after incidents, guiding staff to the TRiM service and other support options. The International TRiM Network, led by UHL, grew significantly this year to 184 members across 96 organisations. TRiM supported over 350 colleagues following potentially traumatic events within the Trust.

Menopause Support

In October, the UHL Menopause Support Service was launched during World Menopause Week, offering confidential and culturally sensitive assistance to colleagues, aiming to reduce stigma and improve access to support. Additionally, "Men Only Menopause Awareness" sessions were introduced in August, led by and for men, to increase understanding and encourage open conversations about menopause.

Flu Programme

The 2025–26 Flu Programme achieved over a 10% increase in vaccination uptake compared to the previous year, with more than 100 additional Peer Vaccinators helping to protect staff, their families, and our patients.

Learning and Development Service Overview

In 2025/26, Learning and Development delivered accessible, timely training across teams, helping staff gain skills for personal and Trust goals, supporting workforce attraction, recruitment, and development.

Core Learning and Development Activities

Induction

In April 2024 the weekly face-to-face induction was relaunched alongside the first 90 days programme to help new colleagues settle in. In 2025/26, 97% of new starters attended the weekly inductions.

Supporting business needs

In 2025/26, Learning and Development directly supported patient care by delivering six key business courses: Appraisal, Assertiveness, Planning for Retirement, Mentoring, Job Hunt, and Being Interviewed. These courses were attended by 362 employees, equipping them with essential workplace skills.

Mandatory training

Mandatory Training is supported through a suite of e-learning programmes, which are aligned with the national Core Skills Training Framework (Skills for Health).

The eLearning Authoring Service has seen significant growth in 2025/26. Thirteen new programmes were developed in collaboration with subject matter experts, while an additional 128 programmes were updated and amended. Staff now have access to 70 eLFH programmes live on HELM, comprising a total of 334 modules.

Across all eLearning topics 2025/26 has seen over 230,762 modules being completed on HELM and HELM provides over 3000 managers and employees with access to live training data. HELM development continues with several key updates designed to enhance system effectiveness and support organisational objectives.

Monitoring mandatory training compliance is an ongoing priority. The Learning and Development function compiles monthly reports that track staff progress, with compliance standing at 94% as of 31 March 2026 – just short of the 95% target. To close this gap, Clinical Management Groups have developed robust action plans, ensuring performance is sustained and improved across all training programmes.

Core Functional Skills

Learning and Development offer the NHS-funded BKSB tool, enabling staff—especially apprentices—to assess and refresh their English, maths, and digital skills. The tool creates tailored learning pathways and includes indicators for dyslexia and dyscalculia, helping colleagues boost their confidence and competence for exams and workplace success.

ECCTIS helps UHL colleagues with international qualifications meet national standards, ensuring they can access apprenticeships and progress their careers.

Through Leicester College, staff gain Level 1 and 2 functional skills in English and maths, enhancing their career prospects and positively impacting their families and communities.

Data on functional skills outcomes now covers all staff, not just apprentices, informing workforce development and recognising achievements through regular celebration events.

IT Training Team

The Learning and Development IT Training Team supported the introduction of the new Patient Administration System, NerveCentre, at UHL and across the local community. New training sessions were introduced in Autumn 2025 for new administration staff and those changing roles, making sure everyone is well prepared and confident in their duties.

The team also supports other projects, like Ambient AI and patient self-checking kiosks, which aim to improve care and make processes easier for both staff and patients.

Apprenticeships for UHL Colleagues

Since the introduction of the apprenticeship levy in 2017, UHL staff have been able to access a wide variety of apprenticeship programmes delivered by both internal and external training providers. The apprenticeship levy is funded by the Government taking 0.5% of UHL's total pay budget each month, which is then ringfenced and can only be used to pay for apprenticeship course fees, not for salaries or other costs. Initially introduced as the Apprenticeship Levy, it has recently been renamed the Growth and Skills Levy, with further changes to the scheme expected in the near future to reflect evolving workforce and skills requirements in the NHS and beyond.

For the 2025/26 financial year, UHL's apprenticeship levy pot totalled £9,204,844, of which £3,838,545.45 was spent directly on apprenticeships for UHL colleagues. The scheme allows up to 50% of unused levy funds to be shared with other organisations, supporting workforce development across the local health and social care sector. This year, UHL supported 248 non-UHL employees from 56 different external employers, allocating £1,712,548 of surplus levy to their apprenticeship training. Any unspent levy funds that are not transferred to other organisations are automatically returned to the Government after 24 months. In 2025/26, this resulted in UHL returning £138,322.39 of unspent funds.

Since 2017, a total of 2,137 colleagues have started apprenticeship programmes at UHL, working with 61 different training providers and covering a vast range of occupational programmes from Level 2 (entry level) through to Level 7 (postgraduate equivalent). In 2025/26 alone, there were 226 new enrolments onto apprenticeship-funded programmes, with 617 colleagues actively undertaking apprenticeship learning during the year.

Around 22% of apprentices joining in 2025/26 were new to the Trust, helping to grow the local workforce, while the remaining 78% were existing staff upskilling or retraining to develop their skills, knowledge, and behaviours for current or future roles.

This year saw 149 UHL colleagues successfully complete their apprenticeships: 73 achieved a Pass grade, 4 received Merit, and 48 were awarded Distinction. This brings the total number of apprenticeship completions at UHL since 2017 to 952.

The majority of UHL apprenticeships are delivered by external providers (85%), with the remaining 15% learning through UHL's own Apprenticeship and Development Centre, which offers tailored programmes and dedicated support to staff.

The Trust continues to provide a comprehensive suite of support activities for apprentices, including masterclasses and awareness sessions on topics such as mentoring, personal safety, online safety, and employability skills. UHL also hosts information events, such as the annual National Apprenticeship Week, where 26 different sessions were offered in 2026. Managers are supported through twice-yearly Manager Forum meetings, online workshops, and seasonal newsletters, helping them better support apprentices in their teams.

Achievements are celebrated with new termly celebration events under the RISE initiative and all apprenticeship completers are recognised in the Trust's communication Roll of Honour, with positive case studies routinely promoted on social media and UHL Connect.

UHL Apprenticeship and Development Centre; Apprenticeships

The UHL Apprenticeship and Development Centre offers accredited learning opportunities to staff across UHL, LLR, and the wider NHS, using hybrid and blended approaches. By working closely with employers, the Centre helps develop the workforce needed to deliver patient care.

Facilitators and Practitioners support apprentices in gaining the skills, knowledge, and behaviours required for their standards and qualifications, preparing them for end point assessment and beyond.

The Centre currently delivers six apprenticeship programmes, including Business Administration, Team Leader, Customer Services, Health at Levels 2 and 3, and Student Nursing Associate Level 5. In 2025/26, the Learning and Development team generated income of £1,000,210.50, with £91,941.64 earned directly from apprenticeship delivery.

Since becoming a main provider in 2017, the Centre continues to meet Department for Education and Ofsted standards, with a full Ofsted inspection in February 2026. The Centre achieved a Qualification Achievement Rate of 69.2% in 2024/25, above the national average of 60.5%.

Programmes adapt to employer and learner needs, with curriculum updates and a new employer engagement event piloted in 2025. The Team Leader Level 3 curriculum was fully revised this year, and end point assessment providers changed for some programmes.

Pastoral support for learners has increased, including tools like Cognassist and Support Connect, as well as access to counselling without referral through Amica. Wellbeing and safeguarding checks are now available for all apprentices. The Centre focuses on supporting the whole learner through enrichment activities.

Governance is robust, with involvement from NHS partners and subject experts. Learner and manager feedback is regularly collected and fed into programme boards and governor meetings.

Monthly Learner Blog newsletters cover relevant topics and celebrate achievements. In 2024/25, 83 learners completed programmes, with high pass

rates for Health apprenticeships.

The Centre also delivers nationally accredited screening qualifications and remains a key provider for programmes such as Newborn Hearing and Diabetic Eye Screening. Proposals for increased funding may ease financial pressures in 2026/27. UHL continues as one of the few national providers for the Screener Diploma, with a new qualification launching in April 2026.

Workforce Development

Work Experience

Work experience placements continued in 2025/26 and the work experience system has been maintained and continues to be refreshed with new placement opportunities, career journeys and information.

Careers Development

In 2025/26, the Learner Celebration and Careers Café honoured 49 learners from a range of programs. The event inspired colleagues to think about career growth within their roles and included stalls focused on employability, functional skills, apprenticeships, and the Directions Service.

The Learning and Development team continues to organise and support events for National Apprenticeship Week, National Careers Week, Learning at Work Week, and Festival of Learning. These activities feature career cafés, bite-sized learning sessions, recommended reading, and information on functional skills.

Throughout 2025/26, 33 events were attended in partnership with UHL Health and Social Care Ambassadors. These included traditional stalls, speed networking, interview practice, and class talks.

Health and Social Care Career Ambassadors/School Networking

The Learning and Development team has expanded its central list to include 78 LLR Ambassadors, reflecting growth from the 2024/25 period. Throughout the 2025/26 academic year, engagement was sustained with senior schools in Leicester, Career Advisors, and Health and Social Care Career Ambassadors. Communications are now distributed to all schools within LLR, and twilight talks have been facilitated in partnership with LEBC, utilising their STEM ambassador network.

Termly newsletters are disseminated to Schools, Career Advisors, and Health and Social Care Career Ambassadors, with the objective of increasing awareness regarding UHL’s initiatives and available resources. Both spring and autumn twilight talks are organised for these stakeholders.

Learning and Development maintains a comprehensive contacts database of LLR schools and colleges and regularly collaborates on termly events, activities such as General Hospital tree planting, and promotes opportunities including the NHS Step into NHS competition, which LLR schools have successfully won for three consecutive years.

In October 2025, the Centre achieved reaccreditation of the MATRIX Standard for

providing impartial and confidential Information, Advice, and Guidance (IAG) on career development to staff across UHL. This service is accessible to both colleagues and individuals considering careers in health and social care.

The Learning and Development team is acknowledged for its ongoing growth and enhancement of services, as well as continuous improvement of processes and quality assurance.

Workforce Development Events

Unbox Your Future ran for a second year with LLBSP as sponsor, organised by Learning and Development for one SEND class at a senior school over four weeks. Students participated in three school visits and a UHL tour, attended career talks, and competed in a nutrition project judged by UHL colleagues.

The School Career Lead praised the students' pride and confidence, noting their unexpected achievements and positive energy, while the school valued the outstanding support from Learning and Development. Student comments highlighted newfound confidence, enjoyment of group tasks, interest in various NHS roles, and personal skill development.

Chef Academy

Chef Academy is now in its third year and has visited 9 senior schools in Leicester, offering cook-along sessions or cooking demonstrations. So far, 194 pupils have participated in this initiative. Each visit includes a discussion about catering careers and NHS roles, supported by the Learning and Development Team, and recipes with slides are sent to schools post-event to encourage continued cooking and healthy living.

To support these efforts, 150 work experience placements are available across barrister, front of house, and back of house roles at three sites. Chef Academy also took part in the 2025 Hospital Caterers Association NHS Chef Showcase and the International Salon Culinaire chef competition, earning finalist honours and being nominated for future awards.

Finance Careers

This programme is now in its second year and offers an opportunity to explore careers in NHS finance and procurement, while also helping young people gain insight into NHS service costs and appreciate the value of numeracy skills.

The scheme operates through a partnership led by Finance and Learning & Development. The session is structured to fit within the school curriculum—typically lasting 45 minutes—and includes a presentation for maths or business studies students about the breadth of NHS Finance career opportunities, followed by a brief activity. This activity involves examining the costs associated with overnight stays, medical interventions, and complications (calculating the total for a patient care episode), as well as budgeting, forecasting, and decision-making when plans change unexpectedly.

Employability Programmes

Kickstart

Kickstarters undertake a real work placement for 25 hours+ per week. 75% of cohort one achieved employment ranging from apprenticeships to Band 3 posts. Two of the 30 employees from cohort one went to university (1 x occupational therapy and 1 x management degree) both now work in the NHS.

Six employees were 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.

It would be beneficial for UHL to take advantage of this programme to support local jobs for local people and Leicester unemployment levels however it is understandable that with the recruitment constraints and systems that this is not easy to work around for the Trust.

Kings Trust Employability Programme

In October 2025, we hosted the Kings Trust 'Get Into' Programme, offering young people hands-on healthcare experience, skill development, and career support. UHL is committed to preparing future staff; these programmes help participants move into roles at UHL or other health providers.

Of the nine participants, one secured a position at UHL, two found jobs in broader healthcare, two obtained roles outside the NHS, and others received support with applications and interview preparation.

The next programme will run in Autumn 2026.

Universal Families Programme

For the second year, UHL has supported the Care Leavers programme through Learning and Development, working alongside public and private sector partners across LLR. The goal is to help some of the 554 care leavers in LLR move into NHS Band 2 roles, with an apprenticeship scheme that allows them to access a care leaver bursary.

Participants were placed in a range of settings across UHL, where they gained structured experience in both clinical and non-clinical settings. These placements helped young people build confidence, employability skills, and a better understanding of career options, especially within the NHS.

During the 2025/26 programme, one student with care experience advanced into a Band 2 apprenticeship.

Looking ahead, UHL plans to expand its initiatives even more in 2026/27 by strengthening partnerships throughout LLR. This will include close work with new organisations such as Warning Zone, which will host employability workshops this year. Learning and Development will also collaborate with a broader network of local partners, like the virtual school. Through these relationships, UHL aims to provide a wider variety of placements, giving more care-experienced young people

access to valuable opportunities, skill development, and long-term NHS career pathways. It is crucial that these networks are maintained so that post-programme employment opportunities exist, especially if recruitment constraints at UHL limit available positions.

Project Search Employability Programme

The third University Hospitals of Leicester (UHL) cohort concluded in July 2025. Two interns from Ellesmere College are gaining valuable experience in the community—one at a care home and another at a LOROS shop—which is enhancing their skills and demonstrating the strong partnership between Project Search and the College. Within this cohort, one intern from Ellesmere College and four interns from Gateway College successfully secured employment.

In the fourth UHL cohort, which commenced in September 2025, eight participants joined the programme from Ellesmere College and ten from Gateway College.

Learning and Development continues to promote the Project Search Programme both internally and externally. Notably, ITV News covered the programme's achievements, underscoring the exemplary collaboration among Project Search, participating colleges, and UHL.

