NHS

University Hospitals of Leicester

NHS Trust

Annual Report & Accounts 2022-23

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University Hospitals of Leicester NHS Trust

Annual Report 2022/23

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

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PART 1: Performance Report *(continued)*

Overview of performance: *Statement from the Chair and Chief Executive*

I will remember 2022-23 at the University Hospitals of Leicester NHS Trust for three reasons; increased stability, sustained performance improvements and the improvements we will make in the future.

I have worked in the NHS for 22 years and most of those years I have not been an executive director or certainly not a Chief Executive. I am aware that much of what an executive team or Trust Board does, does not directly impact on the provision of patient care. However, I do believe stable executive teams can provide strong foundations for high performing teams. UHL, like much of the NHS, has been through a difficult time and in Leicester we have had some uniquely challenging circumstances. We now have a stable executive and senior leadership team. Ten substantive executive directors joined UHL in the last 15 months, with the last director, Michelle Smith, Director of Communication and Engagement joining in October 2022. We have also recruited to other long standing vacant senior roles. Our senior leadership team is more diverse than it was, and we also have three General Practitioners in our Trust Leadership Team. The world remains a difficult and often chaotic place and many colleagues at UHL have family and friends affected by the Russia-Ukraine war and the conflicts in Sudan. As senior leaders we need to focus on creating a culture where colleagues feel listened to and safe at work. We need to make it easier for people to do the right thing and I believe having a stable leadership team is an important first step.

We have undoubtedly delivered sustained performance improvements despite the impact of Covid, prolonged winter pressures and industrial action. In the final quarter of the year, ambulance handovers, which have been a long-standing challenge at UHL, dramatically reduced. This means ambulance crews can get out back into the community more quickly. Under the leadership of Jon Melbourne, Chief Operating Officer, maximum waiting times for planned, diagnostics and cancer care reduced and we now have fewer patients waiting for care than 12 months ago. Waiting times are an important indicator of overall quality, safety and patient experience and we have taken many actions in 2022/23 to improve patient care. Julie Hogg, Chief Nurse, and Andrew Furlong, Medical Director, and their teams are working closely and effectively together. As stated in last year's annual report, there are many great people who choose to work at UHL and our colleagues are our greatest asset. Clare Teeney, Chief People Officer, and team have begun to make improvements to the way we recruit and retain colleagues and some of the work we are doing with our networks is already making a difference. Having our highest ever response to the national staff survey this year, which was higher than the national average for the first time, was an important improvement. We remain in financial special measures because of challenges with financial discipline, performance and governance but our financial performance is much better than the past and we delivered our agreed year end financial position. I am grateful for the work that Lorraine Hooper and team have done from a difficult starting point. Finally, we are proud we provide care to patients from Leicester, Leicestershire, Rutland and across the East Midlands. Leicester is one of the most diverse cities in the UK and the first plural city, where there is no ethnic majority. We are taking steps to ensure our leadership team more accurately reflects the diversity of our workforce and patients and if we could only be known for one thing, we would want it to be our work with partner organisations and groups on health equity and inclusion. This is led by Ruw Abeyratne, Director of Health Equity and Inclusion. Ruw and colleagues are working closely with a range of health, local authority, voluntary and charitable partners to improve access to our services and the quality of the services.

Whilst we have made progress, the list of things to improve is longer than what we have achieved over the last year. Waits for care remain longer than pre Covid and they had deteriorated rapidly in the five years before Covid. Some patients do not receive safe high quality of care and we want to improve care

for all who use our services. The experience of working at UHL is still far too variable. The NHS staff survey has run for eight years and UHL has always ranked below the national advert for place to work and place to receive care. Whilst the experience of working here is so variable, we will not be able to make as much progress as we want on patient care. As stated above, we remain in financial special measures, and we want to further improve the productivity of our services. Our finances need to be an enabler for wider improvements in patient care.

We have a huge amount to do but I am proud to work here. In most respects, last year was better than 2021-22 and we believe 2023-24 will be better still. We have made sustained improvements to patient care, research and education and we are excited about our future.

Richard Mitchell
Chief Executive,

UHL NHS Trust

29 August 2023

John MacDonald
Trust Chair

29 August 2023

PART 1: Performance Report *(continued)*

Overview of performance: *About us*

Welcome to our 2022/23 Annual Report which describes our achievements during the year, how we are governed, our finances, and performance in key areas. Our Quality Account, which is published on our website: www.leicestershospitals.co.uk provides a more in-depth report on how we are continuously improving quality, safety, and patient experience in our hospitals.

Purpose of the overview section

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

Our history and structure

UHL NHS Trust was established on 1st April 2000, from a merger of 3 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 a number of 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
- 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
- Information Management and Technology
- Corporate and Legal Affairs
- Reconfiguration, strategy, transformation

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

Our Strategy

The coverage period of the current University Hospitals of Leicester Strategy (Becoming The Best, Our Quality Strategy) ended in December 2022. The 2019-2022 Becoming The Best Strategy was underpinned by six core elements, including:

- Understanding what is happening in our services
- Giving people the skills to enable improvement

- The right kind of leadership
- Embedding an empowered culture of high-quality care
- Working effectively with the wider system
- Clear priorities and plans for improvement

The six core elements were established to support the organisation deliver 'Caring at its Best' for every patient. The objectives of the Becoming The Best strategy focused on creating and embedding a culture of high-quality care provision. Through empowering as well as supporting our leaders with change management and Quality Improvement methodologies, adoption/dissemination of the best practice required to deliver high quality care was actively encouraged during the coverage of the current Strategy. Becoming the Best and the associated values guided the organisation (and those who work at UHL) through the response to COVID-19 and subsequent recovery of key planned care services. Prior to the COVID-19 pandemic, improvements were seen across patient satisfaction scores as well as reductions in waiting times for planned care services (including cancer).

In October 2022, University Hospitals of Leicester initiated the process of setting the vision, strategic goals & objectives for the next five years. To support this process, an external partner (Clever Together) that specialised in large scale engagement was identified. Between January and March 2023, individuals that work in and with University Hospitals of Leicester (alongside our patients) were engaged to gain their views on what the new strategic goals, objectives and values/behaviours should be. More than 15% of UHL colleagues (more than 3, 000 people) contributed to online conversations, broadly representative of the wider organisation by job role, age, ethnicity and other key factors.
Around 20% of invited external partners (more than 100 people) joined the conversation to answer challenge questions about UHL's purpose, vision and goals.

The feedback gained during the engagement exercise will be analysed and form the basis of the new organisational Strategy (to be launched in September 2023).

Investment in Sustainable Estate and Reconfiguration

UHL has a long tradition of supporting the health of people living in Leicester, Leicestershire, Rutland and beyond. From the establishment of the Infirmary in 1771, to the present day, our hospitals have been central to the lives of virtually every household in Leicester, Leicestershire and Rutland.

But people's healthcare needs are changing. The local population is growing, people are living longer, care is becoming more complex and costly, and long term conditions such as obesity, diabetes and coronary obstructive pulmonary disease (COPD) care more prevalent.

To meet those needs, and to do so with compassion, dignity and efficiency, we need to deliver the care that people need in new, better and different ways, including a strong focus on innovation, technology and research. We're re-organising care in our hospitals through investment in modern facilities, state of the art equipment and skilled staff to truly create a service that supports Leicester, Leicestershire and Rutland people from cradle to grave whenever and however they need us. The Reconfiguration Programme will meet these needs in the following ways:

- Improve the balance between demand and capacity, providing patients with better access to the care they need
- Improve much of the built environment for patients and colleagues, with new hospitals and facilities on all three sites
- Reduce duplication or triplication of maternity and acute services across the three sites ensuring that skilled clinical colleagues, notably in specialties where there are national shortages, are focused on particular sites providing safer care
- Help the more efficient use of financial resources to provide better value care

Working as a System and key Partnerships

A 2022 UK Government White Paper (*Health and social care integration: joining up care for people, places and populations*) outlined the importance of all Health & Social care partners collaborating to address the fundamental challenges/capitalising on the opportunities posed by:

- Increases to life expectancy,
- Technological and medical advancements,
- Growth in long-term (treatable) conditions,
- The ability to recruit and retain a skilled workforce,

University Hospitals of Leicester are committed to working with all partners within the Leicester, Leicestershire, and Rutland (LLR) Integrated Care System (ICS). Throughout 2022/23, the LLR ICS has focused on developing the infrastructure necessary to enable partnership working at scale (for the benefits of our population). The structure of the emerging ICS will be characterised by three tiers: Neighbourhood, Place and System. The System level will be responsible for setting the priorities for the entire Health and Social Care economy. This tier will be directed by the newly formed Integrated Care Board, with University Hospitals of Leicester being a key member of this forum. LLR will be supported by three regions identified as LLR's Places: Rutland, Leicestershire, and Leicester. The presence of three places will enable providers of Health and Social care services to work together to identify how they can re-shape existing services (to meet the unique needs of the local population). At the Neighbourhood level, 26 Primary Care Networks work with local councils and voluntary sector partners to support those with Long Term Conditions access the services necessary to live independent and healthy lives. Throughout 2022/2023, University Hospitals of Leicester supported pilots with several Primary Care Networks in Leicester and Leicestershire to provide expert Respiratory Care for those vulnerable to winter exacerbation (with the aim of preventing potential emergency hospital provision). Initial evidence suggests that the approach of bringing expertise from Place to the Neighbourhood reduced the need for acute hospital treatment by 15% (in the supported cohort).

2022/23 saw University Hospitals of Leicester take the first steps into providing care beyond the traditional boundaries of the organisation. To support the LLR Integrated Care System identify how best to reduce the challenges associated with timely discharge, UHL provided care in the community for patients not able to return to their place of residence, but no longer requiring hospital treatment. University Hospitals of Leicester Staff provided this service from Ashton Care Home located in Hinckley, Leicestershire. Evaluation of this intervention has highlighted that the same organisation providing both acute hospital and immediate step-down care provided many benefits. These benefits included early identification and transfer of patients suitable for step down care as well as a reduction in the number of patients experiencing delays in their discharge from all forms of care. This positive experience provides the basis for UHL to provide further support to the Integrated Care System in 2023/24.

Working With Communities and Local Partners

Colleagues at UHL recognise the importance of proactive patient and public involvement in service improvement and redesign. We actively engaged with several local voluntary and community groups to develop relationships, restore trust and move towards co-designing solutions to inequalities in our services. Key partners over the past 12 months have included South Asian Health Action (SAHA), Shama Women's Centre, the African Caribbean Centre, The Centre Project and the Somali Women's Mosque.
Senior UHL leaders and leaders from local communities and voluntary groups convened on several occasions to discuss barriers to access, community links and relationships. Further several focus groups were held with communities to explore barriers to accessing services, attitudes to cancer screening and experiences of working at UHL. The feedback from these events has informed several of the projects in the programme of work and will continue to influence work to address inequalities going in to 2023-24.

Working with Health and Care Partners

UHL is clear that all of the work undertaken to address health inequalities has to have a whole system approach to enable sustained change across pathways. UHL has worked closely with colleagues from the Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS) to ensure this. For example, working with the Centre Project, UHL and LLR ICS colleagues established a programme of work focused on raising awareness of cancer screening, health promotion and improved health literacy for our most deprived inner-city population. This work will continue into 23-24 and will provide a blueprint for future collaboration.
UHL regularly attended the Health and Wellbeing Boards across LLR through 2022-23 and has led a vital piece of work commissioned by Leicester City Health and Wellbeing Board to determine what actions have been taken to address disproportionately high maternal mortality rates and poor outcomes for Black and Asian women across LLR. The final report will be published in Autumn 2023.

Key Developments

East Midlands Planned Care Centre

During 2022/23 we started to develop plans for our new East Midlands Planned Care Centre at the Leicester General Hospital; a multi-million pound investment to improve care and reduce waiting lists for the people of Leicester and beyond. When the Centre is fully open in late 2024, approximately 100,000 patients will be seen each year.

The first phase opened in late May 2023, providing two operating theatres which will treat an additional 1479 patients in the first year (2023/24). Phase Two is already well underway and will consist of 14 outpatient rooms, 4 clean rooms and a surgical day case facility, together with two 18-bedded wards dedicated to elective day case / 23-hour surgical activity as well as medical day cases.

Interim Intensive Care Unit (ICU) and Associated Services

In August 2021, the ICU Project completed the biggest and most complex service move in UHL's history. The move was a key building block towards the consolidation of our acute sites, which will bring significant clinical benefits for patients who are dependent on those beds i.e. Renal, Transplant, Hepatobiliary (HPB) and General Surgery. During the past 18 months we have seen the benefits of this move including:

- The rate of 'on the day cancellation' of operations due to lack of ICU bed availability has almost halved, from 12.2% in 2019/20 to 6.2% in 2022/23
- An 11-bed extension to ICU at GH, providing a well-planned space in which to deliver care, with space for patient rehabilitation and specialist kit for renal treatment.
- The development of 3 new wards at GH to support the transfer of HBP and Renal Transplant services from LGH.
- The move of Renal beds from the LGH to GH to be located at GH with the Renal Transplant service.
- New facilities to provide enhanced care for patients undergoing elective surgery, who require extra monitoring, and those stepping down from ICU care, in a refurbished specialist environment to aid recovery.
- The expansion of the Interventional Radiology service at GH, which now includes 3 new radiology rooms, support accommodation, patient recovery areas and refurbished waiting areas and new ultrasound rooms.
- Infection prevention facilities have been improved by the refurbishment of 3 wards at the LRI to support the move of colorectal and emergency general surgery services from LGH
- A new 24-hour outreach service at the LGH site to support patient care on that site.
- A new theatre arrivals area at the LGH, improving facilities and the patient experience within the day case service

Safe Staffing (Nursing and Midwifery) 2022/2023

In 2022, a new Lead Nurse for Safe Staffing, Pippa Clark and Midwifery Matron for Safe Staffing, Lorna Phillips-Gray were appointed at UHL to lead on compliance with national safe staffing recommendations set out by the National Quality Board (2016) and NHS Improvement (2018). We declared partial compliance with these in the 022 annual safer staffing report

The recommendations within the UHL Safer Staffing Nursing Bi-Annual Establishment Review in November 2022, included an increase of 248.66 full time equivalent nurses across 97 ward-based establishments over a three-year period, due to conclude in 2025/26 to support substantive recruitment and ongoing assessment of acuity and dependency.

Safe Staffing continues to be a priority for UHL, ensuring 'the right people, with the right skills are in the right place at the right time' (National Quality Board, 2016).

The first Associate Chief Allied Health Professional (AHP) for UHL was appointed in 2023 to support and develop the professional leadership of AHPs across UHL and the Alliance Community Hospitals (part of UHL).

Operational Performance

The Trust measures a range of key performance indicators ('KPIs') in order to ensure the services it provides to patients are the best they possibly can be. These are reported to Board Assurance Committees, and to the Trust Board each month.

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

Performance Against National Standards					
Performance Indicator	**Target**	**2022/23**	**2021/22**	**2020/21**	**Trend**
A&E (UHL) - Total time in A&E (4hr wait)	95%	54.6%	59.4%	73.1%	▼
A&E (UHL+ LLR UCC) - Total time in A&E (4hr wait)	95%	68.9%	70.3%	81.1%	▼
12 hour trolley waits in A&E	0	11,916	3,836	32	▼
MRSA (All)	0	4	1	1	▼
Clostridium Difficile	91	119	116	78	▼
% of all Adults who have had VTE Risk Assessment on admission to hospital	95%	97.8%	98.4%	98.6%	▼
Never Events	0	8	9	7	▲
SHMI mortality	≤100	104	103	101	▼
Urgent operations cancelled twice (UHL+Alliance)	0	10	8	8	▼
Operations cancelled for non-clinical reasons on or after the day of admission	1.0%	1.4%	1.7%	0.9%	▲
RTT - Incompletes 92% in 18 weeks	92%	50.0%	48.0%	51.1%	▲
RTT 52 weeks+ wait (incompletes)	0	12,433	15,994	12,625	▲
Diagnostic test waiting times	1.0%	51.1%	43.6%	35.9%	▼
Cancer: 2 week wait from referral to date first seen - All Cancers	93%	84.1%	75.9%	92.3%	▲
Cancer: 2 week wait from referral to date first seen - For symptomatic breast patients	93%	93.0%	48.7%	95.4%	▲
All Cancers: 31 day wait from diagnosis to first treatment	96%	81.8%	83.0%	91.1%	▼
All Cancers: 31 day for second or subsequent treatment - Anti cancer drug treatments	98%	93.3%	98.3%	99.6%	▼
All Cancers: 31 day for second or subsequent treatment - Surgery	94%	64.9%	64.7%	71.7%	▲
All Cancers: 31 day for second or subsequent treatment - Radiotherapy treatments	94%	56.5%	88.6%	93.4%	▼
All Cancers: 62 day wait for first treatment from urgent GP referral	85%	42.7%	51.3%	68.5%	▼
All Cancers: 62 day wait for first treatment from consultant screening service referral	90%	60.3%	55.6%	63.9%	▲

▲ 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**)

Performance deteriorated across many areas as a consequence of the pandemic. The following sections detail actions taken to address this.