Gateway College's Continuous Improvement Review recognised the outstanding support and collaborative practices within the programme, describing it as one of the best provisions reviewed, with only minimal recommendations for improvement.

T-Levels Employability Programme

In 2025/26, a total of 82 T-Level learners participated in five year-one taster sessions. These half-day events featured presentations and tours focused on NHS careers, complemented by various engaging activities.

UHL provides high-quality year-two T-Level industry placements across multiple pathways, including Adult Nursing, Maternity, Digital, and Business Administration & Finance. These placements offer learners valuable, practical experience within both clinical and non-clinical environments, facilitating the development of technical competencies, professional conduct, and confidence while enhancing their understanding of NHS career opportunities. Learners benefit from comprehensive inductions, rigorous compliance checks, and sustained support to ensure a safe, nurturing, and enriching setting that prepares them for future employment and advancement within the Trust.

During 2025/26, UHL offered 30 clinical industry placements for T-Level Health learners, organized by the Nursing Development team. Of these, 23 year-two learners successfully secured placements and are currently gaining work experience across the Trust's three hospitals. The corporate components of these programmes are supported by the Learning and Development team, which oversees UHL induction processes, contract administration, and core training.

Following completion of college-level T-Levels, UHL has recruited three former learners onto the Student Nursing Associate (SNA) apprenticeship programme, representing an exemplary model of workforce development and progression.

The Nursing Development team continues to collaborate with Learning and Development to recruit the next cohort of T-Level learners for the 2026 intake. This group will be larger and placements will span a broader range of specialities. UHL aims to reserve Health Care Assistant (HCA) and SNA positions for T-Level

graduates who have completed industry placements, supporting the Trust's commitment to internal workforce growth.

Valuing Our Colleagues – Reward and Recognition

Alongside celebrating apprenticeships and graduations, we held our third UHL Recognition Awards, receiving over 750 nominations spread across 15 categories. As in previous years, an external judging panel comprising sponsors and local dignitaries evaluated the nominees. In October 2025, we hosted our third in-person awards since 2019, with approximately 500 colleagues attending.

Since its launch in November 2016, the 'Above and Beyond' informal recognition scheme has continued to thrive, accumulating more than 72,000 nominations overall, including over 9,752 nominations since April 2025. This initiative allows employees to acknowledge peers who go 'above and beyond,' awarding them a special pin badge and card as thanks.

During 2025/26, Learning and Development invited 2,054 colleagues to afternoon tea events, organised and hosted these gatherings in partnership with other teams, distributed vouchers and long service packs to 688 colleagues, and presented 2,859 staff members with long service badges and certificates.

Staff policies

Employee Relations People Policies & "Being Fair" Approach

The Trust has continued to implement an improved approach to Employee Relations case work management, data and reporting, processes and documentation.

The Trust's Disciplinary Policy is currently being reviewed in partnership with our Staff Side colleagues.

You Matter Colleague Support Policy

The "You Matter Colleague Support Policy," created with Staff Side colleagues, combines special leave, family-friendly, and work-life balance policies into a straightforward document that simplifies access to relevant information.

The policy continues to reflect our ongoing commitment to support our colleagues.

Armed Forces Veteran Aware Accreditation

Over the past year, University Hospitals of Leicester NHS Trust has continued to strengthen its commitment to the Armed Forces community through sustained activity focused on both workforce and patient experience. The Armed Forces Staff Network has remained central to this work, providing a trusted forum for colleagues who are veterans, reservists or family members, and influencing Trust-wide policy, communications and leadership engagement. Practical support for colleagues has been reinforced through clear reference to UHL's You Matter Colleague Support Policy, alongside timely Trust-wide messaging during periods of international uncertainty.

In parallel, UHL has continued to embed veteran-aware care into everyday practice. This has included ongoing work linked to Veteran Aware accreditation, learning from patient feedback, and providing support where veteran status is identified. We are very

fortunate to have dedicated colleagues working closely with colleagues across the trust to ensure that Regular, Reserves and Veterans are afforded support and assistance if they are patients with us. Ranging from ward visits, liaising with local councils around required equipment, to contacting Regimental Associations and arranging for them to come and see the patients. This both supports the wellbeing of the patients as well as identify and resolve any issues that may be affecting the patients home life and delaying patients from living independently.

A joint Armed Forces forum between UHL and Leicestershire Partnership NHS Trust has been established, and commemoration and engagement events, including Remembrance Day and inclusion events, are increasingly being delivered in partnership with system colleagues. Engagement with regional and national forums has ensured alignment with emerging best practice, reflecting a shift away from one-off initiatives towards a more embedded and sustainable approach. Building on this momentum, work has begun with University Hospitals of Northamptonshire NHS Group to deliver Armed Forces Community awareness training across the Trust, starting with senior leaders in spring 2026.

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. Our dedicated Freedom to Speak up Guardians (FTSUGs) offer a free service for all staff, regardless of grade, who have any concerns about work.

The Freedom to Speak up Guardian's (FTSUG) 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. 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 most recently 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.

FTSU data trends (concerns raised with the FTSU Guardians)

2017/ 2028	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	2023/ 2024	2024/ 2025	2025/ 2026
77	93	88	160	170	171	225	405	412

There has been a continuing steady increase of concerns being reported from 2024/2025 to 2025/2026. This could be attributed to the independent 24/7 service, returning staff members, sharing Guardian contact numbers with colleagues, continued Guardian support through to end of case, regular updates provided to staff members, increased briefings and presentations, marketing and communications, engagements and presence with staff of all levels and targeted areas of need across the Trust whilst working with the Executive and CMG leadership teams.

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 is 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".*

Segmentation

The Trust is 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: Safeguarding - University Hospitals of Leicester NHS Trust

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

The Trust launched its Equality, Diversity and Inclusion (EDI) Strategy and Plan in November 2025.

The strategy sets out a clear anti-racism and anti-discrimination commitment, reinforcing our determination to create an environment free from discrimination, harassment and bullying. We know that when equality, diversity and inclusion are embedded into everyday practice, we benefit from a workforce that reflects the communities we serve; one that is fulfilled, ambitious, and able to deliver exceptional patient care.

Insights from our staff survey and wider workforce data show that not all colleagues are experiencing the supportive and positive environment we aspire to provide and we will continue to focus on this area of work.

We want to support the development and career opportunities of all of our colleagues.

Over the next five years, we will drive forward initiatives that improve everyone's experience at UHL. Our strategy is built around five pillars; locally led action, data-driven insight, accessible by design, an inclusive culture, and leadership supported by a representative workforce, which together embeds inclusion throughout the organisation.

Our Year One Priorities

- strengthen representation - reduce disparities through targeted actions, promote fairness in recruitment and progression, widen access to development opportunities, and enhance succession planning and talent pipelines.
- create an inclusive, safe and fair workplace culture - reduce experiences of bullying, harassment and discrimination, address disproportionate experiences within our processes, and provide training that strengthens understanding, amplifies staff voices, and tackles disadvantage.
- build stronger inclusive leadership & accountability - embed inclusion objectives into Board, Executive and leadership appraisals, increase visibility of EDI data through dashboards, and enhance local ownership through divisional leads and targeted action plans.

We will continue to measure progress using insights from our Staff Survey, Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), Workforce Gender Equality Standard (WGES) and the Gender Pay Gap

(GPG).

We remain committed to meeting our statutory and legal obligations and improving the experience

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, diversity and inclusion - University Hospitals of Leicester NHS Trust

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 2025/26 can be found on pg 82.

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 2025/26 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 2025/26.

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.

VSM Framework

There were two interim payments made during a period of transition which overlapped with the introduction of the national VSM (Very Senior Managers) framework guidance. Although national approval was not therefore sought, UHL’s Remuneration Committee approved these payments which ensured business continuity and adherence to the requirements of equal pay. For both appointments, the pay approved was a base salary of £175,000 and a £32,762 management allowance.

Salary and pension entitlements of senior managers – salary 2025/26 (subject to audit)

Name	2025-26						2024-25					
	Salary	Expense Payments (Taxable if applicable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total	Salary	Expense Payments (Taxable if applicable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total
	Bands of £5,000	To the nearest £100	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £5,000	To the nearest £100	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000
Executive Directors												
A Furlong, Medical Director [Until 1st March 2026]	240-245	-	-	-	27.5-30	**270-275**	255-260	-	-	-	80-82.5	**335-340**
Gang Xu, Medical Director [From 9th December 2025]	65-70	-	-	-	12.5-15	**80-85**	0-0	-	-	-	0-0	**0-0**
R Cassidy, Director of Corporate and Legal Affairs	145-150	-	-	-	42.5-45	**190-195**	140-145	-	-	-	50-52.5	**190-195**
J Melbourne, Chief Operating Officer / Deputy Chief Executive [Until 26th October 2025]	120-125	-	-	-	37.5-40	**160-165**	205-210	-	-	-	77.5-80	**285-290**
H Hendley, Chief Operating Officer [From 1st September 2025]	105-110	-			110-112.5	**215-220**	0-0	-	-	-	0-0	**0-0**
R Mitchell, Chief Executive *	155-160	7,700	-	-	105-107.5	**270-275**	155-160	5,800	-	-	100-102.5	**260-265**
L Abeyratne, Director for Health Equality and Inclusion	85-90	-	-	-	0-0	**85-90**	80-85	100	-	-	27.5-30	**110-115**
C Teeney, Chief People Officer	195-200	-	-	-	55-57.5	**255-260**	190-195	1,200	-	-	197.5-200	**390-395**
J Hogg, Chief Nurse / Deputy Chief Executive *	110-115	-	-	-	0-0	**110-115**	130-135	-	-	-	0-0	**130-135**
M Smith, Director of Communications and Engagement [Until 15th September 2025]	65-70	-	-	-	15-17.5	**80-85**	140-145	-	-	-	35-37.5	**175-180**
E Casteleijn, Director of Communications and Engagement [From 1st September 2025]	85-90	-			65-67.5	**150-155**	0-0	-	-	-	0-0	**0-0**
S Barton, Deputy Chief Executive	205-210	-	-	-	15-17.5	**220-225**	200-205	-	-	-	137.5-140	**340-345**
W Monaghan, Group Chief Digital Officer*	90-95	1,200	-	-	0-0	**90-95**	55-60	-	-	-	385-387.5	**440-445**
L Bond, Chief Financial Officer	230-235	800	-	-	7.5-10	**240-245**	125-130	-	-	-	95-97.5	**220-225**
Non-Executive Directors												
A Moore, Trust Chairman*	40-45	1,200			0-0	**40-45**	30-35	-	-	-	0-0	**30-35**
J Houghton, Non-executive Director *	10-15	600			0-0	**10-15**	0-5	-	-	-	0-0	**0-5**
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**
I Browne, Non-executive Director	10-15	-			0-0	**10-15**	10-15	-	-	-	0-0	**10-15**
D Moon, Non-executive Director	15-20	-			0-0	**15-20**	15-20	-	-	-	0-0	**15-20**
M Farmer, Associate Non-executive Director [Until 31st December 2025]	5-10	-			0-0	**5-10**	10-15	-	-	-	0-0	**10-15**
A Inchley, Non-executive Director	10-15	-			0-0	**10-15**	0-0	-	-	-	0-0	**0-0**
S Adams, Non-executive Director [From 1st May 2025]	10-15	-			0-0	**10-15**	0-0	-	-	-	0-0	**0-0**
S Kaur, Associate Non-executive Director	10-15	100.00			0-0	**10-15**	0-0	-	-	-	0-0	**0-0**

Salary figures disclosed above represent pay grossed up by the taxable benefits for salary sacrifice schemes (including car and parking schemes). The taxable benefits have not been disclosed separately. These are deemed immaterial. The prior year comparatives have been restated to include the impact of salary sacrifice arrangements in place to be consistent with the current year.

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.

J Hogg was also the Chief Nurse/Interim Chief Nurse for the University Hospitals of Northampton (UHN) and continued her role within UHL and was paid via UHL and recharged 25% Northampton Trust and 25% Kettering Trust.

A Moore was a Non-Executive Director until 30th June 2024, and from 1st July 2024 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.

J Houghton also held a position as a Board member for the University Hospitals Northampton (UHN) during the year. The recharge value for UHL is £15k per annum.

W Monaghan was also the Group Chief Digital Officer for the University Hospitals of Northampton (UHN) and continued their role within UHL and was paid via UHL and recharged 25% Northampton Trust and 25% Kettering Trust.

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 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2026 £'000
A Furlong, Medical Director	2.5-5	0-0	80-85	215-220	1,992	-	-
Gang Xu, Medical Director	0-2.5	0-2.5	35-40	80-85	599	9	691
R Cassidy, Director of Corporate and Legal Affairs	2.5-5	0-0	25-30	0-0	358	25	408
J Melbourne, Chief Operating Officer	0-2.5	0-2.5	45-50	105-110	754	30	835
R Mitchell, Chief Executive	5-7.5	2.5-5	80-85	180-185	1,379	79	1,522
L Abeyratne, Director for Health Equality and Inclusion	0-2.5	0-0	30-35	0-0	404	1	423
C Teeney, Director of People and Organisations	2.5-5	0-0	95-100	0-0	1,509	63	1,620
M Smith, Director of Communications and Engagement	0-2.5	0-0	15-20	0-0	174	8	210
S Barton, Deputy Chief Executive	0-2.5	0-0	60-65	140-145	1,252	17	1,313
W Monaghan, Group Chief Digital Officer	0-0	0-0	45-50	0-0	696	-	617
L Bond, Chief Financial Officer	0-2.5	0-0	85-90	220-225	1,953	20	2,032
H Hendley, Chief Operating Officer	5-7.5	12.5-15	65-70	165-170	1,239	118	1,495
E Casteleijn, Director of Communications and Engagement	2.5-5	0-0	30-35	0-0	356	48	471

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

	Total 2025/26 No.	Permanent 2025/26 No.	Other 2024/25 No.	Total 2024/25 No.
Medical and dental	2,479	2,321	158	**2,392**
Ambulance Staff	13	13	0	**14**
Administration and estates	3,168	3,067	101	**3,178**
Healthcare assistants and other support staff	3,401	3,332	69	**3,293**
Nursing, midwifery and health visiting staff	5,542	5,410	132	**5,532**
Nursing, midwifery and health visiting learners	3	3	0	**36**
Scientific, therapeutic and technical staff	1,842	1,819	23	**1,853**
Healthcare science staff	984	979	5	**975**
Total average numbers	17,432	16,943	488	**17,273**
Of which:				
Number of employees (WTE) engaged on capital projects	106	53	53	**124**

Exit Packages (subject to audit)

There was 0 compulsory redundancy, and 113 other exit packages agreed in 2025/2026.

	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			41	274	41	274		
£10,000 - £25,000			48	811	48	811		
£25,001 - £50,000			15	505	15	505		
£50,001 - £100,000			9	589	9	589		
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Total	0	0	113	2,179	113	2,179	0	0

Expenditure on consultancy (subject to audit)

We spent £6.5m on consultancy services in 2025/26 (£4.6m in 2024/26).

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 2025/26 was £240,000-£245,000 (2024/25, £255,000 - £260,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

In 2025/26, 41 employees received remuneration in excess of the highest-paid director (26 employees in 2024/25). Remuneration across the Trust ranged from £14k to £431k (2024/25 £12k-£384k).

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 2024/25 and 2025/26 there has been no significant movement in the ratio of the highest paid Director's pay to that of the workforce.

2025/26	**25th Percentile pay**	**Median pay**	**75th Percentile Pay**
Total remuneration (£)	32,500	42,500	52,500
Salary component of total remuneration (£)	32,500	37,500	47,500
Pay ratio information	7.5	5.7	4.6
2024/25			
Total remuneration (£)	28,697	37,842	50,844
Salary component of total remuneration (£)	25,674	36,483	44,962
Pay ratio information	9.0	6.8	5.1

		Percentage change in remuneration	
		Highest paid Director	**All Other Employees**
2025/26	Salary and allowances	-5.17%	1.09%
	Total pay	-5.17%	1.09%
2024/25	Salary and allowances	4.46%	4.58%
	Total pay	4.46%	4.58%

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 2025/26 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 2026, for more than £245 per day.
- All new off-payroll engaged during 2025/26, for more than £245 per day.
- Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026.

The Trust had 40 relevant off-payroll engagements as of 31 March 2026, 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 2026, for more than £245 per day.

	Number
Number of existing engagements as of 31 March 2026	
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	40
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
over 4 years at the time of reporting	0

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

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	
Of which...	
No. not subject to off-payroll legislation	40
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 2025 and 31 March 2026.

	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

22 June 2026

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 in 2024/2025 in respect of outstanding legal claims.

Losses and special payments
Refer Note 33 in the Financial Statements

Gifts
The Trust has published an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the

guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

Our Finance Report:

Overview of the 2025/26 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, 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 delivered efficiencies 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 2025/2026 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 the plan was submitted, which materialised within the financial position, such that the final outturn was a deficit against plan of £46.4m. 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 £72.5m against its target of £92m, compared with £69.4m in 2024/2025.

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 achieve its other statutory financial duties, including keeping capital spending and cash within the limits set by DHSC, as set out in the table below.

The key headlines of 2025/2026 from a financial point of view were:

- a revenue deficit of £46.4m, after technical adjustments, following deficits of £37.2m in 2024/25 and £52.8m in 2023/24.
- Capital investment of £97.4m (following £104.5m in 24/25, £122.0m in 2023/24, £96.5m in 2022/23 and £75.3m in 2021/22).
- Delivery of a Cost Improvement of £72.5m(following £69m in 2024/25, £64.2m in 2023/24, £35m in 2022/23 and £17.1m in 2021/22).
- Year on Year cash balances at £34.6m (£40.7m at 31 March 2025).

- Maintained high achievement against the Better Payments Practice Code for paying suppliers promptly of 93% (93% in 2024/25), despite a challenging cash position.

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

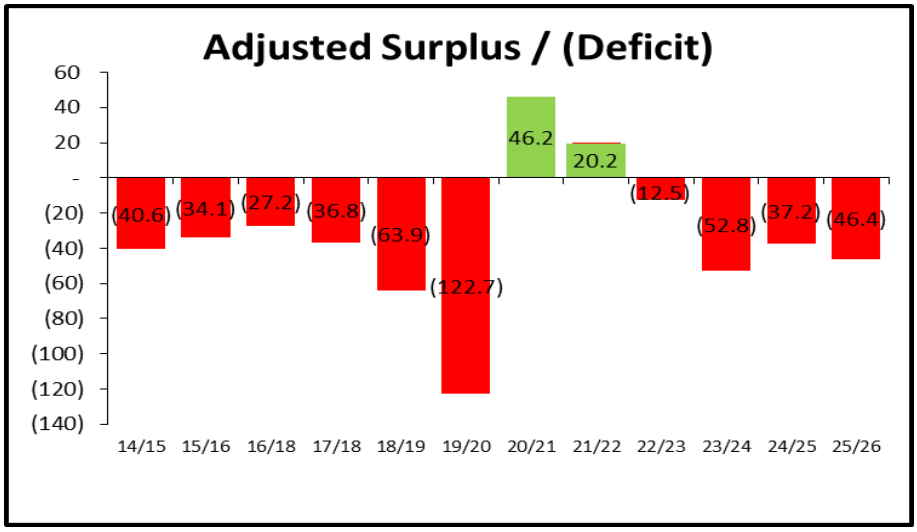
	Group	
Adjusted financial performance (control total basis):	**2025/26 £000**	**2024/25 £000**
Surplus / (deficit) for the period	(146,520)	(77,773)
Remove impact of consolidating NHS charitable fund	452	1,874
Remove net impairments not scoring to the Departmental expenditure limit	102,347	45,175
Remove I&E impact of capital grants and donations	(2,666)	(6,514)
	(46,387)	(37,238)

Following the completion of an intensive amount of work in a concentrated period of time, the Trust once again secured a clean unqualified audit opinion for the third consecutive year in 2025/2026.

The Trust submitted its 2025/26 accounts in accordance with the national timetable to ensure consolidation with the National NHS accounts.

The net impairment of £102m has resulted from the approach the Trust has taken to its annual property valuation in 25/26, where the Trust has transitioned to a valuation based on consolidated hypothetical single site at Leicester General Hospital site, compared with previous years when the valuation has been based on its operation across its current three separate main hospital site and retained the existing configuration of buildings and floor areas with existing site location. The detailed modern equivalent value (MEA) revaluation ensures asset values reflect the true cost of replacing service potential. To this end, revised MEA model presents a more optimised estate that better reflects modern clinical service delivery and the Trust's consolidated operational model. As a consequence, the Trust gross internal area reduces by 62,724 sqm (20%) compared with the current footprint (318,560 sqm).

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 £54m (3%) The table below illustrates the income received in 2025/26 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	2025/26 Actual £000s
NHS England	258,067	288,791	305,886	350,224	380,632	395,912	472,791	503,843	274,384	267,069
Integrated Commissioning Board	513,658	522,902	542,245	539,952	685,583	765,772	848,594	924,425	1,334,281	1,395,755
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	3,370
Other income from Patient Care	5,993	5,766	2,894	34,491	1,515	2,131	2,702	4,628	4,711	4,877
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**	**1,671,071**
Other operating income	143,687	127,958	129,845	144,616	212,142	68,632	69,527	52,026	49,411	45,915
Education training, and Research						84,956	93,548	97,661	120,070	128,528
Other Operating Income	**143,687**	**127,958**	**129,845**	**144,616**	**212,142**	**153,588**	**163,075**	**149,687**	**169,481**	**174,443**
Total Income	**924,269**	**948,289**	**994,316**	**1,090,575**	**1,281,513**	**1,320,143**	**1,490,515**	**1,586,730**	**1,786,323**	**1,845,514**

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 £5m, largely as a consequence of an increase in education and research funding (£5.4m).

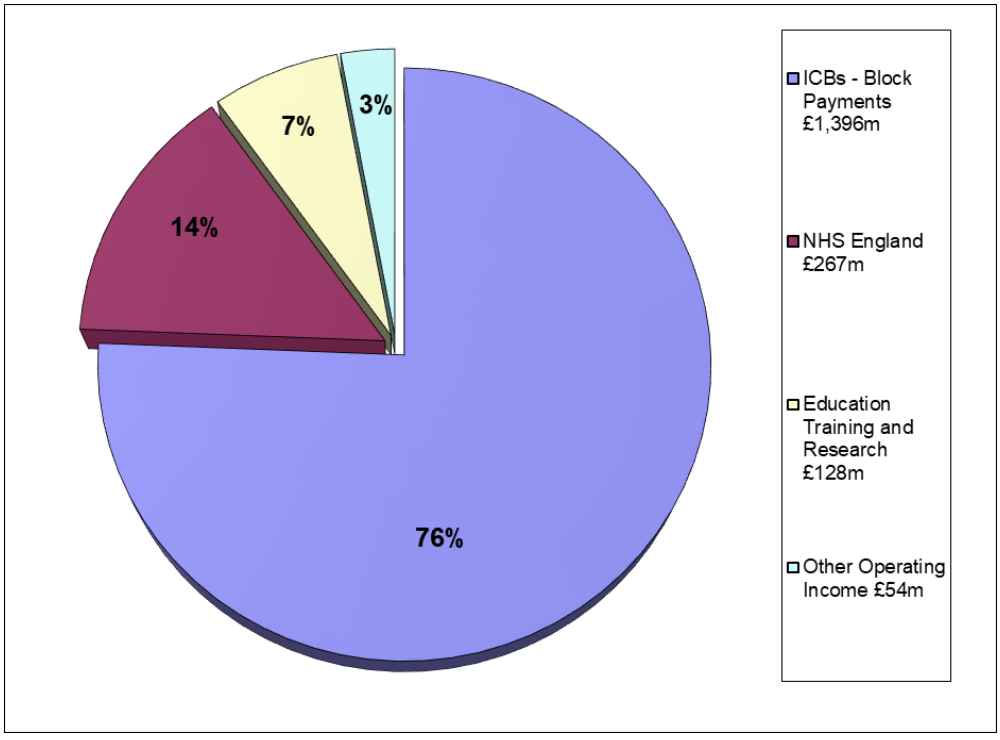
Employment costs accounted for 60% of our total operating costs (61% in 24/25), increasing by £59.4m during the year. This reflected an overall increase in the workforce (average WTE worked) of 159(1%) to 17,432 (permanent and temporary) during 25/26, as the Trust recruited substantively to vacancies. The Trust also has had to account for an additional £2.7m of DHSC funded pension costs in 25/26 compared with 24/25.

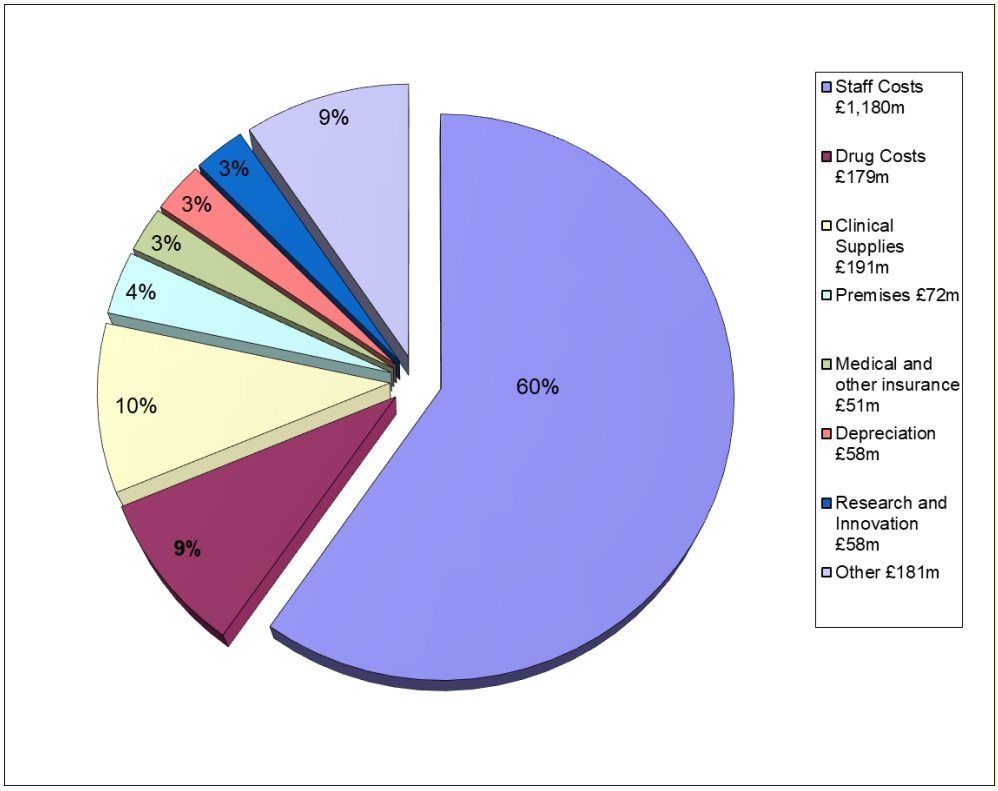
There was a sharp increase in impairments costs which increased by £57m year on year, largely driven by the impairment of MEA revaluation methodology applied to Trust's full property valuation.

	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	2025/26 Actual £000s
Staffing	575,895	597,876	629,537	698,996	745,371	777,761	897,482	1,006,581	1,120,219	1,179,657
Drugs	102,168	105,789	102,124	107,139	124,239	127,949	144,487	152,807	169,323	178,609
Clinical Supplies and Services	103,653	109,211	117,635	124,593	128,314	142,808	167,500	166,509	184,758	191,289
Depreciation and Amortisation	26,407	27,663	32,176	34,991	37,030	39,499	51,730	54,581	57,884	57,998
Clinical Negligence	23,724	27,398	30,664	31,927	34,744	38,204	38,824	48,002	49,610	51,460
Premises	33,308	33,753	43,469	54,976	48,019	52,572	58,928	64,507	66,306	71,618
Research and Development	22,932	34,376	35,763	36,124	35,254	38,680	42,610	48,002	54,762	58,127
Impairemnts	24,826	2,735	1,509	3,480	- 80	- 3,042	12,958	12,225	45,308	102,347
Other Operating costs	53,390	46,800	59,753	104,386	59,100	65,140	90,262	79,069	92,805	84,837
Total Expenditure	**966,303**	**985,601**	**1,052,630**	**1,196,612**	**1,211,991**	**1,279,571**	**1,504,781**	**1,632,283**	**1,840,975**	**1,975,942**

In delivering its year end position, the Trust generated efficiency savings of £72.5m The Trust seeks to identify and remove non value adding practices, procedures or delays which impede the patient experience 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.