PART 1: Performance Report *(continued)*

Quality

Safety and quality priorities

Our safety and quality priorities for 2022/23 are listed below. These priorities were identified in collaboration with members of the public, staff, the Trust Board and key stakeholders. We take pride in using patient and service user feedback to support the quality improvements we wish to focus on. We also worked with clinicians who made recommendations to the Trust Board in order to develop our priorities.

Our 2022/23 quality priorities focused on:

- Ward accreditation
- Safe surgery and procedures
- Improved cancer pathways
- Streamlined emergency care
- Better care pathways

Our quality priorities are enabled by:

- Estates investment and reconfiguration
- People strategy implementation
- Quality strategy Implementation
- E- hospital programme
- Embedded research, training and education
- Embed innovation in recovery and renewal

Progress against Safety and Quality priorities

Progress against the Trust's safety & quality improvements for 2022/23 was as follows:

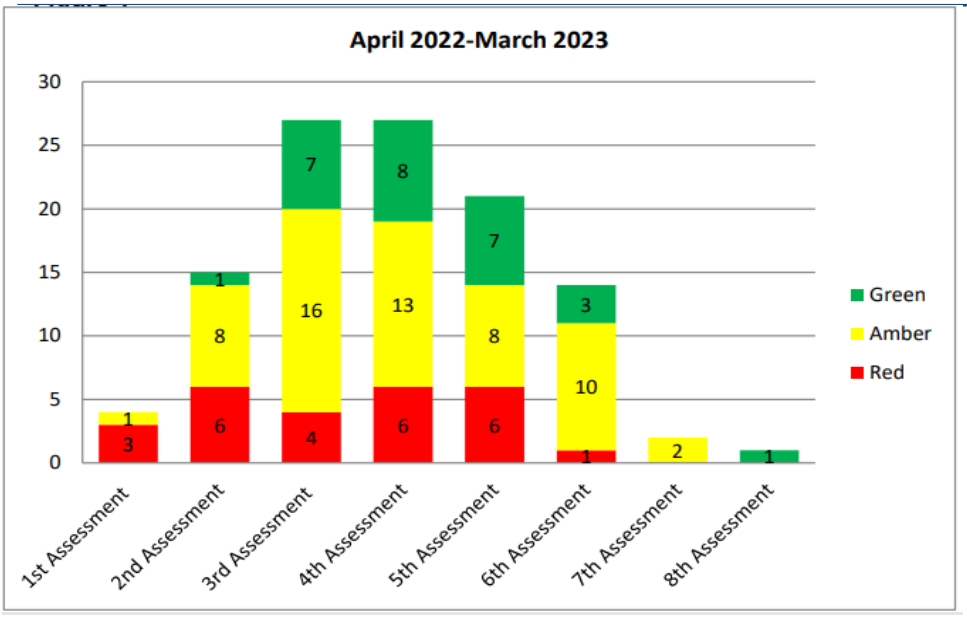
Priority: Ward Accreditation

The Ward Assessment and Accreditation programme was launched in 2019 to ensure that patients are receiving safe, high-quality nursing and midwifery care. It provides nursing and midwifery teams with a set of agreed standards and quality indicators to consistently achieve, thereby supporting a continuous quality improvement programme. The aim of the accreditation process is to work towards achieving 'Blue ward' status.

The framework is designed around 15 standards that align to the Care Quality commissions essential standards. Each ward is assessed against of the individual standards and given a red, amber, or green rating (RAG) rating. When combined, an overall ward rating is produced. For a ward to be recommended for consideration to a panel for *'Blue ward Status'* they must have achieved green status on three consecutive occasions thus demonstrating sustainability and consistency in delivering high standards of care.

Key Achievements

During 2022/23 111 assessments were completed – the breakdown of these assessments is as shown below:



At the end of 2022/23 there were five wards across the organization that had been awarded blue status.

What our Ward Leaders/Matrons say about Assessment and Accreditation:

- *"It has made me feel proud but also more determined to focus on the one thing that our patients need and deserve, and that is quality nursing care."*
- *"Assessment & Accreditation is an immense way of benchmarking practice. It is vital in evaluating performance and engages the nursing team during the process. It benefits not only nursing care but also the clinical environment. I am a great advocate for the process and have always felt* very *supported by the Assessment and Accreditation Matrons."*
- *"It highlights the areas of care and management that require more attention and at the same time emphasises good practice and effective leadership."*
- *"I believe Assessment & Accreditation is an excellent tool to correctly assess the standards of care we provide, not only for the nursing team but the wider multi-professional teams. As a ward leader it allowed me to personally re-shape my management style and I believe the change it has created has had a positive effect on team engagement."*
- *"Assessment & Accreditation encourages ward leaders to look outside of their own specialities and network with their peers to share best practice which harnesses greater creativity in the delivery of care."*

Moving forward

Despite positive comments being shared about Assessment and Accreditation it has been recognised that the approach needs modernising so in 2023-2024 we are developing the accreditation system further with a new UHL accreditation system based on a model used at University College London Hospitals NHS FT. The new system will combine an in-depth interactive quality management dashboard, an accreditation system and a continuous quality improvement process.

Priority: Safe Surgery and Procedures

Safe Surgery Quality Assurance Programme

The Safe Surgery team aims to improve safety for patients at UHL through helping teams to identify areas for potential improvement, working with other safety teams to understand why Never Events have occurred, and ensure patient safety always remains core to any procedures we carry out at UHL.

We aim to achieve no never events, however the current approach to root-cause-analysis does not allow teams to identify and tackle system problems easily, which results in re-occurrence of similar events. The need to move a system wide analysis method has been recognised by NHS England, with the adoption of the Patient Safety Incident Response Framework (PSIRF). Setting targets at this point would not help to achieve better safety but working with team to implement PSIRF will enable us to tackle never-events in a more effective manner.

There has been 8 Never Events at UHL in the last 12 months, similar to previous years. Over the next year, the team will use the new NHS Patient Safety Incident Response Framework to develop new process to reduce the number of Never Events. The team aims to bring more patient engagement into the programme and better understand how patients could help improve safety.

The Safe Surgery Quality Assurance Programme has engaged with 13 different specialist areas within UHL where procedures are carried out regularly. There are over 64 safe surgery champions across UHL, and the teams have developed 37 local procedure checklists to improve safety for patients at UHL when undergoing invasive procedures.

The safe surgery team is overseeing the roll of digital consent across UHL. Digital consent forms gives patients more time to make informed decisions, and allows more personalised information to be given. The feedbacks from patients have been overwhelmingly positive, but team is working to ensure patients who aren't as digital engaged aren't excluded from the benefits of digital pathways.

The Safe Surgery Team will work the patient safety team at the trust to develop Patient Safety Incident Response Framework (PSRIF) approach to never event investigations, aiming to reduce future never events through system redesign and where possible patient empowerment.

Priority: Improved Cancer Pathways

Cancer Care:

In 2022/23 we have continued to drive improvements in our cancer pathways to meet the increasing demand which we are facing, and to improve the experiences and outcomes of our patients and carers. Improvements which we have put in place include:

- Within urology we have invested in our clinical workforce and expanded our prostate template biopsy service to ensure patients can now have rapid access if this is needed
- Within colorectal we have worked with our colleagues in primary care to ensure that from 1st January 2023, patients are now referred with the correct filter test before they are seen. At the same time we have launched our Non Site Specific Symptoms pathway which has already exceeded expected demand
- Within skin we have rolled out the use of AI to help assess digital images of patient skin conditions as a first line option within our 2 week wait pathway. This has now been rolled out to both City and County sites and we have now further invested in our consultant led follow up capacity to ensure that patients have access to faster diagnosis.
- Our patient personalised stratified follow up service has been adopted by more tumour sites which helps provide a more individual care plan for each patient

- We have implemented more clinical reviews within our tumour sites to help reassure patients with a suspicion of cancer that they are cancer free
- We have implemented more nurse led clinics for patients after they have been discussed at multidisciplinary team meeting in order to provide more access to timely results and to increase clinic capacity
- We have replaced our existing surgical robot at our Leicester General Hospital site, with plans in place to introduce a second surgical robot, this time at the Royal Infirmary
- With the support of partners, including East Midlands Cancer Alliance we have invested in our cancer services for the population of Leicester, Leicestershire & Rutland and we are particularly proud of giving every patient diagnosed with cancer the opportunity to have a personalised care plan developed with their Cancer Nurse Specialist

We have made progress in 2022/23, and we exited the year with fewer people waiting longer for treatment than when at the start of the year. Yet we also know that we must do more in 2023/24 and beyond to reduce our cancer waiting times and further improve the experience of patients who come to UHL for their diagnosis and treatment, and we have ambitious plans for the year ahead.

Priority: Streamlined Emergency Care

We have made significant improvements in our emergency care pathway during 2022/23 and continue to work with partners across Leicester, Leicestershire and Ruland to improve pathways of care, with initiatives including:

- An increase in Same Day Emergency Care Services at the LRI and development of a unit at the GH
- Opening a pre-transfer unit for patients awaiting admission or transfer to our other sites
- An increase in Urgent Treatment Capacity in 3 centres – resulting in an ability to redirect patients as appropriate and a reduction in overcrowding for patients in our emergency department.
- Opening rehabilitation capacity at the LGH and step down capacity in Hinckley
- Opening an escalation unit to prevent patients waiting on ambulances

During 2022 we were challenged through the year with 'ambulance handover times' – our ability to take patients from ambulances and into our emergency department – due to challenges of capacity and patient flow in our services. The initiatives which we have put in place has allowed us to see a significant improvement in ambulance handover times – with a reduction of over 85% in delays when comparing January-March 2023 to April-December 2022.

There is however a need to further improve our UEC performance. We failed to meet the Emergency Department 4-hour standard in 2022/23, with performance of 54.6% (type 1 and 2) and 68.9% (type 1-3 across LLR) against a target of 95%. Emergency Department attendances (type 1 and 2) was very similar to 2021/22. 12-hour trolley waits saw an increase from 0 in April 2021 to 906 in March 2022 and to 1,155 in March 2023 as a consequence of the increased pressures in our UEC pathways, and capacity and flow challenges meaning patients often waited for a bed in ED much longer than we would have liked.

Our strategy for improving emergency care performance remains focussed on ensuring patients receive the right care in the right place at all times. 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 2023/24 we will:

1. Build additional bedded capacity at the GH
2. Expand our discharge lounge at the LRI doubling the current capacity for bedded patients
3. Improve our discharge processes building on the improvement we have seen this year
4. Implement and embed digital solutions such as e-beds – a more efficient bed management system
5. Continue to work with our partners on all aspects of UEC including improving access to Urgent Treatment Centres

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

Our Emergency Preparedness, Resilience & Response (EPRR) Team have continued to make progress against NHS England's Core Standards for EPRR, through the development of plans, training and exercising events with multi-agency partners across Leicester, Leicestershire and Rutland. In addition, the EPRR Team also supports the Trust in preparing for the national COVID-19 Inquiry through the development of a series of Investigation Reports, all while supporting the Trust in preparing for and responding to a series of Industrial Action events.

Implementation of Ambulance Handover Facility and Transfer Unit

As part of our urgent and emergency care improvement plan, we opened two facilities which have made a significant difference to our ambulance handover times:

- **The 'transfer unit'**: We opened a new 12-bed unit directly outside the emergency department at Leicester Royal Infirmary for patients awaiting transfer to a ward at one of our sites or another hospital. When a patient enters the care of the pre-transfer unit team, it enables the emergency department to accommodate another patient who requires a bed.
- **The 'handover facility'**; A dedicated medical unit (also outside our emergency department) allowed us to take patients from ambulances at times of significant pressure, giving us the ability to manage variation in patient flow across the day.

Since the opening of the facility the Trust has seen a significant reduction in our ambulance handover times; allowing vehicles to be released back onto the road much more quickly – with a reduction on hours lost to ambulance handover delays of over 85% since the units have opened.

Implementation of Minor Injuries & Minor Illness Unit

Patient demand in UHL's Emergency Department for both children and adults saw a significant rise post-pandemic, including a significant increase in patients requiring urgent treatment services. The Minor Injuries and Minor Illness Unit (MIaMI) was opened in April 2022 to help manage this demand. It is staffed by a multi-disciplinary team alongside UHL GPs. This service aims to treat patients who are appropriately identified by the clinical teams at the front door that can be see treated and discharged in a timely way.

Priority: Better Care Pathways

Planned Care

The elective waiting list grew by 65,000 (87%) in first two years of Covid which was the largest proportional increase in the NHS. UHL has one of the largest waiting lists in the NHS. However we are starting to make progress in reducing our waiting list and time time it take to receive treatment at UHL.

Since March 2022, we have treated over 50,000 people who would have otherwise been waiting over 78 weeks by March 2023 for their care, and over 18,000 who would have otherwise been waiting 2 years for their care. Our waiting list has decreased over the year (March 2022-March 2023) for the first time in four years – standing at 114,795.

During 2022, UHL had one of the highest numbers of 2 year waiters in the NHS, yet by March 2023, UHL was no longer in the top 25 Trusts with the highest number of 2 year waiters with a clear plan to zero by June 2023.

Key achievements throughout the year included:

- Securing additional theatre capacity by installing a mobile theatre suite at the Leicester Glenfield site
- Strengthening the existing relationships with the Independent Sector and other organisations across the region to support with additional capacity
- Partnering with the National Getting it Right First Time (GIRFT) team to support theatre productivity work, learning from national best practice.
- Securing investment to establish the East Midlands Planned Care Centre - increasing elective capacity

Whilst improvement in the numbers of patients waiting the longest for planned care has improved significantly, there is a still a lot of improvement ensure we accelerate our waiting list reductions – including achieving the target have no patients waiting more than 65 weeks for their care by March 2024 and no one waiting more than 52 weeks by March 2025.

The key tenants of the operational plan for planned care falls into three key themes; improving productivity (making our processes as efficient as possible), increasing capacity (ensuring we have the right services and facilities in place) and partnership (building strong links with our partners). Productivity in particular will be a significant focus in 23/24, with plans including:

- The launch of our new Outpatient strategy
- Work to reduce the 'Did not attend' (DNA) and cancellation rates
- Significantly improving the utilisation of our theatres
- Increasing the number of patients operated on as a daycase
- Increasing the number of patients on Patient Initiated follow-ups (PIFU) - giving patients and their carers the flexibility to arrange their follow-up appointments as and when they need them

Diagnostics

We have seen significant improvement in our diagnostic waiting list in 22/23, particularly in January-March 2023. Reducing our longest waiters (13+ weeks) by 40% when compared to October 2022. This was despite known national and local workforce shortages and increased pressure from cancer and emergency pathways.

Key achievements throughout the year included:

- 3 additional mobile MRI scanners in place (April / July / November)
- 2 mobile CT scanners in place (April / November)
- 1 additional DEXA scanner in place (May)
- Increased primary care provision for non-obstetric ultrasound and ECHO
- Improved system and cross-specialty led working

Nationally the expectation in 22/23 was for organisations to deliver 120% of 19/20 activity levels. Comparing the total DM01 activity for 22/23 to the total for 19/20, UHL delivered 124% of 19/20 levels. However, the 6-week standard was not met in any month and remains a significant challenge. Performance as of December 2022 was 57% of patients waiting over 6 weeks, and while this improved to 44% by the end of March 2023, we recognise that there is more that we need to do to decrease the waiting time for diagnostic services.

We continue to work with partners across Leicester, Leicestershire and Ruland with initiatives including:

- Development of a stand-alone Endoscopy Unit at the Leicester General Hospital
- The expansion of community diagnostic capacity (Leicester General Hospital and Hinckley Hospital)
- Extending the diagnostic offer at Primary Care Network level
- Reviewing protocols, increasing productivity and making best use of technology.

Our strategy for improving diagnostic performance remains aligned to the overall planned care strategy focusing on process, productivity and partnership.

Use of Digital to support improvements in waiting times and communication – Accurx

With a significant waiting list challenge post-pandemic as well as a need to improve communication with patients about their appointments, UHL has commenced two-way texting functionality used for communications such as reminding people about their appointments. The response rate from patients have been 76%. If patients can't respond via SMS, they can respond on a computer, iPad, or tablet. If a patient does not respond, their appointment/place on the waiting list will remain in place.

Ashton Care Home Facility

In 22/23, UHL commissioned a facility at the Ashton Care Home in Hinkley in response to the high number of patients who are delayed in hospital who are medically optimised for discharge. The model of care at Ashton has the patient at the centre and addresses their needs with support and reablement providing a home first principle of care whilst the patient is awaiting their formal discharge to assess process or package of care. UHL at Ashton is integrated into Trust governance, the nursing care is provided by Registered Nurses and Health Care Assistants who are employed by UHL, as well as significant input from Therapists to ensure patients receive the right care and support for their reablement and we work with local partners who provide a GP model of care for patients. The data collected to monitor patient outcomes demonstrates that there is robust input to provide reablement for patients; those with an improved outcome have been discharged to their own homes with packages of care.

CQUINS

The CQUIN design criteria has been retained this year. As per National guidance, following an approval of a national variation, a blocked financial arrangement for the 22/23 CQUIN schemes was agreed. The CQUIN financial incentive (1.25% as a proportion of the fixed element of payment) was earnable on the five most important indicators for each contract and in 2022-23 it was greed CQUIN would be fully funded . We are required to report performance against all CQUINS which fell within our scope to do so.

The nine CQUINS in the 2022/23 Integrated Care Board (ICB) scheme and end of year performance is shown in the table below:

PART 1: Performance Report *(continued)*

Table 20 CQUINS -2022-23 Integrated Care Board

CQUIN Indicator	Indicator description	End of year performance	Comments/Actions
CCG1: Flu vaccinations for frontline healthcare workers	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact	45.33% end of Q3	Flu Vaccine uptake Frontline 45.33% Other 48.32% **Overall** as of 31/01/23 **46.10%**
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	Achieving 40%-60% of all antibiotic prescriptions for UTI in patients aged 16+ that meet NICE guidance for diagnosis and treatment	35% end of Q3	Awaiting end of year data
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care.	Achieving 20-60% of all unplanned ITU admissions from non-critical care wards having a NEWS2 score, time of escalation and time of critical response.	89%	CQUIN has been fully met
CCG4: Compliance with timed diagnostic pathways for cancer services	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways.	**Non-Submission**	The Cancer Centre has deferred collecting data until the next version of Somerset due to be released in Spring '23 (v22.2), with the functionality to provide this data. This CQUIN will continue in 23-24 and data will be able to be collected at that time. The latest upgrade of the system has now given the Trust the ability to report on these metrics. Additional staff are being recruited in order to support the greater level of reporting
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle	Achieving 45%-70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle	**57%**	This CQUIN Has been partially achieved
CCG6:Anaemia screening and treatment for all patient undergoing major elective surgery	Ensuring that 45%-60% of major elective blood loss surgery patients are treated in line with NICE guidance NG24	**86%**	CQUIN has been fully met
CCG7:Timely communication of changes to medicines to community pharmacists via the discharge medicines service	Achieving 1.5% of acute trusts inpatients having changes to medicines communicated with the patient's chosen pharmacy within 48hrs following discharge	**1.3%**	This CQUIN Has been partially achieved
CCG8: Supporting patients to drink, eat and mobilise after surgery	Ensuring 70% of all surgical inpatients are supported to drink, eat and mobilise with 24hrs of surgery ending.	**80%**	This CQUIN has been fully Met. This CQUIN will continue in 23-24 with increased threshold and the scope has been widened

NHSE/I Specialised CQUIN indicators relevant to the Trust and our current performance against include:

Table 21 CQUINS 2022-23 NHSE/I

CQUIN Indicator	Indicator description	End of year Performance	Comments Actions
PSS1: Achievement of standards for lower limb Revascularisation	To reduce delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia. 40%-60% patients that have a diagnosis of chronic limb threatening ischaemia (CLTI) that undergo revascularisation (improve blood supply to prevent leg amputation) either open, endovascular, or combined within 5 days of a nonelective admission	40%	The lower threshold has been met a continue as a CQUIN in 23-24
PSS2 Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	The level of Pt. satisfaction with shared decision-making conversations – as measured by patient scores on internationally validated Pt. questionnaires, 65-75%	91.5 %	This CQUIN is fully met and will contin CQUIN in 23-24
PSS3 Achieving Progress towards Hepatitis C elimination	Co-Ordination of ODNs to work towards Hepatitis C elimination	**77%**	Achieved to date.
PSS5 Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical pathways.	The aim of this indicator is to reduce the risks of harm to patients waiting for a AAA, TAVI or complex cardiac devices from a combination of: not being categorised and then should they have been categorised as priority 2 or 3, waiting longer than the clinically advised thresholds.	**100%**	Reviewing RTT Long-Waiters we ha achieved this CQUIN to date.

Key	Met	Partially Met	Not Met	Data not available

Complaints and patient feedback

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

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

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

Periods of 'pause' for complaints during the Covid -19 pandemic and the Covid recovery have significantly affected performance for response times for 2022-2023 due to the backlog of complaints.

Leicester's Hospitals Patient Information and Liaison Service (PILS) administer all formal complaints and concerns. Between 1 April 2022 and 31 March 2023, we received 2,165 formal complaints and 2,134 concerns. This compares to 2,264 formal complaints and 1,515 concerns in 2021/22.

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

We achieved 51%, 41%, and 38% for the 10-, 25-, and 45/60-day formal complaints performance respectively; a decrease in performance against last year and a symptom of the COVID-19 backlog of complaints and PILS staffing issues.

Improving complaint handling

Throughout 2022-23, Leicester's Hospitals suspended its participation in the Independent Complaints Review Panel process due to the focus of work being on reducing the backlog of complaints. Usually, this panel reviews a sample of complaints and reports back on what was handled well and what could have been done better. This feedback is used for reflection and learning with the PILS and CMG teams and reported through our Executive Quality Board. The panel has been reconvened with refreshed terms of reference to commence in April 2023.

This year to improve our complaints process and handling of cases we have:

Completed the proof of concept of the Artificial Intelligence (AI) project that uses 'Natural Language Processing' to automate key parts of the complaints system. This has shown some potential to automatically identify key issues in a complaint but further work is required to be able to utilise this software as part of the complaint process.

In 2023/24, we will:

- Reinstate Independent Complaints Review Panel process
- Focus on providing earlier verbal resolution and less written responses for resolution by trialling an Early Resolution Team based at the LRI site
- Work with the University of Leicester on ensuring that our responses are compassionate and empathetic
- Continue to focus on driving down our numbers of overdue responses

Reopened complaints

Table Number of formal complaints received, and number reopened by quarter April 2020 to March 2023

	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4
Formal complaints received	234	418	474	354	498	560	581	631	605	561	493	505
Formal complaints reopened	44	74	48	52	76	58	69	63	37	27	17	25
% Resolved at first response	81%	82%	89%	85%	84%	89%	88%	90%	93%	95%	96%	95%

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

Parliamentary Health Ombudsman Service

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

Table: Parliamentary Health Service Ombudsman complaints - April 2016 to March 2023

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Investigated - not upheld	12	6	4	0	0	0	0	**22**
Investigated - partially upheld	3	3	3	3	1	2	0	**14**
Enquiry only - no investigation	1	1	0	1	4	3	0	**10**
Awaiting outcome validation	0	0	0	1	0	1	3	**6**
Investigated - upheld	1	0	0	0	0	0	0	**1**
Complaint withdrawn	1	0	0	0	0	0	0	**1**
Apology/explanation	0	0	0	0	0	1	0	**1**
Total	**18**	**10**	**7**	**5**	**5**	**7**	**3**	**55**

Patient Information and Liaison Service (PILS)

Feedback from our patients, their families and carers gives us a valuable opportunity to listen and examine our services and make improvements. The Patient Information and Liaison Service is an integral part of the corporate patient safety team. The PILS service acts as a single point of contact for members of the public who wish to raise complaints, concerns, and compliments or have a request for information.

The service is responsible for coordinating the process and managing the responses once the investigations and updates are received from relevant services or individuals. They are contactable by a free phone telephone number, email, website, in writing or in person.

Table16: PILS activity (formal complaints, verbal complaints, requests for information and concerns) by financial year – 1 April 2015- 31 March 2023

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Formal complaints	1,574	1,467	1,886	2,260	2,534	1,476	2,264	2,165
Verbal complaints	1,449	1,152	856	492	192	218	308	197
Requests for information	439	321	143	118	168	113	210	317
Concern (excludes CCG & GP)	755	1,288	1,146	1,170	1,488	1,001	1,515	1,937
Total	4,217	4,228	4,031	4,040	4,382	2,808	4,297	4,616
Trend	9 % increase	0.2 % increase	4.7 % decrease	0.2 % increase	8.6 % increase	35.9 % decrease	53.02 % increase	7.42 % increase

Patient experience

Patient and Public involvement

During the last year, the Trust was able to relax its former pandemic precautions and recommence face to face engagement with patients and local communities. In the earlier part of the year we were conducting the majority of our engagement with patients and the wider public remotely. This included a series of listening events with local carer groups. The engagement with carers also included telephone interviews and contributions via email. The outcomes from this engagement have now informed a new Carers' strategy which is being developed by our Patient Experience team.

This year, the Trust's Patient and Community Engagement (PACE) team managed a programme of community engagement for a project in our Cardiology services. Cardiology Outpatient data has shown that patients from South Asian backgrounds are more likely to be recorded as "Did Not Attend" (DNA). As such, these patients miss out on clinical monitoring and follow up. In particular, it has been identified that the South Asian population is under-prescribed NICE approved cardiovascular drugs. The project aimed to reduce this health inequality. In order to extend our reach in to local South Asian communities, the team worked in partnership with six local community organisations to conduct focus groups exploring the reasons why patients may be discouraged from attending appointments. Participants have since been invited back to meet with managers and clinicians to "co-design" solutions which will improve patients' experience and encourage better attendance at clinics. As part of our work on the Cardiology project, we also worked with hospital volunteers who speak one or more South Asian languages. Our volunteers

conducted telephone interviews with patients to explore potential barriers to attending clinic and ways in which the Trust might better support them.

With the resumption of face-to-face engagement, the PACE team have been out engaging directly with communities this year. Groups we have engaged with include Wesley Hall, Leicester Mammas, Connecting Communities, Shama Women's Centre, the African Caribbean Centre, VISTA and the Leicester Deaf Forum. We have also attended a number of community events. These events provide a great opportunity to listen to people's experience of hospital care and allow us to reach people that may not come along to the more formal engagement sessions. We have recently participated in events at the Peepul Centre, the Bilal Masjid (Mosque), a community event hosted by the Federation of Muslim Organisations and a Sikh community Vaisakhi family day. We will continue to support events across our diverse communities throughout the year. We are also sharing these engagement opportunities with colleagues at UHL. For example, our Bowel Screening team have joined us at some of the events to promote cancer screening.

The Trust continues to communicate regularly with its public membership, which reaches over 6,000 people across Leicester, Leicestershire and Rutland. Members are provided with news from the Trust, invited to participate in research projects and attend online events.

As part of our membership engagement, we have maintained a programme of online monthly medical talks (Leicester's Marvellous Medicine) which have been very well attended. The talks are delivered by our consultants on a range of medical topics. They provide an opportunity to showcase the Trust's expertise in various fields as well as sharing our latest research projects and promoting services. The talks are interactive and provide opportunities for people to ask questions and give their views on UHL services, with feedback going directly to the responsible consultant. Topics covered over the last year include; Spotting childhood illness, Fibromyalgia, Keyhole Hip Replacement Surgery, Preconception Care, Osteoporosis and Head and Neck Cancers.

Earlier this year we held two public engagement events to share plans for our new East Midlands Planned Care Centre. The events provided an opportunity for members of the public to ask questions and give their opinion on the development. The sessions were led by our Reconfiguration Programme Director, Senior Capital Project Manager and Associate Director of Operations Projects. Participants were broadly supportive of and interested in the plans which will help us to reduce waiting times for patients.

The PACE team have also worked with our Patient Information lead this year to establish a dedicated patient readers' panel. 10 patients were recruited to the first cohort and are now actively engaged in reviewing patient facing literature to ensure it meets readability standards and is clear and understandable. The Readers' Panel operates remotely and has been so successful that we are planning to recruit to a second cohort earlier than planned.

The PACE team were also involved in the Trust's response to the National COVID enquiry. We managed a range of engagement sessions to explore our patients' experience of hospital services during the pandemic. The outcomes from this engagement will form part of our overall response to the enquiry.

Last winter we engaged with patients using our Discharge Lounge facilities to ask about the support they may need on leaving hospital. We spoke to patients at both the Royal Infirmary and Glenfield hospitals, providing feedback to our Discharge team. The team also ran an engagement programme to support some work improving the accessibility of our hospital sites. We spoke with a range of groups as part of this engagement, including the Leicester Deaf Forum and service users from VISTA and Age UK.

Staff across our Trust support a number of patient groups which meet to inform our services, provide peer support or provide education for patients about their conditions. For example, our Renal services have a well-established patient group which meets regularly to steer the delivery of Renal services. A number of cancer specialties have active patient groups, for example, our Breast Care and Head and Neck cancer groups. Our Children's hospital also regularly engages with their Youth Forum to evaluate

children's services and steer future service development. We are currently working with other services in the Trust to develop their own patient reference groups. The PACE team also support staff in our service areas to engage with patients. For example, we recently supported staff in our Emergency Department to run a focus group with patients who had used the service.

Throughout the last year, the Trust has continued to work with its Patient Partner group. Patient Partners are members of the public who have experience of the Trust's services. Although the group is smaller than it was before the Pandemic, Patient Partners continue to sit on several boards and committees within the Trust and are available to provide a patient perspective to staff working on projects and service developments.

Improving the Experience for Patients, Families and Carers

Leicester's Hospital's actively seek feedback from patients, family members and carers. The feedback provides us with a rich picture of patient experience whilst also offering insight into what matters most the citizens of LLR. Importantly, it allows us to develop plans for patient and public engagement to support quality improvement and service redesign.

Over the last twelve months 213,251 feedback forms feedback forms / surveys were received from patients. This was an increase from the previous years activity of circa 207,000

Friends and Family Test

The Friends and Family Test is a nationally set question which is asked in all NHS hospitals and in all clinical areas of Leicester's Hospitals.

> *"Thinking about our ward…Overall how was your experience of our service"*

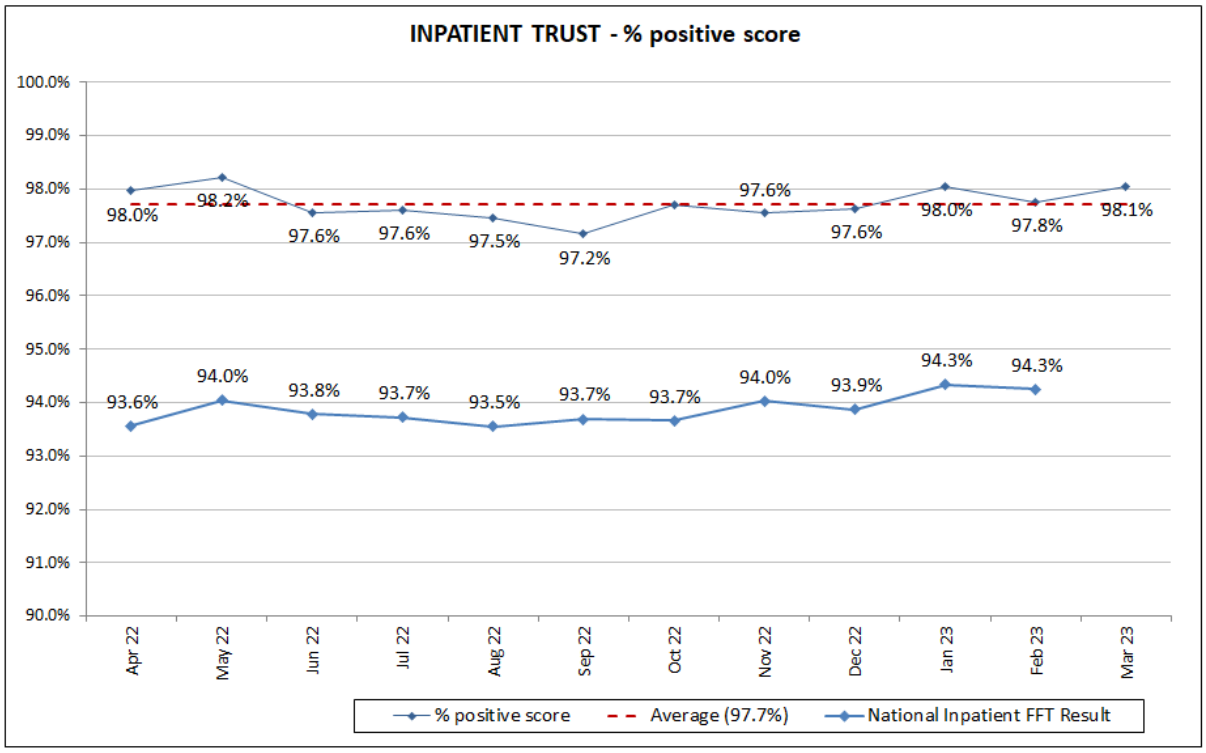
The patient, family member or carer then are given the opportunity to explain why they have given their answer.