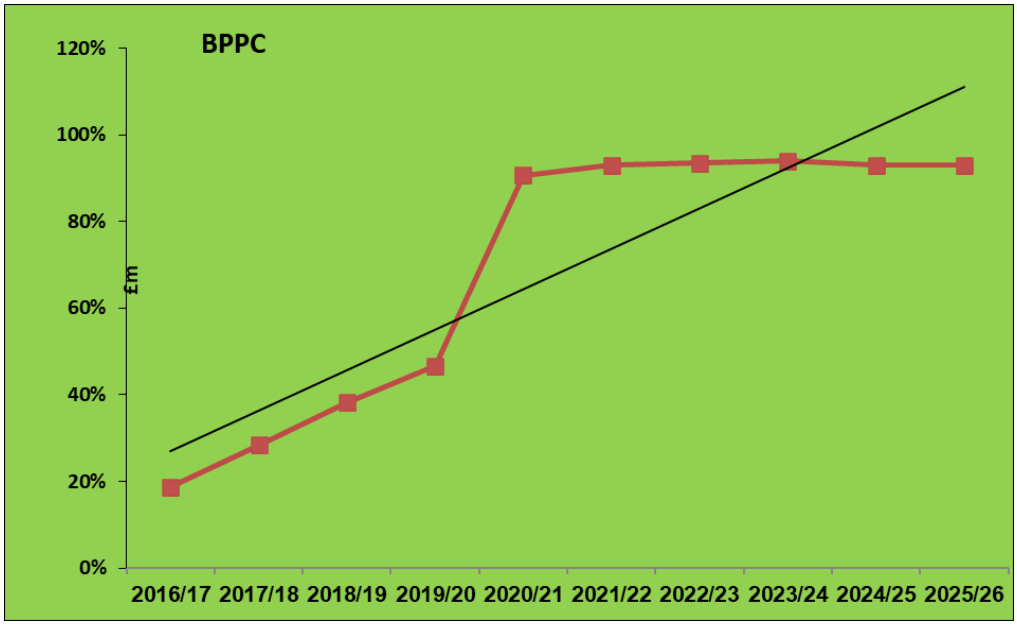


Better Payments Practice Code (BPPC)

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 has remained mid to upper 90s over the period.

Work continues to transform the purchase to pay workstream (refer slide 14), 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 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.

In challenging financial times, it is particularly important to support our suppliers and local businesses by ensuring prompt payments are made to them. Despite cash challenges, the BPPC remains an important performance metric, which is monitored at national level. Despite the cash challenges, cumulative 25/26 BPPC performance remained high at 93% Value and 86% volume, with in year deferment of some payments and extending payment terms impact on performance.



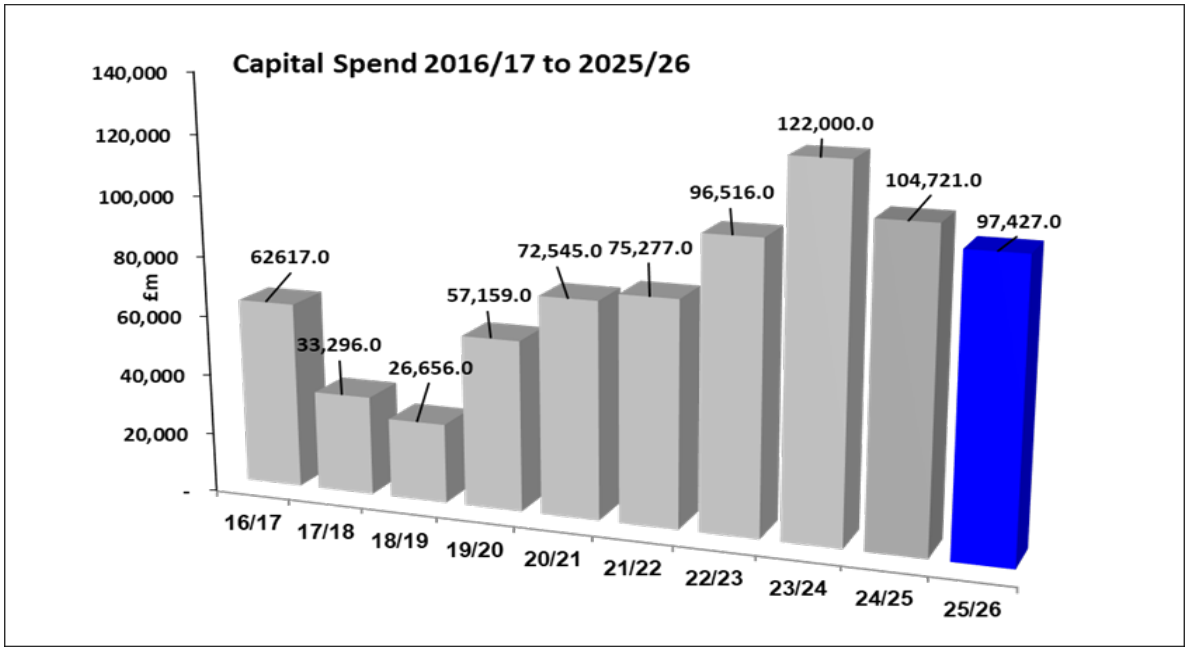
Capital Investment

In 2025/26, the Trust delivered a major capital investment programme of £97m. Key strategic and operational investments in 2025/26 included the opening of a new Endoscopy Unit, 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.

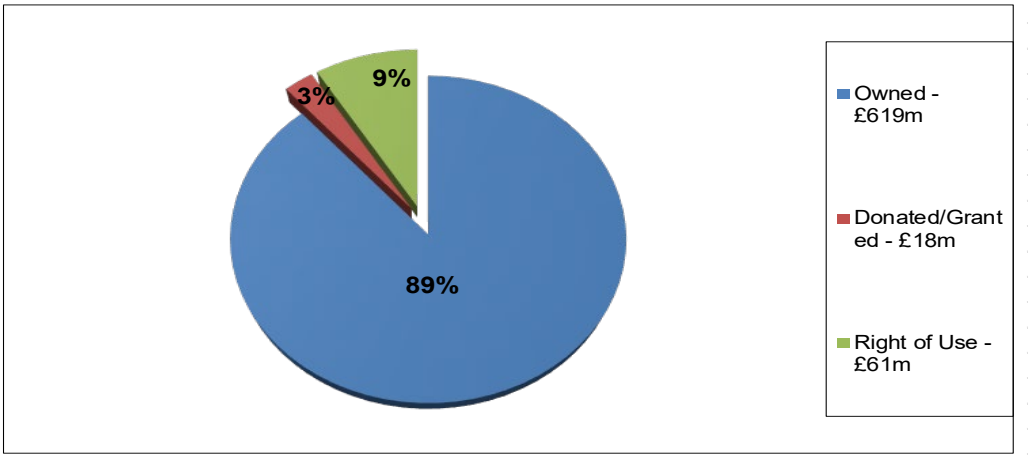
Other significant investments included:

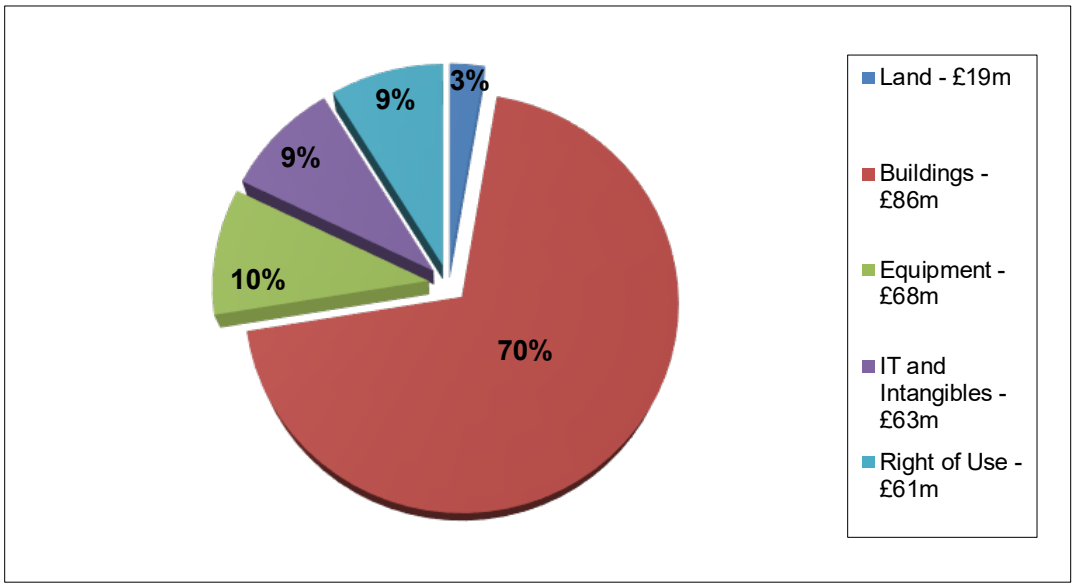
- Investment in urgent and emergency care capacity (£2.7m).
- Extension of the Diabetes Centre at Leicester General Hospital to enable it to provide "future-proof" diabetes research. (£4.8m)
- Continued deployment of electronic patient record (EPR) (£10.7m) including the go live of a new patient administration system (PAS) 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

The move from single-year planning to a medium-term approach has been enabled by the 3-year revenue settlement from the Spending Review 2025, and 4-year capital settlement. As part of this, revenue spending will increase by 3% in real terms over the course of the spending review period to 2028/29.

All ICBs and providers are expected to deliver a balanced or surplus financial position in each of the next three years. To support, NHS England has set every provider a plan limit for each year. These replace the plan limits that were previously issued at a system level. Each organisation will be given either a breakeven plan limit, or a deficit plan limit (including UHL), depending on their financial performance in 2025/26. Those given deficit plan limits will be issued with deficit support funding, which is included when calculating whether they have met their breakeven duty. The deficit support funding is non-recurrent and will reduce over the next three years. Deficit support funding will be removed by the end of the planning period (2028/29), except in exceptional circumstances (where agreed by NHS England).The Trust continues to develop its medium-term financial strategy to deliver this target.

For 2026/27, 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.

The Medium-term planning framework sets out key national targets (Aset out in the table below) AND introduces a new operating model to deliver on the vision set out in the 10 year health plan for England. The new model is rules-based, with defined expectations and consequences, and a focus on accountability at an organisational rather than system level. Providers, like UHL, are accountable for collaboration, productivity and quality, earning greater freedoms when they perform well, and facing proportionate intervention where standards slip. The advanced foundation trust programme will reward strong

performance, with the aim that by 2035 all providers will have earned freedoms such as strategic and operational autonomy, capability-based regulation and greater financial flexibility.

Priority	Success measure	Change since 2025/26
Elective, cancer and diagnostics (pages 26-28 of *Medium-term planning framework*)	**Improve the percentage of patients waiting no longer than 18 weeks for treatment** 2026/27 target: Every provider to deliver at least a 7% improvement, or 65% overall performance (whichever is greater). 2028/29 target: 92% overall performance.	Previous target was at least a 5% improvement (or 65% overall performance if greater)
	Improve performance against cancer constitutional standards 2026/27 target: Performance of 80% against the 28-day cancer faster diagnosis standard; 94% against the 31-day standard; and 80% against the 62-day standard. 2028/29 target: 80% against the 28-day standard; 96% against the 31-day standard; and 85% against the 62-day standard.	No change to 28-day target. Addition of 31-day target. Increase to 62-day target from 75%.
	Improve performance against the DMO1 diagnostics 6-week wait standard[15] 2026/27 target: Every system to deliver at least a 3% improvement, or 20% overall performance (whichever is greater). 2028/29 target: No more than 1% of patients waiting over 6 weeks for a test.	New
Urgent and emergency care (pages 29-30)	**4-hour A&E performance** 2026/27 target: Every provider to achieve 82%. 2027/28 target: National target of 85%.	Previous target was 78%
	12-hour A&E performance 2026/27 target: Improvement on 2025/26 performance. 2028/29 target: Year-on-year improvements.	No change
	Category 2 response times 2026/27 target: Improvement on 2025/26 performance to reach an average response time of 25 minutes. 2028/29 target: Further improvements to reach an average response time of 18 minutes, with 90% of calls responded to within 40 minutes.	Previous target was 30 minutes

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.

Productivity improvements feature heavily in the medium-term planning framework. To help achieve a balanced financial position, all providers are expected to make at least a 2% productivity improvement each year. This will be measured using a new trust-level productivity statistic. As part of the productivity improvements, providers are specifically asked to demonstrate progress against the following transitions:

- Urgent and emergency care: transition to digital-first and clinically prioritised access.
- Outpatients: shift to a digital-first, patient-led mode

In 26/27, Systems have been given a base growth adjustment applied to their baseline funding of 2.7% in 2026/27, which is made up of a cost uplift factor of 2.03%, a general efficiency requirement of 2.0%, increased charges from the clinical negligence scheme for trusts (CNST), growth in the better care fund and affordable growth in activity. Base

growth is expected to be 2.9% in 2027/28 and 3.2% in 2028/29 (including a cost uplift factor of 2.0% and general efficiency requirement of 2.0% in both years). The 2.0% general efficiency requirement is the same as in 2025/26 and will continue across each of the next three years. Clearly providers like UHL that are in receipt of deficit support funding will need to go beyond this if they are to maintain financial balance while their deficit support funding is reduced.

The core principles and payment mechanisms (aligned payment and incentive (API) for the NHS payment scheme in 2026/27 are the same as in 2025/26.

For 2026/27, the LLR system plan is a deficit of £62.5m, of which UHL is £57.4m & ICB £5.1m. The receipt of deficit support of £57.4m would take the Trust to a break even position. This assumes delivery of an ambitious £99m CIP programme. Long term financial sustainability is dependent upon these CIP improvements being delivered recurrently.

This still requires difficult decisions 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.

The key areas of focus nationally for acute providers emain:

- Reduce the time people wait for elective care.
- Improve A&E waiting times and ambulance response times.
- Improve patient flow through acute pathways.
- Address inequalities and shift towards prevention.
- Making the shift from analogue to digital.
- Live within our means, reducing waste and maximising productivity, through:
    - Reducing spend on temporary staffing and support functions. The Trust is expected to reduce expenditure through our workforce bank by £14m.
    - Improved procurement, contract management and prescribing (non pay).
    - Improvements in operational and clinical productivity.

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.

Delivery of the 2026/27 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.

Capital

ICBs and providers have been required to complete four-year capital plans. These are supported by the Spending Review 2025, which set out a four-year capital settlement for 2026/27 to 2029/30 with a further five years of indicative assumptions for capital planning and providing certainty over the next four years and allowing providers to plan over a longer time frame. From 2026/27, operational capital allocations now flow directly to individual providers rather than through systems. The allocations are set using a formula that weights funding at:

• 85% of a provider's depreciation (as a proxy for the scale of its asset base)
• 15% of a provider's critical infrastructure risk (as a proxy for the condition of its asset base)

To this end, the Trust will receive £219m over the next 4 years.

In addition to its operational capital allocation, the Trust has will receive national capital investment over the next 4 years for constitutional standards, including expanding diagnostic capacity (£27.3m) and urgent and emergency care (£23.7m). The Trust has also been allocated Estates Safety Fund capital allocation is £9.3m for 26/27 and £14.2m for 27/28. This includes provisional funding for the theatre refurbishment of £8.2m (£300k in 26/27 and £7.6m in 27/28).

£'000	2026/27	2027/28	2028/29	2029/30	Total
Diagnostics	15,250	4,750	4,750	2,500	**27,250**
UEC	2,000	7,750	8,000	6,000	**23,750**

This all translates into an opening capital programme of £115.7m in 26/27.

Over the course of the next 5 years, the Trust will also receive major national investment through the new hospital programme, which will see over £1bn invested in the facilities and infrastructure at the LRI and Glenfield Hospitals.

Despite much needed national investment, capital funding remains severely constrained, in particular the amount of money available to invest in core Estates, medical equipment and digital infrastructure. Projects are 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 2026/27 with effectively a break-even cash position, despite an opening cash balance of £24m at 31 March 26, as this is offset by 2025/26 capital cash expenditure that will come through in the first quarter of 2026/27, for which funding was received and committed (but not physically spent as cash) in 2025/26.
The 26/27 cash plan assumes that the Trust will achieve its CIP Plan and a balanced financial position which maintains an end of the year cash position largely consistent the opening cash position, all other things being equal. This includes assumed receipt non

recurrent deficit support of £57.4m, which would be jeopardised if the Trust fails to deliver financial balance. The cash risk is therefore equivalent to the value of undelivered or non cash releasing CIP plus any underlying deterioration in run rate plus none receipt of non recurrent deficit support. This would result in PDC revenue support application requirement during 26/27.

The Trust will continue to make prompt payment for goods and services received, wherever possible., in support of critical suppliers and local companies who provide services to the Trust.

Summary

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. 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.

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 2025/26 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 2025/26 Group Accounting Manual issued by the Department of Health and Social Care. They represent a "true and fair view" of our activity in 2025/26, 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 £270k (excluding VAT) for The Trust and £20k (excluding VAT) for TGH. We did not receive any non-audit services from KPMG in 2025/26.

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 2026 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
22 June 2026

Lee Bond
Chief Financial Officer
22 June 2026

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 2026 which comprise the Group Statement of Comprehensive Income, Group and Trust Statements of Financial Position, Group Statement of Changes in Taxpayers' Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2026 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 2025/26; 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 Trust'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 because of the need to achieve financial performance targets delegated to the Trust by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Group's accounting policies.

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, 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 nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Group 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 also recognised a fraud risk related to non-pay expenditure recognition, particularly in relation to year-end accruals.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries with unusual characteristics compared to the total journal population.
- Inspecting a sample of invoices of expenditure and cash payments, in the period post 31 March 2026, to determine whether expenditure has been recognised in the appropriate accounting period.

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 Accounting Officer and other management (as required by auditing standards), and discussed with the Accounting Officer 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.

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 and employment law recognising the nature of the Group and Trust's activities. Auditing

standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer 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 2025/26.

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, on Page [B] 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 weakness:

Significant Weakness – Financial Sustainability

We have previously identified significant weaknesses in the Trust's arrangements in relation to financial sustainability in each of our audits for the four years ended 31 March 2025. 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 (CIP) planning.

Delivery of the agreed financial plan has continued to represent a challenge for the Trust operationally during 2025/26, particularly in relation to delivery of expected CIPs. A financial plan for 2026/27 has been agreed but includes a further large and ambitious cost improvement plan, with a significant amount of savings remaining unidentified as of June 2026.

We have therefore concluded that the underlying 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.

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 13 May 2026 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 2026 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 this work is completed, we are unable to certify that we have completed the audit of University Hospitals of Leicester NHS Trus NHS Trust for the year ended 31 March 2026 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

25 June 2026

Appendix A

Annual accounts 2025/26

University Hospitals of Leicester NHS Trust

Annual accounts for the year ended 31 March 2026

Consolidated Statement of Comprehensive Income

		Group	
		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	1,671,071	1,616,842
Other operating income	4	174,443	169,481
Operating expenses	7,9	(1,975,942)	(1,840,975)
Operating deficit from continuing operations		**(130,428)**	**(54,652)**
Finance income	11	2,452	3,060
Finance expenses	12	(306)	(3,535)
PDC dividends payable		(17,647)	(21,969)
Net finance costs		**(15,501)**	**(22,444)**
Other gains / (losses)	13	(531)	(166)
Corporation tax expense		(59)	(20)
Surplus / (deficit) for the year from continuing operations		**(146,519)**	**(77,282)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-
Surplus / (deficit) for the year		**(146,519)**	**(77,282)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(122,994)	(6,769)
Revaluations	19	77,270	12,720
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	20.5	381	61
Foreign exchange gains / (losses) recognised directly in OCI		-	-
Total other comprehensive income for the period		**(45,343)**	**6,012**
Total comprehensive income / (expense) for the period		**(191,862)**	**(71,270)**
Surplus/ (deficit) for the period attributable to:			
Non-controlling interest, and		-	-
University Hospitals of Leicester NHS Trust		(146,519)	(77,282)
Total		**(146,519)**	**(77,282)**
Total comprehensive income/ (expense) for the period attributable to:			
Non-controlling interest, and		-	-
University Hospitals of Leicester NHS Trust		(191,862)	(71,270)
Total		**(191,862)**	**(71,270)**

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	16	35,142	32,292	35,142	32,292
Property, plant and equipment	17	601,656	720,763	601,650	720,755
Right of use assets	20	61,070	54,016	61,070	54,016
Investment property	21	-	-	-	-
Other investments / financial assets	20	5,777	5,393	4,000	4,000
Receivables	23	4,571	4,417	4,571	4,417
Other assets	25	-	-		
Total non-current assets		**708,216**	**816,881**	**706,433**	**815,480**
Current assets					
Inventories	22	27,773	28,567	25,368	25,706
Receivables	23	40,998	38,039	39,888	36,820
Cash and cash equivalents	24	35,759	41,751	32,980	39,001
Total current assets		**104,530**	**108,357**	**98,236**	**101,527**
Current liabilities					
Trade and other payables	25	(188,537)	(164,296)	(188,052)	(163,514)
Borrowings	27	(13,452)	(9,125)	(13,452)	(9,125)
Other financial liabilities	28	-	-	-	
Provisions	28	(9,083)	(9,305)	(8,982)	(9,254)
Other liabilities	26	(4,927)	(4,650)	(4,927)	(4,650)
Total current liabilities		**(215,999)**	**(187,376)**	**(215,413)**	**(186,543)**
Total assets less current liabilities		**596,747**	**737,862**	**589,256**	**730,464**
Non-current liabilities					
Borrowings	27	(34,653)	(43,101)	(34,653)	(43,101)
Provisions	28	(3,011)	(3,634)	(3,011)	(3,635)
Total non-current liabilities		**(37,664)**	**(46,735)**	**(37,664)**	**(46,736)**
Total assets employed		**559,083**	**691,127**	**551,592**	**683,728**
Financed by					
Public dividend capital		984,623	924,805	984,623	924,805
Revaluation reserve		177,957	223,681	177,957	223,681
Income and expenditure reserve		(610,085)	(464,017)	(610,988)	(464,758)
Charitable fund reserves	21	6,588	6,658	-	
Total taxpayers' equity		**559,083**	**691,127**	**551,592**	**683,728**

The notes form part of these accounts.

Name Richard Mitchell
Position Group Chief Executive
Date **22/06/2026**

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

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 2025 - brought forward	**924,805**	**223,681**	**(464,017)**	**6,658**	**691,127**
Surplus/(deficit) for the year	-	-	(147,491)	972	**(146,519)**
Impairments	-	(122,994)	-	-	**(122,994)**
Revaluations	-	77,270	-	-	**77,270**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	381	**381**
Public dividend capital received	59,818	-	-	-	**59,818**
Other reserve movements	-	-	1,423	(1,423)	**-**
Taxpayers' and others' equity at 31 March 2026	**984,623**	**177,957**	**(610,085)**	**6,588**	**559,083**

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**
Prior period adjustment	-	-	-	-	**-**
Implementation of IFRS 17 at 1 April 2024 transition date	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2024 - restated	**850,303**	**217,730**	**(388,118)**	**7,980**	**687,895**
Surplus/(deficit) for the year	-	-	(78,463)	1,181	**(77,282)**
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)**	**6,658**	**691,127**

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		(130,428)	(54,652)	(124,675)	(53,101)
Non-cash income and expense:					
Depreciation and amortisation	7.1	57,998	57,884	57,996	57,881
Net impairments	8	102,347	45,308	97,026	45,308
Income recognised in respect of capital donations	4	(2,705)	(5,549)	(5,269)	(8,113)
(Increase) / decrease in receivables and other assets		218	1,580	393	1,602
(Increase) / decrease in inventories		794	(770)	338	174
Increase / (decrease) in payables and other liabilities		25,927	4,484	26,154	4,204
Increase / (decrease) in provisions		(900)	(2,798)	(1,035)	(2,803)
Movements in charitable fund working capital		413	(274)		
Tax (paid) / received		(59)	(20)		
Other movements in operating cash flows		(1,426)	(2,549)		
Net cash flows from / (used in) operating activities		**52,179**	**42,644**	**50,928**	**45,152**
Cash flows from investing activities					
Interest received		2,251	2,846	2,251	2,846
Purchase of intangible assets		(10,138)	(15,503)	(10,138)	(15,503)
Purchase of PPE and investment property		(66,249)	(73,180)	(66,249)	(73,180)
Receipt of cash donations to purchase assets		2,705	5,549	4,128	5,549
Net cash flows from charitable fund investing activities		201	214		
Net cash flows from / (used in) investing activities		**(71,230)**	**(80,074)**	**(70,008)**	**(80,288)**
Cash flows from financing activities					
Public dividend capital received		59,818	74,502	59,818	74,502
Capital element of lease liability repayments		(25,245)	(11,065)	(25,245)	(11,065)
Other interest		(93)	(29)	(93)	(29)
Interest paid on lease liability repayments		(158)	(3,451)	(158)	(3,451)
PDC dividend (paid) / refunded		(21,263)	(23,167)	(21,263)	(23,167)
Net cash flows from / (used in) financing activities		**13,059**	**36,790**	**13,059**	**36,790**
Increase / (decrease) in cash and cash equivalents		**(5,992)**	**(640)**	**(6,021)**	**1,654**
Cash and cash equivalents at 1 April - brought forward		**41,751**	**42,391**	**39,001**	**37,347**
Unrealised gains / (losses) on foreign exchange		-	-		
Cash and cash equivalents at 31 March	24.1	**35,759**	**41,751**	**32,980**	**39,001**

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 21

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 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the 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 2026/27 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 2025/26 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 2025/26. TGH's accounting policies are aligned with those of the Trust.

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 the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such 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 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.
Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

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

In accordance with NHS accounting policy, 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 (i.e. operational assets used to deliver either front line services or back office functions) are measured at their Current Value in Existing Use, which is the valuation figure produced by the MEA assessment. 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 Value in Existing Use is defined as Market Value on the specific assumption of a continuation of that Existing Use only (namely no alternative use is considered). Where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence, the valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates Current Value in Existing Use 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. 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.

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.

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.

The Trust was required to undertake a full quinquennial valuation in 2025/26, having been last undertaken in 2020/21. The Trust engaged its valuers, Carter Jonas, to revalue its estate as at the 31st March 2026, with a restatement of opening balances as at 1 April 2025.

This revaluation applied a Modern Equivalent Asset (MEA) valuation methodology. All NHS Trusts value their land and buildings using MEA because hospitals are classified as specialised buildings without active markets for replacement—making MEA the appropriate basis for operational assets. The agreed schedule of properties was valued in accordance with the Royal Institute of Chartered Surveyors (RICS) Professional Standards. It follows that the valuation is compliant with International Valuation Standards.

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 Current Value in Existing Use was primarily derived using the Depreciated Replacement Cost approach to value the service potential, on a Modern Equivalent Asset (MEA) basis. In 2025/26, the Trust has transitioned to a consolidated hypothetical single site at Leicester General Hospital site. Following organisational consolidation, services would be delivered from a single site on this scenario.

The Key Factors Impacting on the Land and Property Valuation

The valuation involves estimation techniques and in arriving at opinions of the useful remaining economic life and value of a building and the Trust’s property valuation takes into account the following aspects:

Physical and Functional Obsolescence - The age, condition and the probable costs of future maintenance and the suitability of the properties for their present use and the prospect of continuance for that use. Another potential cause of functional obsolescence is legislative change, for example, statutory and regulatory compliance, including compliance with sustainability and energy legislation. Once the gross costs of constructing a modern equivalent asset has been determined, an adjustment is made to reflect the difference between the modern equivalent and the actual asset being valued. The adjustment is made by the valuer based on their knowledge and experience and takes into account physical deterioration and functional obsolescence. Had the overall adjustment for obsolescence been 5% higher than the valuer had assumed, this would have reduced the value of specialised properties recorded in the Statement of Financial Position by £78m. If the adjustment for obsolescence was 10% higher than the valuer had assumed, this would have reduced the value of specialised properties recorded in the Statement of Financial Position by £156 m. Note that the actual overall adjustment for obsolescence is 72.09% and these comparisons have been calculated at 77.09% and 82.09%

Floor Areas - The Trust uses a database/repository for its estate data (MICAD), 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 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 and using this baseline data, the Leicester General Hospital. This has resulted in a significant reduction in the size of the land and buildings required to service the population, without loss of capacity, in terms of clinical capacity and non-clinical space requirements, including car parking spaces. The Trust has undertaken a comprehensive review of its Modern Equivalent Asset (MEA) in association with a third party, Shiron Financial Solutions Ltd, who have extensive experience in this area, including neighbouring Trusts. This review has re-assessed the MEA at 1st April 2025, with a subsequent revaluation at 31st March 2026 to align with the financial year-end. This work has been undertaken in conjunction with the Trust's Estates team, and the valuation of the revised area and land has been will be carried out by the Trust's appointed professional RICS qualified valuer (Cater Jonas LLP). The MEA model is based on the gross internal area (GIA) required to deliver current services, ensuring consistency of inputs, assumptions, and methodology in line with RICS guidance. The GIAs calculated in the MEA model have been derived after considering the embedded space occupied by the University, removing duplicate spaces such as canteens, reception areas, toilets, and meeting rooms, along with other relevant factors, to arrive at the GIA required to deliver current healthcare services on a consolidated single site at the Leicester General Hospital. The approach to the MEA valuation was taken through Trust governance committees, including the Trust Leadership Team (ensuring clinical engagement) and Audit Committee and Trust Board which described what we were doing and explained the tenets and key assumptions of the model and in particular that existing clinical capacity would not be compromised in the theoretical model. All clinical and non clinical leaders have therefore had the opportunity to challenge the assumptions and to gain assurance.