> *"Please tell us why you gave this answer and anything we could have done better"*

The responses received are monitored at ward/department level in real time, which helps to shape and plan improvements.

To ensure the collection of the Friends and Family Test is inclusive, it is also available in the top three languages in Leicester, Leicestershire, and Rutland; Guajarati, Punjabi and Polish. There is also an easy read version for those with a learning disability, visual impairment, literacy issues or whose first language is not English.

The Trust monitors the Friends and Family Test (FFT) to see how services are viewed from a patient's perspective. The Friends and Family Test score can be viewed at ward or clinic level but also at Trust level. The graph below illustrates that patients and their families show elevated levels of satisfaction according to the FFT compared to the National picture. The top line shows UHLs inpatient scores and the lower line demonstrates the national average. The scores for UHL have been very similar since the new national wording of the FFT question was introduced in March 2020.



Patient Involvement and Patients Experience Assurance Committee (PIPEAC)

During 2022-23 PIPEAC has met five times. The purpose of this committee is to draw all areas of expertise across UHL together to monitor Patient Feedback, triangulate this against other data, disseminate any key learning and to promote excellence in care.

The committee is a lively forum fostering debate and discussion focused upon feedback from patients and their families and how effectively the organisation is responding to this feedback. The committee often features patient stories and has community representation including Healthwatch and The Carers Centre within the membership.

The National Adult Inpatient Survey from 2021 was presented in August 2022. This mixed method feedback showed a 34% response rate. This has improved slightly from the previous year. The National Survey results from 2022 are due in August 2023.

Feedback from Families and Carers

The Trust is very keen to hear the views of families and carers. A survey for families and carers is available on the public website, on the wards on paper and using an iPad in some areas.

During 2022-23 there have been 913 Family, Carers and Friends feedback forms received within the Trust and this feedback has been widely shared with the individual CMGs and areas.

“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.

Patient Stories

The Clinical Management Groups are requested to identify patient stories to the Patient Experience team. The stories are reviewed by the members of the Nursing, Midwifery and Allied Health Professionals (NMAHPS) committee monthly. NMAHPS decide which stories will be shown at Trust Board. These Stories are taken to Trust board on alternate months.

STAR Award

The STAR Award is an award from patient experience, to celebrate clinical areas achieving positive results and continued improvement in their local patient experience surveys. The STAR award, which is presented twice a year, is given to the clinical area with the most improvement in six months.

Congratulations to Ward 16 at the Glenfield Hospital and the Stroke Unit, LRI, for winning STAR Awards.

Patient Recognition Awards

This award recognises staff who patients, family, and carers have mentioned by name in the Friends and Family Test feedback comments. These comments detail the positive impact the staff member has had on their experience while they have been in hospital. During 2022-23 there have been thirteen winners: four nurses, one therapist, one dietician, three health care assistants, two housekeepers, one consultant and a midwife.

E-Greeting Service and Messages to Loved Ones

The e-greeting service offers relatives and friends of patients the ability to send a short message to their loved ones via the Trust website and the sender chooses a picture to attach to the card.

During this period, the e-greetings service has been enhanced and further publicised through social media and the website.

E-greetings are processed by Volunteer Services at least twice a day and printed and either delivered by staff, a volunteer or through the post room at each site.

During 2022-23 Volunteer Services have delivered 1,897 e-greetings to patients. Patient Experience visited wards and departments to speak with patients who had received an e-greeting to gather feedback on this service and received incredibly positive feedback.

Providing spiritual and religious care

The Chaplaincy team delivers a 24 hours-a-day, seven-days-a-week service offering pastoral, spiritual and religious support to patients and families throughout their time in hospital. We are here to support all who face emotional or spiritual distress arising from questions concerning life, death, meaning and purpose.

We are proud to have a diverse team of Chaplains which includes Christian, Hindu, Muslim, Non-religious and Sikh and made over 4,500 visits to patients over the last year. We believe that diverse Chaplaincy services strengthens our ability delivering excellent care and enhances the quality-of-care experienced by the many communities that access our hospitals.

The service has supported over 700 staff in the last year with significant interventions during staff bereavement and traumatic incidents. Supporting staff individually and collectively we have organised staff memorials and provided ongoing pastoral and spiritual support.

Chaplains strive to enhance the care received by every patient through understanding and responding to the individual personal, spiritual, and religious needs. Working in collaboration with healthcare services across the hospitals and statutory organisations we have delivered urgent support to patients and families in critical situations as well as around the time of death. This has included the facilitation of hospital weddings and delivery of hospital funerals and baby funerals.

“You were so calm at a time of such heightened emotions, and I will never forget those whirlwind 24 hours. It was made possible thanks to you, and even though I miss [patient] so, so much, I am strengthened by our one final memory together.” (Card from a patient relative)

Across UHL our multi-faith chapels and prayer facilities have seen significant use by patients, visitors and staff; we have also made substantial progress on the new St Lukes Chapel and spiritual care space at Leicester Royal Infirmary with positive feedback from across the diverse faith and belief communities of Leicestershire on the vision for these spaces.

We have worked proactively in re-establishing the celebration of religious festivals and days of national significance within the hospital which has been greatly welcomed alongside supporting the Trust as a point of reference to the wider faith and belief communities of Leicester. We continue to provide Chaplaincy services to Leicestershire Partnership NHS Trust, seeing patients and families across mental health units and community hospitals of Leicester, Leicestershire and Rutland.

Aims for the 23/24

- To enhance the delivery of Chaplaincy services across UHL ensuring high quality pastoral, spiritual and religious care to patients, staff and relatives.
- To work collaboratively with other healthcare services to further embed the provision of integrated Chaplaincy services as part of excellent holistic care.
- To improve access to Chaplaincy services for patients, staff and relatives by increasing awareness and visibility of the service across UHL and beyond.

Staff Experience

Health and Wellbeing

- Our Health and wellbeing offer has been continuously developed including the addition of the 'Recognising and Responding to Compassion Fatigue' course which over 280 colleagues have benefitted from.
- 320 colleagues have been offered Trauma Risk Management (TRiM) support
- 188 colleagues trained as Mental Health First Aiders across the Trust.
- We have set up facilitated peer support groups for colleagues with non-visible disabilities and for colleagues that are affected by peri-menopause, menopause and post-menopause.
- Amica Staff Counselling and Psychological Support Services are available for all UHL colleagues 365 days a year. The need for our services has risen by approximately 20% in the last year. The team, alongside quality one-to-one services, have provided in excess of 600 hours of in-reach work across the three UHL sites, in Critical Care, Theatres and the Emergency Department. Amica has also supported teams experiencing extra challenges, with drop-in/support sessions, when requested.
- We were part of the LLR Mental Health and Wellbeing hub which provided a central point of access for support for colleagues in the health and social care system
- Management referrals into OH have slightly dropped in 22-23 – down 5% - approximately 40 per month
- Stress, anxiety, depression (and psychological issues) is the biggest reason for referral into Occupational Health
- There has been a slight increase in the number of conditions that are deemed to be caused by work or made worse by work (now 23% from 21%)
- New starters appointments have increased by 33% in 22-23

Attendance Management

Our sickness absence target is 3%. These are reported retrospectively and an overall Trust sickness absence rate of 5.4% was reported for the year. This compares to 6.82% for 2021/22.

We recognise our staff are our most valuable resource and our approach to managing and supporting staff attendance goes hand in hand with promoting staff health and wellbeing.

We have listened to feedback and have been taking a much more 'person-centred' approach to sickness

absence management, initially over the Winter period (which has subsequently been extended and remains in place), to ensure that we are supporting our colleagues' health and wellbeing. Key changes include the ability for managers to make decisions appropriate to individuals with the right support from the People directorate and Absences only being considered for targets/formal management once the absences have been thoroughly reviewed. Learning from this approach will inform how we shape our sickness policy into 2023-24.

We have also conducted two surveys in January 2023 to seek views on the winter sickness approach and to inform the future sickness absence policy.

The People Services team have worked together to undertake a thorough review of long-term sickness cases, prioritising cases at 6, 10 and 12 months plus since December 22. This is clearly reflected in the data, and a significant number of cases have been resolved between December 22 and March 23. This is positive for our colleagues and for the Trust.

Key actions for 23/24:

- Review and relaunch of the Absence Management Policy, continuing engagement with key stakeholders and incorporating feedback from the surveys.
- Associated communication strategy to support the relaunch of the policy.
- Further support and training for line managers on absence management and health & wellbeing, to continue to build skill sets, and with a focus on taking a people centred and compassionate approach.
- Improved data and reporting on absence to ensure greater visibility and detailed analysis for oversight assurance.
- A continued focus on absence handling and health & wellbeing, taking a people centred approach.

Attracting and retaining staff

Reducing vacancies and ensuring we are able to attract and retain the right staff with the right skills at the right time, continues to be our key priority.

We have continued with bulk recruitment to reduce vacancies in the role of Health Care Assistants and increased the number international recruited nurses to attempt to fill gaps in key areas.

In addition, we have run successful recruitment open days and events, initially focusing on high vacancy roles within Estates and Facilities and Administrative and Clerical roles and then expanding these to Clinical Management Group and job type specific events.

Looking forward, we plan to strengthen our partnerships with local job centres and the community in order to build additional routes into our workforce.

It is recognised that the time taken to recruit impacts on our ability to fill vacancies. A number of improvements have already been made in this area and this will continue to be a priority in 2023 through the development of streamlined processes and greater use of technology.

We recognise that much of how we retain staff is about how we improve the experiences of staff.

This year we were successful in achieving funding to recruit a People Promise Manager as part of the People Promise Exemplar programme. This post is now working alongside a number of other recently appointed retention focused roles, including the Head of Nursing for Recruitment and Retention; Recruitment and Retention Leads within Clinical Management Groups and the System level, ICS Retention Lead.

A Trust wide retention self-assessment was undertaken to establish Trust retention priorities, followed by a Nursing and Midwifery specific self-assessment. Trust priorities established were around improving our data and understanding of why staff leave, improving how we induct new starters, our flexible/agile

working offer, how we recognise and reward colleagues, and how we better support and therefore retain colleagues later in their career. These link to the outcomes of our Staff Survey in both 2021 and 2022. A programme of work has begun which focuses on these areas into 2023.

Reward and Recognition

We have several local and central recognition awards. Our Above and Beyond scheme allows colleagues to thank each other by having their messages passed on in a card with a pin badge. In 2022-23 7,305 acknowledgments were distributed around the Trust.

In 2022 we launched our new Admin and Clerical Star Awards, recognising the contribution of colleagues in administrative and clerical roles around the Trust. Each month an individual and team are awarded by the judging panel and all nominees receive a certificate of recognition.

In 2022 we partnered with Vivup who provide our employee benefits platform. This allows colleagues to access lifestyle savings to support every aspect of your daily life, from supermarkets and high street shopping to utility bills. Colleagues can also access home and electronic goods, cars and bicycles through a salary sacrifice scheme which enables them to spread the cost of the items they want and need direct from your salary avoiding expensive borrowing through credit cards and high interest loans. There are plans in place to further extend our employee benefits provision across 2023 / 24.

British Association for Physicians of Indian Origin

We are a significant employer within our local economy with responsibilities for social and economic growth, population health and environmental and cultural issues. We aim to consistently provide safe effective patient care and to be an inclusive employer of choice, and we know that our civic responsibilities associated with this have wider meaning and impact on the communities we serve.

To fulfil these aims we know we have to achieve many things and promoting good inclusive employment is significant in this.

In terms of our current position, we know that we have caring and compassionate colleagues who are committed to the patients they serve. The majority of our 18,000 workforce live locally. We have a diverse workforce and a diverse community. We have a number of international colleagues working with us who often relocate with their families.

The experience of our colleagues is variable and inequitable both in terms of conditions of employment and experience. This is reinforced by the feedback from the national staff survey and the WRES (Workforce Race Equality Standard) and WDES (Workforce Disability Equality Standards) indicators. Levelling up is something we owe to our colleagues and communities and we believe that working in partnership we can and will do better.

In September 2022, the Trust commenced its strategic partnership with British Association for Physicians of Indian Origin (BAPIO), and signed up to the Locally Employed Doctor Charter and Dignity at Work Standards. These standards have been developed in response to some of the experiences of incivility, discrimination, bullying and harassment that we know exist in our workplaces. The standards provide a framework for organisations to work to. The standards will give more visibility and transparency to the experiences of colleagues at work and provide a framework for improvement and oversight of impact. Following a summit hosted by the Royal College of Surgeons in October 2022 we have the opportunity to participate in a pilot of the standards. The other organisations included in the pilot are: Kings College Hospital NHS Foundation Trust and St Georges and Epson and St Helier University Hospitals.

UHL also hosted a BAPIO conference in April 2023 which further reinforced our commitment to the strategic partnership, our workforce and our communities.

Employee Relations / People Policies / Just Culture

The Trust has sought to continue to implement a revised approach to case work management, aligned to 'Just and Restorative Culture' approaches.
Integral to the work being carried out is the need to embrace learning from previous cases, in accordance with a Restorative and Just Learning Culture approach, whereby reducing the formal management of Employee Relations cases and improving the way case work is undertaken to achieve a positive culture change. Wherever possible the aim is to ensure early handling and timely, fair, transparent, and appropriate resolutions and processes.
The actions taken are summarised below:

- Improved initial triage of cases and preliminary fact finding to determine appropriate handling (no further action / informal / formal / agreed outcomes)
- There has been a review of all cases to ensure appropriate case handling and that the right actions are in place across all cases through line managers and with professional leads, giving greater ownership, visibility, and much greater oversight assurance for handling in place.
- People Services have worked hard to get an accurate baseline of data for casework.
- Improvements in reporting and data analysis of employee relations cases.
- Cascading of Just & Restorative Learning Culture principles across professional and stakeholder forums.

Key actions for 23/24:

- Working collaboratively with colleagues to further implement and embed just and restorative practices to incidents / events and aligned to the Patient Safety Incident Response Framework.
- Keeping a strong focus on engagement for any changes and developments required with key stakeholders e.g., professional leads, staff side colleagues and CMG leadership teams etc to embed improvements.
- Review of policies to implement a just and restorative learning culture.
- We will review and relaunch employee relations policies in 23/24, prioritising the following;
    - Absence Management,
    - Disciplinary,
    - Maintaining High Professional Standards in the NHS,
    - Resolution.
- Develop training for line managers.
- Introduction of the Commissioning manager role for oversight and decision making on conduct cases.
- To focus on further data capture and analysis to ensure this can be used appropriately triangulating to WRES /WDES and other reporting.

Freedom to Speak Up

During 2022/23, the Freedom to Speak Up Guardians received 223 concerns, compared to 231 in 2021/22. The strongest themes staff spoke up about related to worker safety and wellbeing, and inappropriate attitudes and behaviors. During the year, 10 concerns were received relating to bullying and harassment. All reporting of concerns are managed by the Guardians through internal processes and there is an escalation process where needed. All concerns are reported through the People and Culture Committee and detailed discussion takes place on issues which are escalated by the Guardians themselves. A quarterly report is presented by the Guardians to the Trust Board which gives oversight of the concerns, the process to address the concerns and a particular focus on themes, trends and learning.

The Guardians have delivered 87 sessions of civility and respect training for staff. The feedback received has been excellent and colleagues really value the training.

During 2022/23 the Guardians have actively increased their visibility across the Trust by conducting visits across clinical areas, target support during industrial action, carried our "here for you" events and supported the Trust in actively promoting completion of the NHS Staff Survey.

In year the Guardians have maintained contact with the Chief Executive with whom they have a direct line of contact whenever needed. Attendance at People and Culture Committee and Trust Board have also been completed.

Occupational health support

Our Occupational Health (OH) service continues to be an integral part of our organisation and plays an ever-important role in supporting our staff and their managers with all matters relating to health and work.

As we have emerged from the Covid-19 pandemic, we have continued to support the risk assessment of staff with vulnerabilities, as well as the vaccination campaign and have continued to collaborate with colleagues in the Infection Prevention and Control Team to assist with management of outbreaks in clinical areas.

The Occupational Health service again retained its independent accreditation as a Safe, Effective, Quality Occupational Health Service (SEQOHS) following annual review in January 2023, and remains a centre for training in Occupational Medicine, being one of only three units in the UK able to support three medical trainees.

We have begun to roll out more digital services (electronic referrals and clearance for employment, video consultations) and look ahead to more growth within the OH Team in 2023-24 with a continued focus on improving access and we hope to achieve closer alignment of all OH, mental health and wellbeing services across UHL.

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

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

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

Promoting Equality of Service Delivery

Health inequalities have been a key area of focus for UHL over the past 12 months, identified as one of seven strategic priorities for 2022-23. During this time, UHL colleagues have built momentum around a growing body of work to identify and address inequalities which has gained local, regional and national attention.

Programme of Work

The UHL health inequalities programme of work details around 30 projects all of which have a focus on addressing inequality within our services. These programmes were service initiated and each has been mapped to an element or theme of NHS England's Core20Plus5 framework for inequalities. The projects cover a range of services across all Clinical Management Groups. This programme of work grew steadily over the year, with some projects nearing completion and several leading to smaller pieces of iterative engagement work with local communities. Challenges were largely around resourcing some of the projects but teams remained committed to improving services through the lens of health equality and inclusion. As the projects move into 23-24, it is anticipated that each will report back to the UHL Health Inequalities Taskforce to share and cascade learning and embed a culture of equality driven improvement.

Highlights from UHL Health Inequalities Programme of Work

i) Non-Attendance at Outpatients

The non-attendance project was set up in response to higher-than-average non-attendance at outpatients noted among our most deprived populations (up to 50% in some cohorts). An initial small-scale pilot was set up to test the impact of a personalised phone call to patients identified as being at high risk of non-attendance based on post-code data (Indices of Multiple Deprivation (IMD) 1). Patients were called two weeks prior to a planned appointment to remind them of their appointment and offer support to attend.

The initial pilot proved hugely successful, eliminating the differential in non-attendance between our most deprived populations and the trust's average non-attendance rate (8-10%). The pilot was iteratively scaled-up to include any patient with a scheduled outpatient appointment, across all specialities, with a post code relating to IMD1. Funding was secured to further increase the scope of the project to include all patients from IMD2 (therefore covering the 20% most deprived of the population) and patients registered under Inclusion Healthcare (rough sleepers) and embed this work as business as usual.

Moving into 23-24, it is anticipated that the scope of this work will broaden to include other identified at-risk groups.

ii) UHL Health Inequalities Minimum Dataset

Data intelligence has underpinned the health inequalities work at UHL over 22-23. The UHL Health Inequalities Minimum Dataset group worked to define the scope and remit of a dataset that could highlight inequalities within UHL services to provide focus for service improvement through a health equality and inclusion lens. The group secured funding to recruit a Data Engineer and Data Analyst through the Leicester Academic Health Partnership and began the process of extracting and analysing data to define initial areas of work to align to the trust's operational and strategic priorities going into 2023-24. The first pilot project is expected to begin by Autumn of 2023.

iii) Inequalities in Paediatric Diabetes services

Local data has shown children and young people from ethnic minority and low socioeconomic group have lower usage of diabetes technology; only 27.5% of children and young people from ethnic minority use an insulin pump compared to 50% of white children.

Bridge the Gap (BTG) clinics were set up in the evenings and weekends to support children and families with structured education about the use of technology in managing diabetes. These sessions addressed multiple barriers to accessing and optimal use of technology:

- Cultural barriers – families hesitant to share about their child's diabetes due to stigma
- Lack of numeracy skills in the carers.
- Language

- Diet
- IT skills

NHSE funding enabled the paediatric diabetes specialist nurses, dietitian, and support worker to have additional time and resources to teach, train, reassure, support and educate the children and young people and their families to dispel any fears and anxiety about using technology and help them the embrace the benefits.

After demonstrating impact for children and their families, this work has received further NHSE funding to develop and grow the service through 23-24.

Working With Communities and Local Partners

Colleagues at UHL recognise the importance of proactive patient and public involvement in service improvement and redesign. We actively engaged with several local voluntary and community groups to develop relationships, restore trust and move towards co-designing solutions to inequalities in our services. Key partners over the past 12 months have included South Asian Health Action (SAHA), Shama Women's Centre, the African Caribbean Centre, The Centre Project and the Somali Women's Mosque.

Senior UHL leaders and leaders from local communities and voluntary groups convened on several occasions to discuss barriers to access, community links and relationships. Further several focus groups were held with communities to explore barriers to accessing services, attitudes to cancer screening and experiences of working at UHL. The feedback from these events has informed several of the projects in the programme of work and will continue to influence work to address inequalities going in to 2023-24.

Working with Health and Care Partners

UHL is clear that all of the work undertaken to address health inequalities has to have a whole system approach to enable sustained change across pathways. UHL has worked closely with colleagues from the Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS) to ensure this. For example, working with the Centre Project, UHL and LLR ICS colleagues established a programme of work focused on raising awareness of cancer screening, health promotion and improved health literacy for our most deprived inner-city population. This work will continue into 23-24 and will provide a blueprint for future collaboration.

UHL regularly attended the Health and Wellbeing Boards across LLR through 2022-23 and has led a vital piece of work commissioned by Leicester City Health and Wellbeing Board to determine what actions have been taken to address disproportionately high maternal mortality rates and poor outcomes for Black and Asian women across LLR. The final report will be published in Autumn 2023.

Research and Education

i) Biomedical Research Centre (BRC)

The NIHR Leicester BRC is dedicated to integrating principles and best practices of equality, diversity, and inclusion into all aspects of its work. Through 22-23 we initiated key efforts to inform our inclusion strategy in alignment with Best Research for Best Health: The Next Chapter (2021) and the NIHR Research Inclusion Strategy (2022-27).

We developed a shared commitment to integrating EDI principles in all areas of our operations, between the University Hospitals of Leicester NHS Trust and the University of Leicester. This was supported by a joint Statement of Commitment, where in collaboration we aim to address disparities, reduce inequities, and foster an inclusive culture. This includes initiatives such as, supporting women in leadership, attracting and retaining a diverse workforce and engaging stakeholders to inform our priorities and implementing interventions across the employee lifecycle. Expanding upon this shared commitment,

Leicester BRC submitted to the NIHR a new joint five-year EDI strategy (2022-2027) with the NIHR Leicester Clinical Research Facility (CRF).

ii) Research

The causes of health inequalities are not always understood and interventions to mitigate them are not always available. Therefore, research into this area is key to making progress. Health inequalities featured as a key theme in the research and development strategy published early in 2023. This will be monitored by the Leicestershire Academic Health Partners Board as well as within UHL. One area of particular importance is the influence of ethnicity on health outcomes and Leicester academics have continued to lead research in this field.

iii) Health Education England Fellows

UHL successfully secured funding from Health Education England to host clinical fellows in health inequalities across three CMGs (in Obstetrics, Emergency and General Medicine and Renal Medicine). The fellows will commence their year at UHL in August 2023.

iv) Pursuing Equity

UHL was the only UK and European organisation accepted onto the Institute for Healthcare Improvement (IHI) Pursuing Equity Programme. This programme aims to address racial injustice in healthcare through quality improvement methodology with intensive support from the IHI. The programme commenced in January 2023 and will run until June 2024. UHL established a Pursuing Equity team to take part in the programme and focus on a key clinical area, identified as adverse maternal outcomes in ethnic minorities. Three colleagues from the team attended in person training with the IHI in March 2023 and are working with the wider team towards the aim of reducing late booking for antenatal care for women of Black and Asian ethnicity through 2023-24.

Prevention

Preventing ill health reduces morbidity and mortality, promotes health equality, and contributes to a reduction in healthcare utilisation in the population UHL serves. Prevention is a major strand of the NHS Long Term Plan (LTP) and the recent Hewitt review which recommended a greater focus on prevention. UHL has embraced Prevention, focusing on the modifiable risk factors set out in the NHS LTP, specifically; tobacco, alcohol, obesity and TB.

At the beginning of 2022 a Prevention board was set up to provide a focal point for the different strands of prevention work taking place across UHL. This board has membership that includes the clinical leads, management leads, IT representatives and ICS colleagues, promoting system wide collaboration. The Prevention board reports into the UHL Health Inequality board.

Successes over the past 12 months include fully implementing a tobacco dependency treatment service for all in-patients across UHL, the formation of an Alcohol Care Team based in the Emergency Department at Leicester Royal Infirmary and work to expand Tier 3 obesity services. The latent TB screening programme continues to play an important role for new migrants to LLR. A key focus of our prevention work includes the health and well-being of UHL staff and as an NHS England early implementer site for staff smoking cessation support, we have now received over 100 self-referrals to help UHL staff to quit smoking. We will be publishing a full UHL Prevention report each year which details activity and outcomes.

The case history from a patient who experienced our new tobacco dependency service is presented below:

I made the decision to quit smoking after a conversation with a nurse in hospital who helped me to realise how my genetic lung disease was negatively affecting my health. Following this wake-up call, I had a consultation with the tobacco dependency team on quitting; "they offered me nicotine patches and

lozenges as a nicotine replacement". I found these to be quite helpful in starting my journey to stay smoke-free as they helped to curb my cravings, then I switched to vaping once I joined the Live Well stop smoking service.

Overall, my experience with the hospital tobacco dependency advisor and the Live Well stop smoking service has been positive. With their support, I have been able to quit smoking and make significant progress in improving my health. It hasn't been an easy journey, but their guidance and resources have made a significant difference

Our priorities for the next year are to improve our new Prevention services using quality improvement methodology and promote Prevention work across UHL, so that it becomes business as usual. We are submitting patient level data to NHS England for the tobacco and alcohol programmes but there is more work to do on IT systems to improve the quality of data submission and to link hospital and Primary Care data for the TB programme. National funding allocations and mechanisms provided to ICS's for Prevention may change in 2024-25 to which our Prevention services will need to adapt.

Our sustainability report

As one of the largest NHS Trusts in the UK we are launching an ambitious Sustainability program as part of our journey to Net Zero Carbon.

The ambition for the programme is to collaboratively work across the local health economy linking all key stakeholders within our Trust, across all levels of seniority, on all sustainable matters. Embedded within this programme will be work streams that will trial and test new ways of working both in clinical and non-clinical environments.

We will also be promoting and encouraging peer to peer engagement on our sustainability objectives across our entire estate.

To deliver the UHL net zero carbon targets, we must innovative with our approach to sustainability. The nature and scale of this challenge is such that UHL will be seeking to achieve a 50% reduction in carbon outputs by 2025 enroute to achieving an 80% reduction by 2028-32. The need for a significant shift in mind set around sustainability management in the NHS is clear if we are to achieve the carbon reductions.

Our Green Plan sets out a three-year strategy and is supported by our Trust Board which is one of the key objectives set out by NHS England and the Greener NHS Team.

Key areas for 2023/24

Green Plan Area	Leadership
Workforce & Leaderships	**Finance / HR/ Procurement / Comms / Corporate Risk Manager / QSHE Manager / Trust Board, Exec and Non executives**
Sustainable models of care	**IM&T, CMG, Reconfiguration, Commissioning Group, Strategy Digital Clinical**
Digital Transformation	**UHL Digitalisation Strategy, Estates Lead, Clinical lead**
Sustainable Travel & Transport	**Delivery Group, NHS Leased Fleet, Owned Vehicles/ HR system, Payroll Ops and project**

Estates & Facilities	**Energy, Green Champions, Recon programme, Capitol Projects , Eric reporting**
Medicines	**ITPAS / Pharmacy EMDOC, Pathology**
Supply Chain and Procurement	**Head of contracts / Head or Procurement/ Material Management**
Food & Nutrition	**Facilities Managers / Retail catering management**
Waste	**Waste Manager / Behavioural change team**

Key achievements in Waste Management

One of the biggest areas of focus for us this year has been improving the management of waste across our sites. We have appointed a full-time Head of Sustainability, whose primary focus for the first 12 months is to improve waste compliance across the estate. We have now deployed an award winning behavioural change team that are currently upskilling our workforce, and delivering bespoke training at ward and department level. A dedicated waste manager will be appointed to oversee this work by the end of 2023.

UHL clinical waste strategy and commitment is to segregate our clinical waste into 3 categories

- 60 % Offensive non-infectious waste
- 20% Infectious waste
- 20% Incineration Waste

Our current performance:

- 0.2 % Offensive non-infectious waste
- 89.1 % Infectious waste
- 10.7 % Incineration Waste

We have also launched a Trust Waste Management committee which includes a wide range of clinical and non-clinical team members; we are continuingly trying different ways of working. We meet monthly and report back into the Health & Safety and compliance team to provide assurance that we are on track.

Aims for 2023/24

- We have made commitment to be “zero waste to landfill by the end of 2023
- By the end of 2024 we aim to have implemented a robust recycling schemes across all three sites
- Data collection – we are now starting to map our waste journey both in terms of volumes and spend but monitoring compliance
- To attain 80% compliance – UHL currently sites 15%

Travel Achievements

- Staff have access to travel discount scheme
- Travel survey completed – we are now creating a heat map so we can identify where we need to apply our energy for improvements

- Full review of hopper bus and the timetable
- Formed a great partnership with the council to explore the possible changes to the Park and Ride services
- A free city centre bus loop has been launched by the council
- Monthly bike marking and maintenance sessions on all 3 sites again funded by UHL
- Link in with council to provide offers and information to staff on cycling opportunities e.g. ebike hire, cycling training
- Night time escorts to and from football club car parks, as well as the manning of the NCP car park
- Automatic Number Plate Recognition systems now live on the main car parks at the LRI and GH
- Improve shower and changing room facilities for our staff to cycle to work

Aims for 2023/24

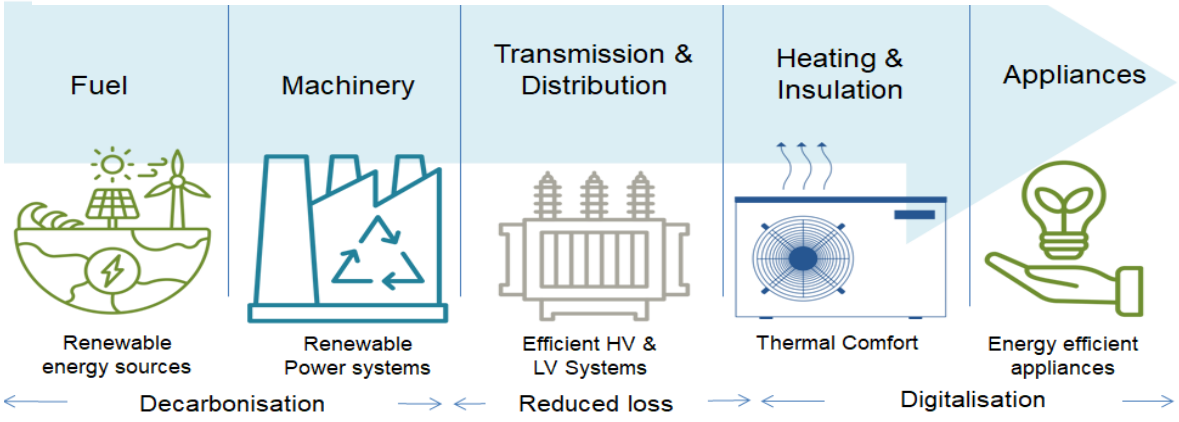
Our plans for the next year include:

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

Energy update

In our efforts to enhance operational efficiency and to adhere to the wider NHS England Green Plan, we continue to make every effort to decarbonise our operations. We have embarked on a new journey towards energy efficiency across the 3 hospitals under UHL. We reviewed our energy infrastructure and identified gaps that we seek to amend from our energy fuels, machinery, heat generation and distribution network and consumption.