Values - In assessing the land and property values, the Valuer uses actual cost data from the recognised BCIS source to calculate the gross cost that would be incurred in constructing a modern equivalent asset. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 5% higher, this would increase the value of specialised properties recorded in the Statement of Financial Position by £21.76m. In consolidating onto one site at the General Hospital, the floor area of the existing properties that have been considered under the MEA approach have an existing gross internal floor area of 318,560 sqm for Trust occupied areas. The model assumes the floor area can be significantly reduced by 62,724 sqm (19.69%) by removing the inefficiency and functionality of the current buildings. Had the MEA floor area been 5% higher or lower, the overall value (land and buildings) of the single site would have moved by +/-£21.9m.

It should noted that the 'hypothetical' single site model valued in these Accounts, using the depreciated replacement cost (DRC)/MEA valuation cannot be directly compared with a new hospital cost because the DRC valuation includes age-related depreciation, also known as physical obsolescence. The gross replacement cost would be £1.5bn. This is then depreciated significantly to reflect the actual hospital's age-related obsolescence and may also include other obsolescence adjustments applied by the valuer to arrive at the valuation used in the Accounts. This compares with an estimated a £1.1bn investment required to modernise significant elements of the LRI and Glenfield sites in the New Hospitals Programme.

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

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

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	3	12
Development expenditure	-	-
Websites	-	-
Software licences	3	12
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-

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.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, 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.

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 1.13 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

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

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 28.3 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in Note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 29.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

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 1.17 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

The Trust has no corporation tax liability itself however the Trust's subsidiary is liable to pay corporation tax and this is recognised in the group accounts.

Note 1.19 Climate change levy

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

Note 1.20 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 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s *FReM*.

Note 1.22 Losses and special payments

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 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 1.24 Early adoption of standards, amendments and interpretations

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

Note 1.25 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 1.26 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 was required to undertake a full quinquennial valuation in 2025/26, having been last undertaken in 2020/21. The Trust engaged its valuers, Carter Jonas, to revalue its estate as at the 31st March 2026, with a restatement of opening balances as at 1 April 2025. This revaluation applied a Modern Equivalent Asset (MEA) valuation methodology. All NHS trusts value their land and buildings using MEA)because hospitals are inherently specialised buildings without active markets for replacement—making MEA the appropriate basis for operational assets. The agreed schedule of properties was valued in accordance with the Royal Institute of Chartered Surveyors (RICS) Professional Standards. It follows that the valuation is compliant with International Valuation Standards.

The Trust has historically operated across three separate main hospital sites, reflecting legacy service configuration and in previous years, for asset valuation purposes, University Hospitals of Leicester NHS Trust have retained the existing configuration of buildings and floor areas with existing site location. In 2025/26, the Trust has transitioned to a consolidated hypothetical single site at Leicester General Hospital site. Following organisational consolidation, services would be delivered from a single site on this scenario. The Trust's Estates team determined that relocating the MEA to a single consolidated alternative site at Leicester General hospital better right-sizes the estate in line with current and future operational need, while also positioning the Trust in a location that offers more cost-effective land, superior infrastructure and improved accessibility for the population it serves. It is an existing Trust site located in east Leicester, within the same target population catchment across Leicester, Leicestershire and Rutland, with direct road access, ensuring equivalent accessibility and service reach. The Trust's determination that a single consolidated site at Leicester General Hospital site, represents the modern equivalent asset is fully supported by the analysis undertaken, having reviewed floor plans, undertaken site visits (to inform the assessment of the condition and expected life of the buildings) and considered alternative site locations and infrastructure, car parking and a clinical service review against target population need. Land requirement calculations were benchmarked against MEA-approved hospitals of comparable bed size and service provision.

The detailed MEA revaluation ensures asset values reflect the true cost of replacing service potential, thereby improving the robustness of the Trust's balance sheet and enhancing comparability across trusts. The value of the property is based on the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of obsolescence rather than an exact replica provided that the location requirements of the service are still met. The Trust's Estates team determined the obsolescence and space optimisation position. supported by benchmarking expertise across comparable NHS programmes, the analysis demonstrates that the Trust's current gross internal area is disproportionate to its consolidated service model. A n alternative site location (or in this case an existing a one merged site) may be assumed for valuation purposes, as long as they meet the operational needs of the service. The valuation reflects current design standards, space efficiencies, and technological advancements. To this end, the revised MEA model presents a more optimised estate that better reflects modern clinical service delivery and the Trust's consolidated operational model.

Note 1.27 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 contract mechanism between ICBs and the Trust for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) is to pay unit prices for activity delivered, called an aligned payment and incentive (API) payment model . NHS England will cover additional costs where systems exceed agreed activity levels. Urgent and emergency pathways remain on a block funding arrangement . These contract mechanisms provide funding certainty, although block funding arrangements for non elective care present the Trust with rising operational and financial pressures. System working on this challenge will be the key area of focus to achieve a financially sustainable position.

Deferred Income
Deferred income is, in accrual accounting terms, money received for goods or services which has not yet been earned. In accordance with revenue recognition principle, it is recorded as a liability until delivery of service is made, at which time it is released into the revenue position. The Trust legitimately provides for deferred income where there is evidence that there is an ongoing condition or liability with regard to this funding. As a principle, the Trust follows national guidance in deferring research income, in particular, in order to build sustainable research and innovation capacity building capacity. The other significant element of deferred income relates to income received from our commercial housing provider, which the Trust received in dispensation for the land transferred as part the development on Walnut Street. The Trust works in partnership with Sovereign Housing to provide affordable accommodation to patient relatives and visitors to the Trust. This income is released over the life of the contract.

Accrued Expenditure
The Trust will apply in full the matching and the accruals accounting concepts in producing the 2025/26 Accounts. The matching concept recognises revenues and their related expenses in the same accounting period. In accordance with the matching principle, the Trust recognises (accrues) expenditure in the accounting period when they been incurred and committed in delivering the activities of the Trust, pebding receipt of teh invoice for payment. Key financial controls applied included:
>Journal controls, including electronic authorisation.
>Review of accruals in a timely manner to determine that accruals posted are relevant and accurate.
>Review of the matching process for Good received not invoiced accruals. The Trust has maintained its GRNI policy of force completing of all GRNI balances exceeding 6 months. Although the Trust will effectively remove all GRNI balances over 6 months old from the reported position, the Trust will still continue to pay all valid and approved invoices older than 90 days, as they are presented.
>Timely completion and review of balance sheet control accounts to the prescribed standard and prompt resolution of reconciling items.
>In terms of capital, the status of each project is monitored with asset under construction status being updated monthly on the Trust's Fixed Asset register, which provides a robust platform for financial reporting and accounting of fixed assets.
>Annual Leave Accrual - Whilst all Trust staff have been encouraged to take as much outstanding leave as possible for their own wellbeing, it is recognised that this is not always possible and some staff, due to their circumstances, will be required to carry forward unused leave to the next financial year. The Trust has currently holds a provision of £3.7m.

Valuation of assets
The valuation of plant, property and equipment represents a significant source of estimation uncertainty, with the risk that it could result in a material adjustment to carrying values of assets. To mitigate the risk of material misstatement, the Trust engages the professional services and advice of a professional RICS qualified valuer. The qualified valuer is recognised as a suitable provider of a range of valuation and surveying services to public sector bodies and their estimates can be relied upon in respect of these services, including estimates of the remaining useful economic lives of property assets. The Trust has adopted a modern equivalent asset valuation (MEA) approach to its valuation. The MEA considers the replacement costs of a modern asset that has the same productive capacity and operational output as existing properties. Using the MEA methodology, the three main sites (Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital) would not be provided in their current locations, but combined as a single hypothetical site (on the Leicester General site). The MEA not only considers the location of the services but also considers the inefficiency and functionality of the existing buildings and the alternative site would be the least expensive site that could realistically be suitable and appropriate for delivering the healthcare services to the Trust's patient population. The hypothetical site has the same productive capacity and would be capable of the same operational output with no reduction in facilities offered ie the same number of beds, operating theatres and car parking spaces etc. The Trust has determined that the work carried out during the year to refine the MEA valuation is a change in estimate. The principle on which the MEA is based, that of a theoretical modern asset, is unchanged and the valuation method employed by the Trust's professional valuers remains the same. The changes to the estimation include a revision to the Trust's Gross Internal Area (GIA) and land required for the MEA following re-examination of the information. None of the revisions are a change in the underlying policy of valuing the Trust's land and buildings on an MEA basis or indicate that there was an error in the previous estimation, but rather that this is a refinement of the accounting estimate. Accounting standards direct that a change in estimation only affects the period to which the change occurs and future periods and must not be accounted for retrospectively.
Depreciation
The Trust adopts a straight line method of depreciation across the useful economic lives of all its assets, guided by NHS Accounting Policy for asset lives and the expert professional opinion of our valuers for property assets. Whilst the aim is to give informed useful economic lives to our assets, there is inevitably 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)	2025/26 £000	2024/25 £000
Income from commissioners under API contracts - variable element*	357,471	324,802
Income from commissioners under API contracts - fixed element*	1,061,857	1,047,618
High cost drugs income from commissioners	170,016	163,990
Other NHS clinical income	8,606	6,199
Private patient income	3,370	3,466
National pay award central funding***		3,958
Additional pension contribution central funding**	64,957	62,280
Other clinical income	4,794	4,529
Total income from activities	**1,671,071**	**1,616,842**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	267,069	274,384
Integrated care boards	1,395,755	1,334,281
Non-NHS: private patients	3,370	3,466
Non-NHS: overseas patients (chargeable to patient)	2,589	2,642
Injury cost recovery scheme	2,205	1,887
Non NHS: other	83	182
Total income from activities	**1,671,071**	**1,616,842**
Of which:		
Related to continuing operations	1,671,071	1,616,842

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

	2025/26 Total £000	2024/25 Total £000
Income recognised this year	**2,589**	**2,642**
Cash payments received in-year	610	1,007
Amounts added to provision for impairment of receivables		
Amounts written off in-year	**2,610**	**1,978**

Note 4 Other operating income (Group)

	2025/26 Total £000	2024/25 Total £000
Research and development	58,661	55,603
Education and training	69,867	64,467
Non-patient care services to other bodies	8,105	7,862
Income in respect of employee benefits accounted on a gross basis	6,162	5,677
Revenue from finance leases	-	-
Amortisation of PFI deferred income / credits	-	-
Charitable fund incoming resources	2,107	2,675
Other income	26,510	27,397
Total other operating income	**174,443**	**169,481**

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 (2024/25 - £Nil).

Note 5.2 Transaction price allocated to remaining performance obligations

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Fees and charges (Group)

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2025/26	2024/25
	£000	£000
Income	10,618	5,020
Full cost	(7,759)	(3,342)
Surplus / (deficit)	**2,859**	**1,678**

Note 6 Operating leases - University Hospitals of Leicester NHS Trust as lessor

This note discloses income generated in operating lease agreements where University Hospitals of leicester NHS Trust 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)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	326	251
Total in-year operating lease income	**326**	**251**

Note 6.2 Future lease receipts (Group)

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	326	284
Total	**326**	**284**

Note 7.1 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,434	4,361
Purchase of healthcare from non-NHS and non-DHSC bodies	17,505	17,203
Staff and executive directors costs	1,179,465	1,120,031
Remuneration of non-executive directors	192	188
Supplies and services - clinical (excluding drugs costs)	191,289	184,758
Supplies and services - general	17,189	19,699
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	178,609	169,323
Inventories written down	14	32
Consultancy costs	6,534	4,613
Establishment	10,771	10,614
Premises	71,618	66,306
Transport (including patient travel)	7,316	8,153
Depreciation on property, plant and equipment	50,710	51,222
Amortisation on intangible assets	7,288	6,662
Net impairments	102,347	45,308
Movement in credit loss allowance: contract receivables / contract assets	2,035	2,109
Increase/(decrease) in other provisions	(4,039)	1,881
Change in provisions discount rate(s)	(62)	8
Fees payable to the external auditor		
audit services- statutory audit	307	316
Internal audit costs	195	153
Clinical negligence	51,460	49,610
Legal fees	1,207	1,097
Insurance (as a policy holder)	732	735
Research and development	58,127	54,762
Education and training	3,712	4,770
Expenditure on short term leases	9,690	8,096
Car parking & security	356	742
Losses, ex gratia & special payments	94	50
Other NHS charitable fund resources expended	1,319	1,692
Other	7,528	6,481
Total	**1,975,942**	**1,840,975**
Of which:		
Related to continuing operations	1,975,942	1,840,975

Note 7.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 8 Impairment of assets (Group)

	2025/26	2024/25
	£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	102,347	20,836
Impairments of charitable fund assets	-	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**102,347**	**45,308**
Impairments charged to the revaluation reserve	122,994	6,769
Total net impairments	**225,341**	**52,077**

The material impairments charged to I&E and revaluation reserve are reflective of the revised MEA valuation methodology based on a single consolidated site approach, resulting in a reduction in land and property values. The opening valuation as at 1 April 2025 has been revised on thid basis. The MEA valuation is a change in estimate, and not a prior period restatement. The principle on which the MEA is based, that of a theoretical modern asset, is unchanged and the valuation method employed by the Trust's professional valuers remains the same. The changes to the estimation include a revision to the Gross Internal Area (GIA) and land required following re-examination of the information. There is no change in the underlying policy of valuing the Trust's land and buildings on an MEA basis or indicate that there was an error in the previous estimation, but rather that this is a refinement. The accounting standard is very clear that a change in estimation only affects the period to which the change occurs and future periods and must not be accounted for retrospectively.