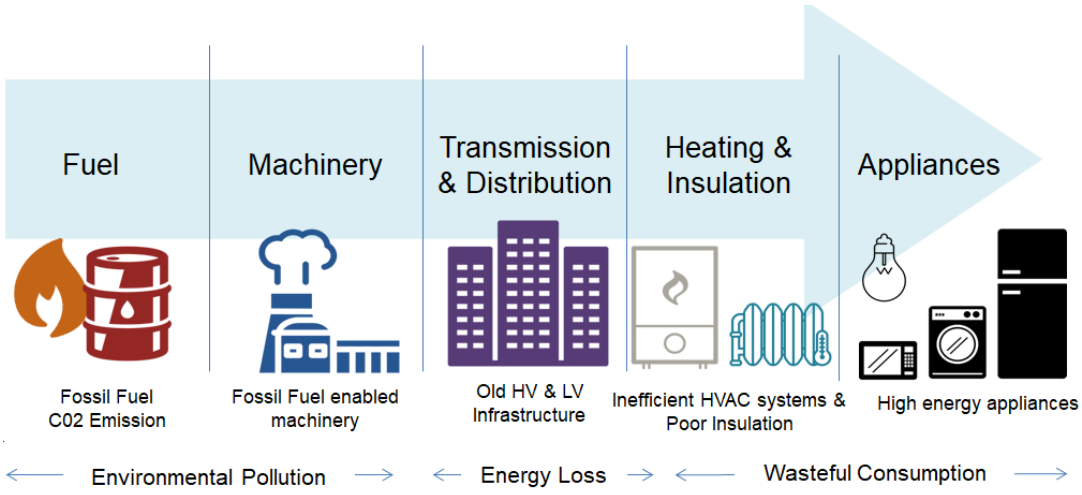
Figure 1 UHL Energy & Heat Network (Present)



Presently, we are ensuring that our current assets such as the gas house are infrastructure align with defined market standards while we perfect our decarbonisation and transition plans to a more sustainable future. We have worked closely with the National Gas Metering team review the suitability of our present infrastructure while considering our future consumption. Repairs have been identified and already being effected to mitigate the risk of supply. Furthermore, we have also discussed our distribution

infrastructure aspirations with the National grid which doesn't seem too promising due to grid availability, cost and time for construction hence there is a dire need to consider decentralisation (local production and consumption of energy) where appropriate.

Figure 2 UHL New Energy & Heat Network (Aspiration)



We are presently reviewing sustainable energy options to help us mitigate our C02 emissions as we have been one of the highest emitters in the Midlands region. We are in discussion with our present energy partners such as 2G to consider Hydrogen options etc. We are also in application for grant support to fund studies to identify and understand the feeble state of our heat network. There is a dire need to look beyond the heat distribution network to the façade of our buildings ability to retain heat and offer thermal comfort to occupants given that our buildings are quite old. We are working closely with the Capital team to prioritise these repairs.

At the epicentre of every transition are dedicated people to enable the desired change, hence we have

set up our energy champion scheme to foster behavioural change in our team from energy and water use. These programmes will be led by members of the green meeting with the primary objective to communicate and lead the implementation and adoption of green initiatives across UHL.

Aims for 2023/24

- We intend to release a green plan video to educate our colleagues on the efforts of Estates and Facilities department
- Nudges to prompt behaviour; such as stickers and flyers to serve as reminders to use less water and turn off the light. We expect this to reflect a 5% reduction in energy consumption
- Hold sustainability workshops / Drop in clinics
- Carry out heat network study
- Identify project financing options to afford the transition

Car parking

UHL is under constant pressure to provide staff with parking provision within a limited parking footprint.

The current allocation of nearly 2.5 Permits allocated per space (+240% allocation), additional permit requests awaiting availability identify 1 request for every 3 spaces. Currently minimal data supports the management of Car Park and day to day delivery needs, this includes:

- Manual collection and allocation of Permits against the current Policy Protocols.
- Manual understanding of Car Park availability, Space volume and flow (Visual adhoc counting in the field).
- Manual intervention for activities outside the norm, change management of individual permit needs.
- CAME initial ANPR solution starting to provide some data and reporting to support a move to data driven environment.
- Leicester City Council focus on reduction of on and offsite Parking in support of the Government green agenda, limiting support to expand any Car Parking which required planning

Plans for 2023/24

We intend to implement a new car park management system that will automate all manual processors, next steps will be:

Build a Car Park Management System IT solution deployment programme, as follows

- Develop the CPMS workflows
- Provide Live access for new permit requests to support reapply
- Establish any UHL integrations as well as its security solution needs

Build field equipment deployment programme, as follows

- Advanced 12/24-month view of carparks use / lease / risk / management needs
- Understand and programme next steps per location
- Provide priority deployment programme

Richard Mitchell

Chief Executive

29 August 2023

Directors' Report

The Trust Board – Role and responsibilities

Information about our current Trust Board members (including their experience and skillset) from 2022/23 is available at this link:

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

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

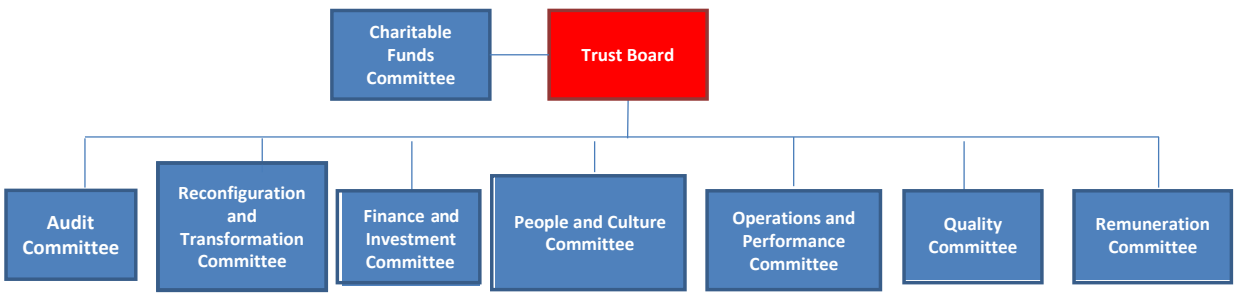
Moira Durbridge, Director of Quality Transformation, Efficiency and Improvement
Joanne Tyler-Fantom, Acting Chief People Officer
Dr Gopal Sharma, Associate Non-Executive Director
Eleanor Meldrum, Acting Chief Nurse

The Trust Board functions in accordance to corporate governance best practice. The 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 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
GOVERNANCE STRUCTURE



The Standing Financial Instructions, Scheme of Delegation and Standing Orders have been reviewed during 2022/23. These have been 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 an advisory (non-voting) capacity. During 2022/23 there were changes to the Trust Board membership which is described in more detail in the Annual Governance Statement.

The size of the Board and skill mix has been broadened during 2022/23 with the addition of a Director of Health, Equality and Inclusion. The expertise and skill is appropriate for the for the current requirements of Trust business.

The Executive Directors, Directors and Very Senior Managers are appointed by the Remuneration and Appointment 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 and Appointments 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 2022/23

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 2022/23 is set out in the table below including, committee attendance, commencement of post and voting status:

Name	**Public Trust Board** (max = 11)	**Audit Committee** (max = 5)	**Finance and Investment Committee** (max = 12)	**Operational Performance Committee** (max =)	**People and Culture Committee** (max = 7)	**Quality Committee** (maximum = 11)	**Reconfiguration and Transformation Committee** (max = 4)	**Remuneration Committee** (max = 3)	**Charitable Funds Committee** (max = 6)
*John MacDonald – Chairman	11/11 100% **(Chair)**	N/A	N/A	7/10 70%	N/A	N/A	N/A	2/3 66%	5/5 100%
*Vicky Bailey – Non-Executive Director	11/11 100%	5/5 100%	N/A	N/A	6/7 86%	11/11 100% **(Chair)**	N/A	2/3 66%	6/6 100%
Gaynor Collins-Punter – Associate Non-Executive Director	10/11 91%	N/A	9/11 82%	6/10 60%	1/7 14%	1/2 50%	2/4 50%	N/A	N/A
*Steve Harris – Non-Executive Director	8/11 73%	5/5 100%	14/15 93% **(Chair)**	N/A	N/A	0/3 0%	N/A	N/A	N/A
*Dr Andrew Haynes – Non-Executive Director	10/11 91%	N/A	N/A	8/10 80%	7/7 100%	10/11 91%	4/4 100% **(Chair)**	N/A	N/A
*Ballu Patel – Non-Executive Director	10/11 91%	5/5 100%	14/15 93%	10/10 100%	6/7 86% **(Chair)**	N/A	4/4 100%	3/3 100%	N/A

PART 2: Accountability Report *(continued)*

Name	**Public Trust Board** (max = 11)	**Audit Committee** (max = 5)	**Finance and Investment Committee** (max = 12)	**Operational Performance Committee** (max =)	**People and Culture Committee** (max = 7)	**Quality Committee** (maximum = 11)	**Reconfiguration and Transformation Committee** (max = 4)	**Remuneration Committee** (max = 3)	**Charitable Funds Committee** (max = 6)
*Professor Tom Robinson – Non-Executive Director	7/11 64%	N/A	N/A	N/A	1/7 14%	6/11 55%	3/4 75%	N/A	6/6 100% **(Chair)**
*Dr Gopal Sharma – Associate Non-Executive Director *from April 2022*	8/11 73%	N/A	N/A	N/A	4/7 57%	8/11 73%	N/A	N/A	N/A
*Mike Williams – Non-Executive Director	10/11 91%	5/5 100% **(Chair)**	14/15 93%	10/10 100% **(Chair)**	N/A	0/3 0%	2/4 50%	2/3 66%	N/A
Jeff Worrall – Associate Non-Executive Director	9/11 82%	N/A	15/15 100%	10/10 100%	N/A	11/11 100%	3/4 75%	N/A	N/A
*Richard Mitchell – Chief Executive	11/11 100%	N/A	3/4 75%	7/10 70%	N/A	0/3 0%	N/A	3/3 100%	N/A
Dr Ruw Abeyratne – Director of Health Equality and Inclusion *from June 2022*	8/9 89%	N/A	N/A	N/A	0/2 0%	1/3 33%	N/A	N/A	N/A
Simon Barton – Deputy Chief Executive *from June 2022*	7/8 88%	N/A	11/11 100%	N/A	N/A	N/A	3/4 75%	N/A	N/A
Andy Carruthers – Chief Information Officer	11/11 100%	N/A	11/11 100%	N/A	7/7 100%	N/A	4/4 100%	N/A	N/A
Becky Cassidy – Director of Corporate and Legal Affairs	11/11 100%	5/5 100%	14/15 93%	N/A	N/A	3/3 100%	N/A	2/3 66%	6/6 100%
Moira Durbridge – Director of Quality Transformation Efficiency and Improvement *until December 2022*	7/8 87%	N/A	10/10 100%	N/A	N/A	8/8 100%	3/3 100%	N/A	N/A
*Mr Andrew Furlong – Medical Director	10/11 91%	N/A	10/14 71%	7/10 70%	N/A	10/11 91%	2/4 50%	N/A	N/A
*Julie Hogg – Chief Nurse *from late May 2022*	9/9 100%	N/A	N/A	4/9 44%	4/6 67%	8/10 80%	N/A	N/A	4/5 80%

Name	Public Trust Board (max = 11)	Audit Committee (max = 5)	Finance and Investment Committee (max = 12)	Operational Performance Committee (max =)	People and Culture Committee (max = 7)	Quality Committee (maximum = 11)	Reconfiguration and Transformation Committee (max = 4)	Remuneration Committee (max = 2)	Charitable Funds Committee (max = 6)
*Lorraine Hooper – Chief Financial Officer	10/11 91%	5/5 100%	14/15 93%	N/A	N/A	N/A	3/4 75%	N/A	N/A
Jon Melbourne – Chief Operating Officer	9/11 82%	N/A	13/14 93%	9/10 90%	1/2 50%	3/3 100%	N/A	N/A	N/A
Eleanor Meldrum – Acting Chief Nurse *until late May 2022*	2/2 100%	N/A	N/A	0/1 0%	0/1 0%	0/1 0%	N/A	N/A	0/1 0%
Clare Teeney *from 23 May 2022*	6/9 67%	N/A	N/A	N/A	6/6 100%	N/A	N/A	2/2 100%	N/A
Joanne Tyler-Fantom – Acting Chief People Officer *until 23 May 2022*	2/2 100%	N/A	N/A	N/A	1/1 100%	N/A	N/A	N/A	N/A
Mike Simpson – Director of Estates and Facilities *from April 2022*	10/10 100%	N/A	8/11 73%	N/A	2/7 40%	N/A	1/4 25%	N/A	N/A
Michelle Smith – Director of Communication and Engagement *from October 2022*	4/5 80%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*Voting members

The table below provides information on the declarations of interests entries made by Trust Board members and attendees for the year 2022/23:

NAME	POSITION	INTEREST(S) DECLARED
John MacDonald	Trust Chairman	• Chair, Derbyshire Integrated Care Board • Member of the UHL Corporate Trustee Board
Dr Ruw Abeyratne *From June 2022*	Director of Health Equality and Inclusion	• Director of Larks Ameus Ltd – property investment company • Committee member for Boarding and Welfare, Trent College Board of Governors, Trent College • Ad hoc paid coaching and speaking (annually less than £500)
Vicky Bailey	Non-Executive Director	• Council Member, University of Nottingham • Chair of University of Nottingham Audit and Risk Committee • Member of the University of Nottingham Remuneration Committee • Fellow of Queen's Nursing Institute

NAME	POSITION	INTEREST(S) DECLARED
		• Family member is employed by Pricewaterhouse Coopers (PwC) • Member of the UHL Corporate Trustee Board
Simon Barton *From June 2022*	Deputy Chief Executive	• Confirmed no declarations to be made
Andrew Carruthers	Chief Information Officer	• Confirmed no declarations to be made
Becky Cassidy	Director of Corporate and Legal Affairs	• Confirmed no declarations to be made
Gaynor Collins-Punter	Associate Non-Executive Director	• Outside employment with Rolls Royce plc
Moira Durbridge	Director of Quality Transformation and Efficiency Improvement	• Fellow and Council Member of the Royal Society of Medicine (RSM). Full RSM subscription is paid personally but the costs of any attendance at those meetings whilst holding a Council position are met by the RSM
Mr Andrew Furlong	Medical Director	• Member of the UHL Corporate Trustee Board •
Steve Harris	Non-Executive Director	• Outside employment with Travis Perkins (and shareholder) • Company Directorships: The BSS Group Ltd; Keyline Civils Specialist Ltd; CCF Ltd; Rudridge Ltd • Director of Trust Group Holdings (TGH) • Member of the UHL Corporate Trustee Board
Dr Andrew Haynes	Non-Executive Director	• Special Advisor to Sherwood Forest Hospitals Trust on a 12-month contract 3 days a month (Paid) • An advisor to the Faculty of Medical Leadership and Management (FMLM) working 1 day a week (Paid) • Registered as an expert with Academic Health Solutions • Member of the UHL Corporate Trustee Board
Julie Hogg *from May 2022*	Chief Nurse	• Trustee, EGA Hospital Charity • Chief Nurse representative, CNO England safe staffing faculty, NHSE/I • Member, Safer Nursing Care Tool Steering Group, Shelford Group • Research Fellow, Centre for Nursing, Midwifery and AHP led Research (CNMAR), University College London Hospitals NHS FT • Member, Digital Nursing Oversight Board, NHSE/I • Member, UHL Corporate Trustee Board
Lorraine Hooper	Chief Financial Officer	• Member of the UHL Corporate Trustee Board
Eleanor Meldrum *until May 2022*	Acting Chief Nurse	• Member of the UHL Corporate Trustee Board • Honorary Professor for the Faculty of Health and Life Sciences, De Montfort University (unremunerated)
Jon Melbourne	Chief Operating Officer	• Member of the UHL Corporate Trustee Board • Shareholder and Company Director of Ten Five Four Homes Ltd
Richard Mitchell	Chief Executive	• Chair East Midlands Cancer Alliance • Chair Midlands Regional Talent and Leadership Board

NAME	POSITION	INTEREST(S) DECLARED
		• Occasional consultancy work (value is less than £500 per year) • Member of the UHL Corporate Trustee Board
Ballu Patel	Non-Executive Director	• 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) • Trustee of the Stroke Association (voluntary post) • National Institute for Health and Care Research (NIHR) National Specialty Lead for Stroke.
Dr Gopal Sharma	Associate Non-Executive Director	• *Declaration added at the 9.2.23 public Trust Board:* Medical Examiner *(wide-ranging discussions were held with all concerned parties, a statement of assurance was provided and also robust processes were agreed to monitor and support any potential conflicts of interests)* • Associate Medical Director NHSE/I – Midlands (until 30 September 2022) • GP Appraiser, NHSE/I - Midlands • Retainer Scheme NHS GP - Fosse Medical Director • First Tier Tribunal Member for PHL, War Pensions & Social Security Chambers • Honorary Lecturer/GP Tutor - Leicester Medical School
Michael Simpson	Interim Director of Estates and Facilities	• Ambassador for Health within the Institute of Directors (IoD) • Adviser to Lincoln College Group
Michelle Smith *from October 2022*	Director of Communication and Engagement	• Confirmed no declarations to be made
Clare Teeney *from May 2022*	Chief People Officer	• Confirmed no declarations to be made
Joanne Tyler-Fantom *Until May 2022*	Acting Chief People Officer	• Confirmed no declarations to be made
Mike Williams	Non-Executive Director	• Board Member and Trustee Midlands Arts Centre Limited • Chair Midlands Arts Centre Trading Company Limited • Board Member and Trustee Chamberlain Highbury Trust Limited • Trustee Badley Memorial Trust • Member of the UHL Corporate Trustee Board
Jeff Worrall	Associate Non-Executive Director	• *declaration added at the 9.2.23 public Trust Board:* Chair of Trust Group Holdings Ltd • Senior Adviser to Newton Europe • Outside employment with East Midlands Ambulance Trust

Non-Executive Directors chair key 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 Committee Chairing roles that our Non-Executive Directors carried out over the last 12 months:

Board member	Chairs
John MacDonald (Trust Chair)	Trust Board
Vicky Bailey	Quality Committee
Steve Harris	Finance and Investment Committee
Dr Andrew Haynes	Reconfiguration and Transformation Committee
Ballu Patel	People and Culture Committee
Professor Thompson Robinson	Charitable Funds Committee
Mike Williams	Audit Committee Operations and Performance Committee Remuneration Committee

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

Non-Executive	Role
Vicky Bailey	• Senior Independent Director • Board champion for Maternity Safety • Board lead for Maintaining High Professional Standards
Mike Williams	• Vice Chair
Ballu Patel	• Board champion for Freedom to Speak Up
Jeff Worrell	• Board champion for EPRR

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

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

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

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

The People and Culture Committee focuses on workforce issues, organisational culture, and organisational systems and processes. This Committee meets monthly and amongst the standing items which feature on its agenda are (a) workforce issues – including regular review of the Workforce Strategy (UHL People Plan) and the Trust's progress against its equality and diversity plan; (b) urgent and emergency care performance; and (c) performance against the cancer waiting time standards.