Note 9 Employee benefits (Group)

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	918,560	878,896
Social security costs	117,631	93,270
Apprenticeship levy	4,432	4,316
Employer's contributions to NHS pensions	164,057	157,877
Pension cost - other	95	72
Temporary staff (including agency)	4,272	12,603
Total gross staff costs	**1,209,047**	**1,147,034**
Recoveries in respect of seconded staff	-	-
Total staff costs	**1,209,047**	**1,147,034**
Of which		
Costs capitalised as part of assets	4,130	4,298

Note 9.1 Retirements due to ill-health (Group)

During 2025/26 there were 6 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £161k (£70k in 2024/25).

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

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 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.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,251	2,846
NHS charitable fund investment income	201	214
Total finance income	**2,452**	**3,060**

Note 12.1 Finance expenditure (Group)

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	158	3,451
Interest on late payment of commercial debt	93	29
Total interest expense	**251**	**3,480**
Unwinding of discount on provisions	55	55
Total finance costs	**306**	**3,535**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£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	93	29

Note 13 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	-	54
Losses on disposal of assets	(531)	(220)
Gains / losses on disposal of charitable fund assets	-	-
Total gains / (losses) on disposal of assets	**(531)**	**(166)**

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 surplus/(deficit) for the period was £141 million (2024/25: £76 million). The trust's total comprehensive income/(expense) for the period was £190 million (24/25: £68 million).

Note 15 Discontinued operations (Group)

The Group and Trust had no discontinued operations in 25/26 (Nil 2024/25).

Note 16.1 Intangible assets - 2025/26

Group	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**71,450**	**12**	**1,201**	**72,663**
Additions	10,138	-	-	**10,138**
Cost at 31 March 2026	**81,588**	**12**	**1,201**	**82,801**
Amortisation at 1 April 2025 - brought forward	**40,371**	**-**	**-**	**40,371**
Provided during the year	7,288	-	-	**7,288**
Amortisation at 31 March 2026	**47,659**	**-**	**-**	**47,659**
Net book value at 31 March 2026	**33,929**	**12**	**1,201**	**35,142**
Net book value at 1 April 2025	**31,079**	**12**	**1,201**	**32,292**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn

Note 16.2 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 - as previously stated	**57,148**	**12**	**5,679**	**62,839**
Transfers by absorption	-	-	-	**-**
Additions	14,302	-	1,201	**15,503**
Reclassifications	-	-	(5,679)	**(5,679)**
Valuation / gross cost at 31 March 2025	**71,450**	**12**	**1,201**	**72,663**
Amortisation at 1 April 2024 - as previously stated	**33,709**	**-**	**-**	**33,709**
Provided during the year	6,662	-	-	**6,662**
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 17.1 Property, plant and equipment - 2025/26

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 2025 - brought forward	**53,006**	**583,806**	**6,885**	**23,016**	**154,417**	**338**	**63,175**	**6,081**	**890,724**
Additions	-	43	9	48,897	8,458	-	8,640	88	**66,135**
Impairments	(21,902)	(105,103)	(918)	-	-	-	-	-	**(127,923)**
Reversals of impairments	1,205	3,353	371	-	-	-	-	-	**4,929**
Revaluations	(13,447)	(71,752)	1,360	-	-	-	-	-	**(83,839)**
Reclassifications	-	35,329	-	(38,905)	1,492	-	2,045	39	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,141)	-	-	-	**(2,141)**
Valuation/gross cost at 31 March 2026	**18,862**	**445,676**	**7,707**	**33,008**	**162,226**	**338**	**73,860**	**6,208**	**747,885**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**39,387**	**821**	**-**	**90,028**	**201**	**36,811**	**2,713**	**169,961**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	18,160	394	-	8,889	78	9,047	391	**36,959**
Impairments	16,739	103,963	34	-	-	-	-	-	**120,736**
Reversals of impairments	(971)	(17,384)	(34)	-	-	-	-	-	**(18,389)**
Revaluations	(15,768)	(144,126)	(1,215)	-	-	-	-	-	**(161,109)**
Disposals / derecognition	-	-	-	-	(1,929)	-	-	-	**(1,929)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**96,988**	**279**	**45,858**	**3,104**	**146,229**
Net book value at 31 March 2026	**18,862**	**445,676**	**7,707**	**33,008**	**65,238**	**59**	**28,002**	**3,104**	**601,656**
Net book value at 1 April 2025	**53,006**	**544,419**	**6,064**	**23,016**	**64,389**	**137**	**26,364**	**3,368**	**720,763**

Note 17.2 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 - as previously stated	**52,956**	**537,916**	**6,635**	**64,053**	**140,776**	**338**	**49,460**	**4,122**	**856,256**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2024 - restated	**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 - as previously stated	**-**	**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**
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 17.3 Property, plant and equipment financing - 31 March 2026

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	18,862	435,601	7,707	32,367	58,153	53	27,991	2,916	-	**583,650**
Owned - donated/granted	-	10,075	-	641	7,085	6	11	188	-	**18,006**
NBV total at 31 March 2026	**18,862**	**445,676**	**7,707**	**33,008**	**65,238**	**59**	**28,002**	**3,104**	**-**	**601,656**

Note 17.4 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 17.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

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 2026	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Note 17.6 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 18 Donations of property, plant and equipment

	Group and Trust	
	2025/26	2024/25
	£000	£000
Assets purchased with donations from the Trust's charitable fund	1,423	2,564
Assets received from DHSC relating to Covid treatment	-	-
Other	-	.
	1,423	**2,564**

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.

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 - 2025/26

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 2025 - brought forward	**37,162**	**91,596**	**58**	**17,917**	**146,733**	**16,134**
Transfers by absorption	-	-	-	-	**-**	-
Additions	-	19,923	-	-	**19,923**	-
Remeasurements of the lease liability	2,433	(323)	-	(880)	**1,230**	224
Disposals / derecognition	-	(348)	-	-	**(348)**	-
Valuation/gross cost at 31 March 2026	**39,595**	**110,848**	**58**	**17,037**	**167,538**	**16,358**
Accumulated depreciation at 1 April 2025 - brought forward	**13,365**	**64,940**	**58**	**14,354**	**92,717**	**1,961**
Transfers by absorption	-	-	-	-	**-**	-
Provided during the year	4,552	7,799	-	1,400	**13,751**	1,168
Accumulated depreciation at 31 March 2026	**17,917**	**72,739**	**58**	**15,754**	**106,468**	**3,129**
Net book value at 31 March 2026	**21,678**	**38,109**	**-**	**1,283**	**61,070**	**13,229**
Net book value at 1 April 2025	**23,797**	**26,656**	**-**	**3,563**	**54,016**	**14,173**

Net book value of right of use assets leased from other NHS providers	2,409
Net book value of right of use assets leased from other DHSC group bodies	10,820

Note 20.2 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**	11,247
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**	**16,134**
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**	**14,173**
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	2,409
Net book value of right of use assets leased from other DHSC group bodies	11,764

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 27.1.

	Group	
	2025/26	**2024/25**
	£000	**£000**
Carrying value at 1 April	**52,226**	**43,807**
Transfers by absorption	-	-
Lease additions	19,923	17,930
Lease liability remeasurements	1,230	1,601
Interest charge arising in year	158	3,451
Early terminations	(29)	(47)
Lease payments (cash outflows)	(25,403)	(14,516)
Other changes	-	-
Carrying value at 31 March	**48,105**	**52,226**

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

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

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

Note 20.4 Maturity analysis of future lease payments at 31 March 2026

	Group & Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2026	**31 March 2026**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	13,452	1,225
- later than one year and not later than five years;	34,653	11,776
- later than five years.	-	-
Total gross future lease payments	**48,105**	**13,001**
Finance charges allocated to future periods	-	-
Net lease liabilities at 31 March 2026	**48,105**	**13,001**
Of which:		
Leased from other NHS providers		1,957
Leased from other DHSC group bodies		11,044

Note 20.5 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	14,215
- later than five years.	938	-
Total gross future lease payments	**52,226**	**14,355**
Finance charges allocated to future periods	-	-
Net finance lease liabilities at 31 March 2025	**52,226**	**14,355**
Of which:		
Leased from other NHS providers		2,568
Leased from other DHSC group bodies		11,787

Note 20.5 Other investments / financial assets (non-current)

	Group & Trust	
	2025/26	**2024/25**
	£000	**£000**
Carrying value at 1 April - brought forward	**5,393**	**5,347**
Acquisitions in year	1,664	765
Movement in fair value through OCI	381	61
Disposals	(1,661)	(780)
Carrying value at 31 March	**5,777**	**5,393**

Note 21 Analysis of charitable fund reserves

	31 March 2026	31 March 2025
	£000	£000
Unrestricted funds:		
Unrestricted income funds	5,177	5,403
Restricted funds:		
Other restricted income funds	1,411	1,255
	6,588	**6,658**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 22 Inventories

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Drugs	9,199	9,199	6,794	6,338
Consumables	18,134	19,151	18,134	19,151
Energy	440	217	440	217
Total inventories	**27,773**	**28,567**	**25,368**	**25,706**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £23,601k (2024/25: £91k). Write-down of inventories recognised as expenses for the year were £14k (2024/25: £0k).

Note 23.1 Receivables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables	19,060	22,659	19,060	22,659
Allowance for impaired contract receivables / assets	(2,522)	(3,863)	(2,522)	(3,863)
Prepayments (non-PFI)	7,557	8,058	7,527	8,036
PDC dividend receivable	4,901	1,285	4,901	1,285
VAT receivable	9,828	8,315	8,843	7,572
Other receivables	1,889	1,015	2,079	1,131
NHS charitable funds receivables	285	570		
Total current receivables	**40,998**	**38,039**	**39,888**	**36,820**
Non-current				
Contract receivables	4,431	3,944	4,431	3,944
Allowance for impaired contract receivables / assets	(1,067)	(894)	(1,067)	(894)
Other receivables	1,207	1,367	1,207	1,367
Total non-current receivables	**4,571**	**4,417**	**4,571**	**4,417**
Of which receivable from NHS and DHSC group bodies:				
Current	13,088	15,492		
Non-current	1,207	1,367		

Note 23.2 Allowances for credit losses - 2025/26

	Group & Trust
	Contract receivables and contract assets
	£000
Allowances as at 1 Apr 2025 - brought forward	**4,757**
New allowances arising	3,484
Changes in existing allowances	-
Reversals of allowances	(1,449)
Utilisation of allowances (write offs)	(3,203)
Allowances as at 31 Mar 2026	**3,589**

Note 23.3 Allowances for credit losses - 2024/25

	Group & Trust
	Contract receivables and contract assets
	£000
Allowances as at 1 Apr 2024 - as previously stated	**5,104**
Transfers by absorption	-
New allowances arising	2,676
Changes in existing allowances	-
Reversals of allowances	(567)
Utilisation of allowances (write offs)	(2,456)
Allowances as at 31 Mar 2025	**4,757**

Note 24.1 Cash and cash equivalents movements

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

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**41,751**	**42,391**	**39,001**	**37,347**
Net change in year	(5,992)	(640)	(6,021)	1,654
At 31 March	**35,759**	**41,751**	**32,980**	**39,001**
Broken down into:				
Cash at commercial banks and in hand	2,780	2,780	1	29
Cash with the Government Banking Service	32,979	38,971	32,979	38,972
Total cash and cash equivalents as in SoFP	**35,759**	**41,751**	**32,980**	**39,001**
Total cash and cash equivalents as in SoCF	**35,759**	**41,751**	**32,980**	**39,001**

Note 24.2 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 2026	31 March 2025
	£000	£000
Bank balances	-	4
Monies on deposit	-	-
Total third party assets	**-**	**4**

Note 25.1 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	57,772	58,903	58,267	59,209
Capital payables	8,996	10,533	8,996	10,533
Accruals	81,551	57,031	80,969	56,303
Social security costs	12,636	10,972	12,615	10,955
Other taxes payable	12,990	12,636	12,971	12,617
Pension contributions payable	13,544	13,589	13,544	13,589
Other payables	701	413	690	308
NHS charitable funds: trade and other payables	347	219		
Total current trade and other payables	**188,537**	**164,296**	**188,052**	**163,514**
Of which payables from NHS and DHSC group bodies:				
Current	12,544	10,462		

Note 26 Other liabilities

	Group & Trust	
	31 March 2026	31 March 2025
	£000	£000
Current		
Deferred income: contract liabilities	4,927	4,650
Total other current liabilities	**4,927**	**4,650**

Note 27.1 Borrowings

	Group & Trust	
	31 March 2026	31 March 2025
	£000	£000
Current		
Lease liabilities	13,452	9,125
Total current borrowings	**13,452**	**9,125**
Non-current		
Lease liabilities	34,653	43,101
Total non-current borrowings	**34,653**	**43,101**

Note 27.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2025	**52,226**	**52,226**
Cash movements:		
Financing cash flows - payments and receipts of principal	(25,245)	**(25,245)**
Financing cash flows - payments of interest	(158)	**(158)**
Non-cash movements:		
Additions	19,923	**19,923**
Lease liability remeasurements	1,230	**1,230**
Application of effective interest rate	158	**158**
Early terminations	(29)	**(29)**
Carrying value at 31 March 2026	**48,105**	**48,105**

Group - 2024/25	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2024	**43,807**	**43,807**
Prior period adjustment	-	**-**
Carrying value at 1 April 2024 - restated	**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**
Application of effective interest rate	3,451	**3,451**
Early terminations	(47)	**(47)**
Carrying value at 31 March 2025	**52,226**	**52,226**

Note 28.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Pay-related claims (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**1,633**	**934**	**-**	**1,247**	**9,125**	**12,939**
Change in the discount rate	(26)	(36)	-	-	(98)	**(160)**
Arising during the year	193	90	3,854	-	822	**4,959**
Utilised during the year	(215)	(73)	-	-	(534)	**(822)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	(377)	(91)	-	(1,247)	(3,244)	**(4,959)**
Unwinding of discount	34	21	-	-	82	**137**
At 31 March 2026	**1,242**	**845**	**3,854**	**-**	**6,153**	**12,094**
Expected timing of cash flows:						
- not later than one year;	211	72	3,854	-	4,946	**9,083**
- later than one year and not later than five years;	1,031	773	-	-	1,207	**3,011**
- later than five years.	-	-	-	-	-	**-**
Total	**1,242**	**845**	**3,854**	**-**	**6,153**	**12,094**

Note 28.2 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Pensions: injury benefits	Pay-related claims (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**1,633**	**934**		**1,247**	**9,075**	**12,889**
Transfers by absorption						**-**
Change in the discount rate	(26)	(36)			(98)	**(160)**
Arising during the year	193	90	3,854		822	**4,959**
Utilised during the year	(215)	(73)			(634)	**(922)**
Reversed unused	(377)	(91)		(1,247)	(3,244)	**(4,959)**
Unwinding of discount	34	21			82	**137**
At 31 March 2026	**1,242**	**845**	**3,854**	**-**	**6,003**	**11,944**
Expected timing of cash flows:						
- not later than one year;	211	70	3,854		4,796	**8,931**
- later than one year and not later than five years;	1,031	775			1,207	**3,013**
- later than five years.						**-**
Total	**1,242**	**845**	**3,854**	**-**	**6,003**	**11,944**

Note 28.3 Clinical negligence liabilities

At 31 March 2026, £503,645k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals of Leicester NHS Trust (31 March 2025: £492,905k).