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

The Reconfiguration and Transformation Committee plays an assurance role in the delivery of the programme to reconfigure services across the UHL estate. This committee sets the direction and oversees the delivery programme, whilst providing leadership and advice.

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'.

Following ratification at their next meeting, the minutes of each Board committee meeting are then submitted to the next available Trust Board meeting for their oversight. A written escalation report is provided to the Trust Board following each committee with the Chair of each committee personally presenting a summary of the committee's deliberations, highlighting material issues arising from the work of the Committee to the Trust Board.

Policies and key corporate governance documents

We have in place a suite of corporate governance policies which are reviewed and updated as required. This year the Trust has reviewed its standing orders, standing financial instructions, and scheme of delegation.

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 Board subscribes to the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles, 'the seven principles of public life'. 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).

Register of Interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the national guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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 22/23 can be found on pg 46.

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 22/23, the committee met its responsibilities as set out in its terms of reference by:

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

Salary and pension entitlements of Senior Managers

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

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

All pension-related benefits are calculated using the HMRC method as set out in Section 229 of the Finance Act 2004. The Department of Health and Social Care have clarified that for NHS bodies this is the "Real increase in pension multiplied by 20 plus the real increase in lump sum less contributions made by the individual equals Accrued Pension Benefits". The NHS Pension Scheme is a "defined benefits" scheme based on final salary and/or career average earnings. Thus where a senior manager's salary increases this results in a larger movement in the overall value of their pension entitlement. Similarly, where there is a limited increase in the value of the pension payable relative to inflation and the employees' contributions, then the HMRC calculation can show a "negative pensions benefits" figure for the year which is then shown as a "nil" figure in the table. These factors mean that year on year there can be significant volatility in the reported pensions' benefits for an individual.

The Trust is a member of the NHS Pension Scheme which is a defined benefit Scheme, though accounted for locally as a defined contribution scheme. The Trust does not operate nor contribute to

a stakeholders' pension scheme other than contributions to the National Employment Savings Trust (NEST) scheme for a small number of qualifying employees who have opted out of the NHS Pension Scheme. Non-Executive Directors are not members of the Trust pension scheme. Disclosure is made in respect of pension benefits for those Directors who were active members of the NHS Pension Scheme during 2023/24.

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

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

PART 2: Accountability Report *(continued)*

Salary and pension entitlements of senior managers – salary 2022/23 (subject to audit)

Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
BOARD MEMBERS						
EXECUTIVE DIRECTORS						
A Furlong, Medical Director	225-230	400	0	0	55-57.5	285-290
A Carruthers, Chief Information Officer	120-125	3,300	0	0	17.5-20	140-145
D Kerr, Director of Estates and Facilities (to 10 April 2022)	0-5	0	0	0	N/A	0-5
R Cassidy, Director of Corporate and Legal Affairs	120-125	0	0	0	147.5-150	265-270
M Durbridge, Director of Quality Transformation Efficiency and Improvement	110-115	0	0	0	25-27.5	140-145
L Hooper, Chief Financial Officer	160-165	0	0	0	47.5-50	210-215
J Melbourne, Chief Operating Officer	175-180	300	0	0	55-57.5	230-235
E Meldrum, Acting Chief Nurse (to 8 May 2022)	5-10	0	0	0	N/A	5-10
R Mitchell, Chief Executive	210-215	100	0	0	200-202.5	415-420
J Tyler-Fantom, Acting Chief People Officer (to 31 May 2022)	20-25	0	0	0	20-22.5	45-50
L Abeyratne, Director for Health Equality and Inclusion (from 7 June 2022)	50-55	400	0	0	95-97.5	150-155
M Simpson, Director of Estates and Facilities (from 11 April 2022)	130-135	700	0	0	32.5-35	165-170
C Teeney, Director of People and Organisations (from 1 June 2022)	130-135	2,800	0	0	190-192.5	320-325

J Hogg, Chief Nurse (from 9 May 2022)	155-160	0	0	0	7.5-10	165-170
M Smith, Director of Communications and Engagement (from 17 October 2022)	50-55	0	0	0	35-37.5	85-90
S Barton, Deputy Chief Executive (from 13 June 2022)	130-135	0	0	0	102.5-105	235-240
NON EXECUTIVE DIRECTORS						
J McDonald, Trust Chair	65-70	0	0	0	0	65-70
B Patel, Non-executive Director	10-15	0	0	0	0	10-15
V Bailey, Non-executive Director	10-15	0	0	0	0	10-15
M Williams, Non-executive Director	10-15	200	0	0	0	10-15
T Robinson Non-executive Director	10-15	0	0	0	0	10-15
S Harris, Non-executive Director	10-15	0	0	0	0	10-15
A Haynes, Non-executive Director	10-15	0	0	0	0	10-15
G Collins-Punter, Associate Non-executive Director	10-15	0	0	0	0	10-15
G Sharma, Associate Non-executive Director (from 1 April 2022), Non-executive Director (from 11 October 2022)	10-15	0	0	0	0	10-15
J Worrall, Non-executive Director (from 1 April 2022)	10-15	0	0	0	0	10-15

In 2022/23 the Trust continued to pay the salary of M Wightman, who left the Board in 2021/22. This remuneration was in the range £145-£150k.

Name and Title	**Real Increase in accrued pension at pension age**	**Real Increase in lump sum at pension age**	**Accrued pension at pension age as at 31/03/23**	**Lump Sum at pension age as at 31/03/23**	**CETV AS AT 31/03/23**	**CETV AS AT 31/03/22**	**Real increase in CETV**
Pension	**(bands of £2500) £'000**	**(bands of £2500) £'000**	**(bands of £5000) £'000**	**(bands of £5000) £'000**	**£'000**	**£'000**	**£'000**

A Furlong, Medical Director	2.5-5	2.5-5	65-70	145-150	1,442	1,306	72
A Carruthers, Chief Information Officer	0-2.5	0	30-35	60-65	501	461	9
D Kerr, Director of Estates and Facilities (to 10 April 2022)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
R Cassidy, Director of Corporate and Legal Affairs	7.5-10	0	10-15	0	148	56	73
M Durbridge, Director of Quality Transformation Efficiency and Improvement	0-2.5	0-2.5	55-60	160-165	1,339	1,234	52
L Hooper, Chief Financial Officer	2.5-5	0-2.5	35-40	60-65	488	430	25
J Melbourne, Chief Operating Officer	2.5-5	2.5-5	30-35	45-50	409	352	35
E Meldrum, Acting Chief Nurse (to 8 May 2022)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
R Mitchell, Chief Executive	7.5-10	12.5-15	50-55	85-90	733	576	125
J Tyler-Fantom, Acting Chief People Officer (to 31 May 2022)	0-2.5	0	20-25	25-30	360	321	3
L Abeyratne, Director for Health Equality and Inclusion (from 7 June 2022)	5-7.5	0	15-20	0	163	104	38
M Simpson, Director of Estates and Facilties (from 11 April 2022)	2.5-5	0	5-10	0	80	52	7
C Teeney, Director of People and Organisations (from 1 June 2022)	10-12.5	0	75-80	0	1,064	870	121
J Hogg, Chief Nurse (from 9 May 2022)	0-2.5	0	5-10	5-10	89	79	3
M Smith, Director of Communications and Engagement (from 17 October 2022)	0-2.5	0	5-10	0	73	51	2
S Barton, Deputy Chief Executive (from 13 June 2022)	5-7.5	7.5-10	40-45	70-75	726	605	66

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

	Total	Permanent	Other	Total
	2022/23	2022/23	2022/23	2021/22
	No.	No.	No.	No.
Medical and dental	**2,183**	745	1,438	**2,011**
Administration and estates	**2,892**	2,468	424	**2,816**
Healthcare assistants and other support staff	**3,967**	3,334	633	**3,893**
Nursing, midwifery and health visiting staff	**4,484**	3,038	1,446	**4,173**
Nursing, midwifery and health visiting learners	**95**	95	0	**109**
Scientific, therapeutic and technical staff	**1,353**	1,167	186	**1,774**
Healthcare science staff	**499**	464	35	**8**
Total average numbers	**15,473**	**11,311**	**4,162**	**14,784**
Of which:				
Number of employees (WTE) engaged on capital projects	**59**	59		43

The Trust has reclassified relevant staff from Scientific, therapeutic and technical staff to Healthcare science staff in 2022/23.

Exit Packages (subject to audit)

There was 1 compulsory redundancy and 1 other exit package agreed in 2022/23.

	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)								
£25,001 - £50,000			1	38	**1**	**38**	1	38
£150,001 - £200,000	1	160			**1**	**160**		
Total	**1**	**160**	**1**	**38**	**2**	**198**	**1**	**38**

Exit packages: other (non-compulsory) departure payment

	Payments agreed	Total value of agreements
	Accounts	Accounts
	No.	£000
Exit payments following employment tribunals or court orders	1	38
Total	**1**	**38**

Expenditure on consultancy (subject to audit)

We spent £2.6m on consultancy services in 2022/23 (£3.3m in 2021/22).

Fair Pay Disclosure (subject to audit)

		Percentage change in remuneration	
		Highest paid Director	All Other Employees
2022/23	Salary and allowances	6.5%	8.1%
	Total pay	6.5%	8.2%
2021/22	Salary and allowances	2.2%	3.7%
	Total pay	2.2%	3.8%

Pay Ratio Information

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 2022/23 was £235,000-240,000 (2021/22, £220,000 - £225,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022/23	25th Percentile pay	Median pay	75th Percentile Pay
Total remuneration (£)	25,814	35,207	46,801
Salary component of total remuneration (£)	25,782	35,207	46,743
Pay ratio information	9.2	6.7	5.1
2021/22			
Total remuneration (£)	23,154	32,324	43,318
Salary component of total remuneration (£)	23,141	32,306	43,294
Pay ratio information	9.6	6.9	5.1

In 2022/23, 21 employees received remuneration in excess of the highest-paid director (13 employees in 2021/22). Remuneration across the Trust ranged from £9.1k-£538k (2021/22 £8.6k-£397k).

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.

In making decisions about the level of remuneration awarded to any individual director, the Trust takes steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS foundation trusts, and that this rate enables the Trust to attract and retain senior managers with the necessary abilities to lead and develop the Trust's activities fully for the benefit of patients. As such, when appointing to this highest paid director position of Chief Executive, due regard was given to remuneration benchmarking data, market conditions, and the individual's level of experience.

Between 2021/22 and 2022/23 there has been no significant movement in the ratio of the highest paid Director's pay to that of the workforce

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 2022/23 all existing off-payroll engagements were subject to a risk-based assessment as to whether assurance needed to be sought that the individual was paying the right amount of tax. Where necessary, that assurance has been sought.

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

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

- For all off-payroll engagements as of 31 March 2023, for more than £245 per day.
- For all new off-payroll engagements, for more than £245 per day.
- For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023.

The Trust has 57 relevant off-payroll engagements as of 31 March 2023, 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.

	Number
Number of existing engagements as of 31 March 2023	57
Of which, the number that have existed:	
for less than one year at the time of reporting	13
for between one and two years at the time of reporting	11
for between 2 and 3 years at the time of reporting	9
for between 3 and 4 years at the time of reporting	17
over 4 years at the time of reporting	7

Table 2: Off-payroll workers engaged at any point during the financial year
For all off-payroll engagements between 1 April 2022 and 31 March 2023, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 31 March 2023	18
Of which...	
No. not subject to off-payroll legislation	3
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	15
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 2022 and 31 March 2023.

	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.	26

Staff report

Staff composition

Analysis of staff numbers

Workforce statistics

Senior Manager Gender Split at 31 March 2023

	Heads		WTE		Total Heads	Total WTE
Grade	Female	Male	Female	Male		
Band 8 - Range A	421	142	391	142	563	533
Band 8 - Range B	109	53	101	55	162	156
Band 8 - Range C	56	21	56	22	77	78
Band 8 - Range D	29	11	28	10	40	39
Band 9	17	9	17	9	26	25
Senior Manager	10	4	10	4	14	14
Executive Director		1		1	1	1
Director	2		2		2	2
Grand Total	644	241	605	243	885	848
All Staff	13,303	4,026	11,887	3,910	17,329	15,788

The Trust's gender pay gap report can also be found on the website.

Staff numbers

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

Sickness absence rate

Sickness Absence

Annual Sickness 2022-23

Clinical /Corporate	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Cumulative Position
358 Clinical CMGs	6.43%	5.17%	5.50%	6.68%	5.23%	4.96%	5.67%	5.50%	6.65%	5.57%	5.17%	5.40%	5.66%
358 Corporate	3.39%	3.03%	3.06%	4.19%	3.35%	3.45%	4.37%	4.11%	4.64%	3.76%	3.27%	2.96%	3.63%
UHL	6.13%	4.96%	5.25%	6.43%	5.05%	4.81%	5.54%	5.36%	6.45%	5.39%	4.98%	5.16%	5.46%
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%

Annual Sickness Rate 5.46%

Trade Union (Facility Time Publication Requirements) Regulations 2021/22

Trade Union

Relevant TU/PO Representative

Number of employees who were relevant TU/PO Representatives during the relevant period	*Full-time equivalent employee number*
19	**17.79**

Percentage of time spent on facility time

Percentage of time	*Number of employees*
0%	**0**
1-50%	**18**
51%-99%	**0**
100%	**1**

Percentage of pay bill spent on facility time

First Column	*Figures*
Provide the total cost of facility time	**£86,503.34**
Provide the total pay bill	**£886.2m**

Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	**0.010%**

Paid TU/PO activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant TU/PO representatives during the relevant period ÷ total paid facility time hours x 100*	**5.10%**

The NHS National Staff Survey

The NHS Staff Survey was carried out in October and November 2022, on behalf of NHS England and the results form a key part of the Care Quality Commission's assessment of NHS Trusts in respect of its regulatory activities such as registration, the monitoring of on- going compliance and reviews.

A full census survey was undertaken, which means every member of staff (16,674) that was eligible to take part and would have received a survey to complete. 8012 responses were returned, giving a response rate of 48 per cent. This was an increase of 3 percentage points from the previous year; the national average (median) for Acute and Acute & Community Trusts stands at 45 per cent, which means we were above average for the first time.

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

	Trust 2021	**Trust 2022**
q21c. Would recommend organisation as place to work	55%	55%
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	63%	58%

Whilst there was no improvement in colleagues recommending the Trust as a place to work, the national average score dropped by 2 percentage points. This year there was a deterioration of 5 percentage points for colleagues who were happy with the standard of care, this mirrored the National average deterioration in this question.

Improvements were seen against last year, in how people feel about teamwork, appraisals, career development and having a better work-life balance.

Our promise for 2023 is we will work together to make UHL a place where more people feel:

Recognised: Whether it is long service or extra effort, we will radically improve how we recognise and value all colleagues.

Included: We should all be able to contribute equally. We will celebrate diversity, challenge poor behaviour, and strengthen our mechanisms for reporting concerns.

Supported: Flexible working, better recruitment and retention, and consideration of health and wellbeing are what matter most to you.

Equipped for your role: From ward equipment and communal areas, to IT, parking, and payroll - we will focus on getting the basics right. We need to make it easier for colleagues to do their job well.