Note 29 Contingent assets and liabilities

There Group and Trust had no contingent assets or liabilities at 31.3.26 or 31.3.25

Note 30 Contractual capital commitments

	Group & Trust	
	31 March 2026	**31 March 2025**
	£000	**£000**
Property, plant and equipment	21,548	16,012
Intangible assets	2,591	1,925
Total	**24,139**	**17,937**

Note 31 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 32 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	21,241	-	-	**21,241**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	34,670	-	-	**34,670**
Consolidated NHS Charitable fund financial assets	1,089	-	5,777	**6,866**
Total at 31 March 2026	**57,000**	**-**	**5,777**	**62,777**

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	-	5,393	**6,445**
Total at 31 March 2025	**65,096**	**-**	**5,393**	**70,489**

Note 32.1 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets				**-**
Other investments / financial assets				**-**
Cash and cash equivalents				**-**
Total at 31 March 2026	**-**	**-**	**-**	**-**

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				**-**
Other investments / financial assets				**-**
Cash and cash equivalents				**-**
Total at 31 March 2025	**-**	**-**	**-**	**-**

Note 32.2 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under leases	48,105	-	**48,105**
Obligations under PFI, LIFT and other service concessions	-	-	**-**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	144,942	-	**144,942**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Consolidated NHS charitable fund financial liabilities	347	-	**347**
Total at 31 March 2026	**193,394**	**-**	**193,394**

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**

Note 32.3 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care			**-**
Obligations under leases	48,105		**48,105**
Obligations under PFI, LIFT and other service concessions			**-**
Other borrowings			**-**
Trade and other payables excluding non financial liabilities	144,508		**144,508**
Other financial liabilities			**-**
Provisions under contract			**-**
Total at 31 March 2026	**192,613**	**-**	**192,613**

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**

Note 32.4 Fair values of financial assets and liabilities

The book value of financial liabilities is a reasonable approximation of fair value.

Note 32.5 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 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	158,741	132,306	157960	131882
In more than one year but not more than five years	34,653	42,163	34653	42163
In more than five years	-	938		938
Total	**193,394**	**175,407**	**192,613**	**174,983**

Note 33 Losses and special payments

	2025/26		2024/25	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Bad debts and claims abandoned	929	3,202	976	2,456
Stores losses and damage to property	1	415	-	-
Total losses	**930**	**3,617**	**976**	**2,456**
Special payments				
Ex-gratia payments	195	2,172	100	242
Special severance payments	-	-	1	10
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**195**	**2,172**	**101**	**252**
Total losses and special payments	**1,125**	**5,789**	**1,077**	**2,708**

Compensation payments received

The Trust incurred Pharmacy stores losses of £415k over the course of the 2025/26.

Note 34 Gifts

The Group and Trust made no gifts in 2025/26 (2024/25 - none)

Note 35 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the University Hospitals of Leicester NHS Trust. The Leicester Hospitals Charity is a related party of all members of the Trust Board, as the Trust Board is the Charity's corporate trustee.

MATERIAL DEPARTMENT OF HEALTH AND SOCIAL CARE ENTITIES

The Department of Health and Social Care is regarded as a related party. During the year University Hospitals of Leicester NHS Trust has had a significant number of material transactions with the DHSC and with entities for which the DHSC is regarded as Parent Department. These included:

Cambridge University Hospitals NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust

Kettering General Hospital NHS Foundation Trust

Lincolnshire Partnership NHS Foundation Trust

North West Anglia NHS Foundation Trust

Northamptonshire Healthcare NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust

Oxford Health NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust

University Hospitals Birmingham NHS Foundation Trust

University Hospitals of Derby and Burton NHS Foundation Trust

Leicestershire Partnership NHS Trust

Northampton General Hospital NHS Trust

Nottingham University Hospitals NHS Trust

United Lincolnshire Teaching Hospitals NHS Trust

University Hospitals Coventry And Warwickshire NHS Trust

NHS Leicester, Leicestershire and Rutland ICB

NHS England (statutory entity - populated by completing table of sub-entities below)

NHS Property Services

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 & Customs - VAT

contributions

NHS Pension Scheme

NHS Blood and Transplant

Leicester City Council

Lincolnshire County Council

The Trust also had significant transactions with Leicester University, mainly concerning medical research.

Note 36 Better Payment Practice code

Non-NHS Payables	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Total non-NHS trade invoices paid in the year	174,123	1,176,955	162,182	824,282
Total non-NHS trade invoices paid within target	149,728	1,087,395	139,024	761,834
Percentage of non-NHS trade invoices paid within target	86.0%	92.4%	85.7%	92.4%
NHS Payables				
Total NHS trade invoices paid in the year	3,782	113,003	1,801	67,693
Total NHS trade invoices paid within target	3,329	107,783	1,704	67,491
Percentage of NHS trade invoices paid within target	88.0%	95.4%	94.6%	99.7%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 37 Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	97,426	104,721
Less: Disposals	(560)	(213)
Less: Donated, granted and peppercorn leased capital additions	(4,128)	(8,113)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	-
Charge against Capital Resource Limit	**92,738**	**96,395**
Capital Resource Limit	93,828	96,395
Under / (over) spend against CRL	**1,090**	**-**

Note 38 Breakeven duty financial performance

	2025/26 £000
Adjusted financial performance surplus / (deficit)	(46,387)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**(46,387)**

Note 39 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £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
Cumulative breakeven position as a percentage of operating income		0.6%	0.7%	0.7%	0.7%	(4.5%)	(9.0%)	(12.6%)	(14.8%)

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000
Breakeven duty in-year financial performance	(34,455)	(44,879)	(111,368)	9,715	3,778	(12,459)	(52,831)	(37,105)	(46,387)
Breakeven duty cumulative position	(170,808)	(215,687)	(327,055)	(317,340)	(313,562)	(326,021)	(378,852)	(415,957)	(462,344)
Operating income	960,790	992,246	1,086,969	1,284,222	1,318,977	1,486,225	1,587,499	1,786,212	1,844,830
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%)	(25.1%)

Staff costs

	Group			
			2025/26	2024/25
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	918,560	-	**918,560**	878,896
Social security costs	117,631	-	**117,631**	93,270
Apprenticeship levy	4,432	-	**4,432**	4,316
Employer's contributions to NHS pension scheme	164,057	-	**164,057**	157,877
Pension cost - other	95	-	**95**	72
Temporary staff	-	4,272	**4,272**	12,603
Total gross staff costs	**1,204,775**	**4,272**	**1,209,047**	**1,147,034**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**1,204,775**	**4,272**	**1,209,047**	**1,147,034**
Of which				
Costs capitalised as part of assets	4,130	-	**4,130**	4,298

Average number of employees (WTE basis)

	Group			
			2025/26	2024/25
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	2,321	158	**2,479**	2,392
Ambulance staff	13	-	**13**	14
Administration and estates	3,067	101	**3,168**	3,178
Healthcare assistants and other support staff	3,332	69	**3,401**	3,293
Nursing, midwifery and health visiting staff	5,410	132	**5,542**	5,532
Nursing, midwifery and health visiting learners	3	-	**3**	36
Scientific, therapeutic and technical staff	1,819	23	**1,842**	1,853
Healthcare science staff	979	5	**984**	975
Total average numbers	**16,944**	**488**	**17,432**	**17,273**
Of which:				
Number of employees (WTE) engaged on capital projects	53	53	**106**	124

Reporting of compensation schemes - exit packages 2025/26

	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	-	41	**41**
£10,000 - £25,000	-	48	**48**
£25,001 - 50,000	-	15	**15**
£50,001 - £100,000	-	9	**9**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**113**	**113**
Total cost (£)	£0	£2,179,000	**£2,179,000**

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 resource cost (£)	£11,000	£10,000	**£21,000**

Exit packages: other (non-compulsory) departure payments

	2025/26		2024/25	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	107	2,018	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	6	161	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT / DHSC approval	-	-	1	10
Total	**113**	**2,179**	**1**	**10**
Of which:				
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Appendix B

Code of governance: UHL 2025/26 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		'Sustainability' section of Annual Report 2025/26
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	Y		'About Us' section of Annual Report 2025/26

Provision	Description	Comply	Explain any deviation	Comments
	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.			
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 2025/26
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	Y		Monthly Integrated Performance Report Assurance role of Board Committees including FIC and Quality Committee

Provision	Description	Comply	Explain any deviation	Comments
	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.			
A2.5	In line with principle 1.3 above (principle 1.3 = *"The board of directors should give particular attention to the Trust's role in reducing health inequalities in access, experience and outcomes."*), the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.	Y		Role of Director of Health Equality and Inclusion sitting on the Trust Board. Quarterly updates provided to Board 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	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
	organisation clinical governance matters are considered.			
A2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. ~~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		Safety Champion as part of PSIRF and ICB representation on Quality Committee. Healthwatch Chair attends Trust Board meetings at the table 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 of directors should keep engagement mechanisms under review so that they remain effective.	Y		Part of the 'Accountability Report' section of Annual Report 2025/26
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	Y		Externally-provided FTSU function sits within an independent Directorate (Corporate and Legal Affairs). The FTSU Guardian provides regular quarterly reports and an annual report to the Trust

Provision	Description	Comply	Explain any deviation	Comments
	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.			Board public session and attends for those updates. Detailed FTSU reports are also reviewed at People and Culture Committee 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 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).	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 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)		

Provision	Description	Comply	Explain any deviation	Comments
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 effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	Y		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.			
B2.6*	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: - has been an employee of the trust within the last two years - has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the Trust - has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme - has close family ties with any of the trust's advisers, directors or senior employees - holds cross-directorships or has significant links with other directors through involvement with other companies or bodies - has served on the trust board for more than six years from the date of their first appointment (but note 4.3 in Section C	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 2025/26 – the position at the medical school is recorded in the Trust Board declarations of interests report

Provision	Description	Comply	Explain any deviation	Comments
	below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval). - is an appointed representative of the trust's university medical or dental school.			
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 Executive 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 by invitation of the particular committee.	Y		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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.			
B2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	Y		Chair meets monthly with Non-Executive Director colleagues
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 2025/26
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.	Y		Reflected in the declarations of interests made by Trust Board members each year

Provision	Description	Comply	Explain any deviation	Comments
	They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.			
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	management and governance, are robust and implemented.			
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 8 times per year 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-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	Y		Remuneration and Appointments Committee

Provision	Description	Comply	Explain any deviation	Comments
	responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.			
	Board appointments: provisions applicable to both NHS Foundation Trusts and NHS Trusts			
C4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Y		Trust has a Fit and Proper Persons Policy, and relevant documentation is held centrally

Provision	Description	Comply	Explain any deviation	Comments
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 2025/26, but the information is on the Trust's external website	Annual Report 2025/26 contains a hyperlink to the detailed information on the Trust's public website https://www.uhleicester.nhs.uk/about/board/members/
C4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a 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.	Y		
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~~	Y		

Provision	Description	Comply	Explain any deviation	Comments
	~~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.			
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 their time commitment to the role, without the	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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 to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	Y		

Provision	Description	Comply	Explain any deviation	Comments
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 individual and collective development programme.	Y		
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~~	Y		

Provision	Description	Comply	Explain any deviation	Comments
	~~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.~~			
C5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	Y		
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.			
C5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	Y		
C5.12	The board should ensure that directors, especially non-executive directors, have	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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.			
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 challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	Y		
	Insurance cover			

Provision	Description	Comply	Explain any deviation	Comments
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		2025/26 Annual Accounts confirm that UHL has LTPS insurance in place
Section D	Audit, risk and internal control			
D2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	Y		
D2.2	The main roles and responsibilities of the audit committee should include:	Y		

Provision	Description	Comply	Explain any deviation	Comments
	- monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them - providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy - reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself - monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether 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 - an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Y		AGS and 'Annual Accounts' section of the Annual Report 2025/26
D2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. ~~An NHS~~	Y		

Provision	Description	Comply	Explain any deviation	Comments
	~~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.~~			
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 2025/26
D2.7*	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Y		
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	Y		'AGS' section of the Annual Report 2025/26

Provision	Description	Comply	Explain any deviation	Comments
	through the annual governance statement in the annual report.			
D2.9*	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	Y		'Going Concern' section of the Annual Report 2025/26
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	Y		

Provision	Description	Comply	Explain any deviation	Comments
	should be relevant, stretching and designed to match the long-term interests of the public and patients. - Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. - Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. ~~- 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		
E2.3*	Where a trust releases an executive director, eg to serve as a non-executive	Y (in the event		

Provision	Description	Comply	Explain any deviation	Comments
	director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	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 whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	Y		
E2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum	Y		

Provision	Description	Comply	Explain any deviation	Comments
	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.			
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 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.	Y		

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.

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.

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.

Information Management and Technology (IM&T)/Digital and Data refers to the use of information held by the Trust, in particular computerised information and the department that manages those services.

Integrated Care Board is a statutory NHS organisation responsible for managing the local NHS budget, planning health services, and commissioning care for a specific local population.

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.

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.

People Services 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.

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.

Speaking Up is the act of informing a relevant person in an organisation of instances or services in which patients are at risk.

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.

If you would like this information in another language or format such as EasyRead or Braille, please telephone **0116 250 2959** or email **uhl-tr.equalitymailbox@nhs.net**

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।

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All information is accurate at time of publishing (September 2026).

Leading in healthcare,
trusted in communities