Apprenticeship programmes, Medical and Nurse training

Nursing, Midwifery and Allied Health Professionals (NMAHP)

UHL School of Nursing and Midwifery Practice - Nursing and Midwifery Education and Workforce

Our School of Nursing Practice based at the Glenfield Hospital has eight Faculties including the Leicestershire School of Nursing Associates. Our Nursing and Midwifery Educators deliver a range of accredited and specialist clinical education and leadership programmes endorsed by the Royal College of Nursing. For our healthcare support workers and undergraduate students, there are opportunities to undertake essential skills updates, access apprenticeships and participate in clinical simulation, all delivered at our School.

A significant contribution has also been made by the nursing and midwifery education team and clinical practice facilitators to grow our workforce during this year

Healthcare Support Workers (HCSW)

All new Health Care Support Workers recruited to University Hospitals of Leicester will undertake a three-week induction programme at the School of Nursing and Midwifery to prepare them for all aspects of their role. The programme consists of the delivery of theoretical knowledge and practical skills sessions, completion of mandatory and statutory learning and commencement of the 12-week period which supports the completion of the National Care Certificate.

From April 2022 - March 2023 we recruited 589 Healthcare Assistants including Theatre Support and Maternity Care Assistants

In addition to this, the faculty has delivered HCSW Induction and Care Certificate training to 330 First Year University of Leicester Medical Students (September 2022 cohort) of which **80** students went on to join UHL's Nursing Bank. This is a programme that runs year on year with the University and is successfully supporting our Medical Student colleagues into flexible working opportunities both in Leicester Hospitals and local NHS Trusts.

During 2022 - 2023 we have trained **64** HCSW Buddy's to support and aid retention of our new support worker colleagues.

In 2022 / 2023, we were able to expand our HCSW Faculty Team and welcomed two additional Band 3 Education Support Workers, two Band 4 Registered Nursing Associate educators and a Registered Nurse

Clinical Tutor. This has helped us to increase our training capacity to support pastoral support and the NHSE Ambition to reduce HCSW vacancies in UHL.

New HCAs receiving their Care Certificate outside the School of Nursing & Midwifery

Recruitment of Internationally Educated Nurses and Midwives (INEMs)

UHL, like other NHS Trusts continued to ethically recruit internationally educated nurses and midwives throughout 2022/23 to support the growth of our workforce. On arrival to UHL the nurses undertake a six-week induction and preparation programme towards completion of their Objective Structured Clinical Examination (OSCE) and registration as a UK nurse with the Nursing and Midwifery Council (NMC).

Achievements for 2022/23:

- Recruited 399 nurses and midwives who are working across a range of adult, child and maternity specialities
- 100% OSCE pass rate
- Celebrated the arrival of our 1000th candidate
- Introduction of a Nursing Pastoral Care Team who are all internationally educated nurses to support the arrival and ongoing support of our IENMs
- Introduced an innovative career conversation model using StrengthsMatch^{TM} to support the development and career progression of our nurses
- Supported 19 IENs working in UHL as Healthcare Assistants to gain UK nursing registration
- Continued to work in partnership with a local NHS Trust to deliver their International Recruitment Programme

Internationally Educated nurses completing their OSEC preparation programme at UHL

Leicester, Leicestershire and Rutland (LLR) Nursing Associate Programme

The LLR Nursing Associate Programme is now in its sixth year and has seen seven cohorts of trainees from Health and Social Care providers across LLR including UHL, Leicestershire Partnership Trust, LOROS, Primary and Social Care. The programme has expanded from a single cohort to three per year in 2022. With increasing awareness of the value of the role, recruitment to the programme is expanding through internal interest from our HCA workforce and externally through the provision of apprenticeship posts. the total number of trainees enrolled since programme commenced 2017: is 443 trainees with a total number of active trainees on the programme: 129

Clinical Leadership Development

There is strong research-based evidence that strong leadership contributes to better patient outcomes. Leadership development also supports a positive practice environment by ensuring that leaders are accessible, visible and that they facilitate collaborative decision-making within a shared governance structure.

The RCN Clinical Leadership Programme which is our flagship programme is for Ward Leaders. It is a year-long programme and designed to support, develop, challenge and for individuals to gain a greater sense of self awareness. In 2022, with permission from the RCN we have adapted this programme for Matron level and specialist nurses at UHL.

Throughout 2022/23 our Faculty of Clinical Leadership provided suite of leadership development opportunities supporting our clinical colleagues from senior band 5 upwards on both ward and specialist pathways.

- Royal College of Nursing Clinical Leadership Programme
- Leading an Empowered Organisation (LEO)
- Specialist Nurse and Midwife Leadership Development
- Senior Staff Nurse and Midwife Leadership Development
- Deputy Sister / Charge Nurse / Team Leader / Operating Department Assistant Leadership Development
- Florence Nightingale Foundation opportunities

- Nurse in-Charge Leadership Development
- 360 appraisal
- One to one coaching and mentoring

Continuous Professional Development Funding

The 2019 Ministerial announcement of £50m increased investment in Continuous Professional Development, over 3 years, for Nursing Associate, Nurses, Midwives & Allied Health Professional (AHP) funding has been in place from April 2020. This funding was distributed through Health Education Regional(HEE) offices and in 2022/23 equated to £1000 over three years (£333.33/year) per registrant.

The funding in 2022/23 was used in line with NHSE guidance for the following CPD opportunities

- HEI assessment & Non-medical Prescribing modules to support specialist Nurses/Midwives/AHP's to undertake new roles/new ways of working
- Leadership programmes such LEO/RCN/NHS leadership academy/In house Band 5,6,7 leadership programmes & Nurse In Charge
- HEI Ultra sound modules to support new roles for AHP's
- ITU education programmes to support the national standards
- University programmes to upskill staff with clinical modules or support the uplift to Degree/Masters level study
- Conferences to update staff in their areas of clinical expertise

Doctors' Rotas

UHL has worked closely with HEE EM to expand our foundation training programme and is expecting 26 more foundation level doctors from August 2023. We have also expanded other trainee numbers and are training 26 more postgraduate doctors in a range of specialties from August 2023.

Gaps within the rotas do occur and we have introduced a new App based system through partnership with "Locums Nest" UHL which allows doctors to book onto vacant shifts . This has a number of other advantages regarding swifter payment of sessions and transparency a large part of which is driven by a significantly reduced paper-based process.

Health and Wellbeing of our workforce is a priority and we have developed a new role to support our Specialty and Specialist Doctors through the appointment of an SAS advocate who has commenced in post March 23 with a focus on improving the working life and wellbeing of this group of substantive employees.

Medical Education

UHL provides Undergraduate and Postgraduate medical training, working closely with Leicester Medical School and Heath Education England (HEE). We strive to be the best training provider across the East Midlands and further afield, with a strategic aim to 'develop a competent, caring and capable workforce working in an excellent learning environment to provide high quality, safe patient care'

Whilst the Trust has continued to ensure that the impact of COVID on education and training is minimised, a number of new, exciting development and projects were initiated in 2022/23.
Educational Facilities will be improved as part of the wider reconfiguration project. A new facility at LRI is expected in 2025 with additional, improved space at GH at a later stage. In the meantime, the current LRI Education centre and offices have benefited from refurbishment and redecoration, recognising the importance of providing a high quality learning environment. Additional surgical skills training space is

now available at GH and there are plans to explore opportunities for improving the Education Centre at LGH.

The 2022 Medical Educator Awards were presented at an Education Showcase event in December 2022.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 300 nominations for the awards and winners were from across a number of professions and specialties.

Over 100 UHL educators attended the 2022 showcase event which included updates from HEE and Leicester Medical School. Workshops on technology in education, finance for educators and giving difficult feedback were well evaluated. A similar event will be held in October 2023.

UHL Library and Clinical Librarian teams have expanded in 2022 with additional staff in both services. The Patient Information team have recently been awarded the PIF Tick as a trusted information creator. This is the UK quality mark for health and care information and UHL is only the 3rd trust in the country to receive this accreditation.

Undergraduate Medical Education

Leicester Medical School is now ranked 5th nationally and there has been an increase in application ratios this year to 12:1. National Foundation Programme data shows an improvement in the number of Leicester graduates who are staying locally for their Foundation training. This has increased from 23% in 2017 to 32% in 2022.

The number of medical students is increasing nationally to support the future medical workforce, and UHL will continue to accommodate additional University of Leicester medical student placements.

A number of Surgical Teaching Fellows were appointed in 2022 to support the increase in medical student placements and ensure consistent access to high quality teaching. The five Fellows are Postgraduate Doctors in Training who have taken a year out of training to develop their teaching and assessment skills. The Fellows have worked across a number of surgical specialties with approximately 150 year 3 students with excellent feedback. The concept of Teaching Fellows is being explored by other specialties to support the pressure on senior medical staff to supervise and teach increasing numbers of learners.

Postgraduate Medical Education

In line with the NHS People Plan, there is an ongoing redistribution and expansion of trainee posts. UHL will benefit from an increase in Foundation and Specialty trainee numbers. Challenges with supervision for increasing numbers are acknowledged and proposals are in place to support and expand the numbers of Supervisors.

Changes in the demographics of the medical workforce were described in a recent GMC publication ‘Workforce Report 2022’. UHL has 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.

Initiatives have been introduced to ensure effective trust level engagement with Postgraduate Doctors’ in Training, recognising the valuable contribution of this group of staff and that the rotational nature of training posts can impact on engagement. These include quarterly events with the CEO, Medical Director

and other Executive members. Topics discussed recently have included training and patient safety concerns, wellbeing, access to car parking, rest facilities and payroll.

The Trust continues to use a local annual survey to review the quality of experience and training for all Postgraduate Doctors in Training (including LEDs). Survey outcomes are shared with CMGs and with the Medical Director at Corporate Medical Operational meetings. There are also two national surveys, the GMC National Training Survey (NTS) for Postgraduate Doctors in Training (trainees only) and the National Education and Training Survey (NETS) which includes all healthcare learners. National survey outcomes are shared with UHL and where HEE have concerns, the Trust is asked to investigate and provide a formal response +/- an action plan. The Department of Clinical Education works closely with services where training challenges are identified to monitor progress and offer support.

In 2022, UHL were successful in a number of bids to secure funding from HEE. The funding has been used to support educators, improve the learning environment and support training recovery for trainees whose progress has been affected by the pandemic. One of the successful bids was for a multi-specialty surgical simulator which will enable doctors in General Surgery, Trauma and Orthopaedics, Urology, Vascular Surgery and Obstetrics and Gynaecology to meet their curricular needs for training.

Training & Organisational Development

Learning and Development

Ensuring all our staff have access to the right skills and knowledge at the right time and in the most accessible way continued to be crucial in 2022/23. We, through the range of sub teams and work streams within Learning and Development, have provided flexible blended learning across our whole portfolio to meet the needs of our learners and the Trust since the COVID response and continues to support the development of our workforce.

UHL offers a wide range of apprenticeships and other courses e.g., telephone skills, report writing, academic writing and minute taking, by working together with local colleges and private training providers to support workforce development needs.

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

During 2022/23 whilst the still recovering from the effects COVID had and is still having on services, we continued to enable our hospital to provide a service to our patients, there were seven core business courses (Appraisal, Assertiveness, Planning for Retirement, Sickness Absence, Manager Workshops, telephone skills and minute taking) led by the team that continued to run to support the core service which were attended by 766 members of staff.

Other highlights of the year include:

- The Core Training Team developed 28 new programmes which were launched in 2022/23 and around 113 modules in development or being reviewed/updated, with more than 175 modules currently live for colleagues to access
- An increase in eLearning with over 200,000 modules being completed this year, compared to 197,097 in 2021/22
- The IT training team has continued their delivery of training for staff who work with various clinical IT applications. A significant increase of over 1900 learners have attended in-classroom training sessions compared to 1200 in 2021/22 and 219 have completed eLearning modules
- Our internal apprenticeships team have supported more than 1304 staff learners on Apprenticeship Education Programmes. 237 of these enrolled in 2022/23

- Our externally UHL Apprenticeship and Development Centre supported 153 learners from 11 other health and social care organisations including Leicestershire Partnership Trust and LOROS
- We continued to broaden the offer of apprenticeships during 2022 to support working towards the Public Duty of Care target, (2.3 % of the workforce – Trust figure increased to 2.7% in 21/22 from 2.48% in 20/21)
- Overall, the centre achieved 74 learner completions this year – 40 gained distinctions, 5 gained merits and 29 passed
- Our Health Levels 2, 3 and 5 continues to have a 100% pass rate
- UHL successfully delivered the government initiative The Kickstart Scheme - The centre has set up a credited level 2 City in Guilds Employability in Health programme to support individuals to gain a recognised qualification along with individuals' placement at UHL, the scheme gives opportunities for individuals to have an experience to what it is like to work in the NHS and observe the variety of different roles there is within an NHS. 30 Kickstarters were placed with 75% gaining employment (apprenticeship to Band 3).

Embedding Research and Innovation

This year, we recruited 15,339 participants into research: of these, 8,801 we recruited to National Institute for Health and Care Research (NIHR) portfolio studies and 595 took part in commercial trials. While the total number of participants has decreased in the last year, the complexity and intensity of studies has increased.

There were 552 open studies, including 103 commercial trials. Our researchers have published 1100 papers in peer-reviewed journals.

Research and Innovation generated £42m of income in 2022/23, of which £X million came from commercial research. In line with the UK Government strategy for the Life Sciences, we have prioritised the rebuilding and expansion of our portfolio of commercial trials. Our recruitment to these studies is almost equal to all other trusts in the East Midlands combined, meaning that more University Hospitals of Leicester (UHL) patients can access potentially life-changing treatments. Furthermore, these commercially funded interventions have a cost saving because they are not paid for by the NHS (National Health Service).

Our NIHR Biomedical Research Centre (BRC) was renewed for 2022-2027 for £26.1m - over twice the funding in the last round. It now has six themes: cardiovascular disease; respiratory and infectious diseases; lifestyle (including type 2 diabetes); personalised cancer prevention and treatments; environment and health; and using data to understand long term health conditions and health inequalities.

The contract for the NIHR Patient Recruitment Centre (PRC): Leicester has been extended until March 2024. In addition, the Experimental Cancer Medicine Centre (ECMC) has been awarded £1.8M for next 5 years. UHL has also recorded the highest number of recruits to commercial research studies in the East Midlands ensuring patients have access to cutting edge treatments much earlier.

In terms of patient experience, over 5% (463) of our research participants shared their feedback on taking part in research. More than 95% said they would take part in research again. 97% agreed or strongly agreed that research staff treated them with courtesy and respect.

Some research highlights for the year include:

- Research conducted at our NIHR Leicester BRC has shown that any increase in physical activity is beneficial, but there is a greater reduction in cardiovascular disease risk when more of that activity is of at least moderate intensity (Dempsey et al.: *European Heart Journal*).
- A study that aimed to identify differences in the airway microbiome from bronchial brushings in patients with Chronic Obstructive Pulmonary Disease (COPD) and healthy individuals, and to investigate whether any distinguishing bacteria are related to bronchial gene expression, showed that Prevotella was the genus that most robustly distinguished samples of patients with mild-to-moderate COPD from those of healthy individuals (Brightling et al: *Lancet Microbe*).
- Professor Melanie Davies led the update to the international *American Diabetes Association and European Association for the Study of Diabetes consensus guidelines on managing hyperglycaemia in type 2 diabetes*, which for the first time included sleep, along with sedentary time and physical activity. Much of the evidence cited to inform the guidelines was supported by research at the NIHR Leicester BRC.
- The Smart Work and Life intervention led by Dr Charlotte Edwardson and published in the BMJ in 2018 has now been developed into a nationally available occupational health programme https://www.smartworkandlife.co.uk/ that has been used in local councils, among other workplaces. Most recently, it was shown that combining a standing desk with this intervention reduced workplace sitting by over an hour a day.

Improving the culture of the Finance Department

Building on the successes of last year, the finance department is continuing on its journey of improvement to ensure it becomes best in class. The new expanded structure for the finance department has been fully populated with an additional 25 posts, and an in-year review has ensured the structure remains fit for purpose. Many of the restructure Key Performance Indicators (KPIs) have now been achieved; delivery of departmental mandatory training target rates, delivery of Trust-wide training target rates for finance (budget holders) and procurement, appraisal rates of 93.7% at year end, percentage of qualified accountants at Agenda for Change Band 7 and above exceeding levels in peer Trusts, investment into the department ranked as upper mid-quartile per the Corporate Returns.

The KPIs also demonstrate the cultural improvements being made; the department has secured accreditation with the professional accountancy bodies, received One NHS Finance (ONF) Towards Excellence Level 1 accreditation and are awaiting approval for Level 2 accreditation, internal stakeholder survey results reflect improvements in finance service provision to the Trust, finance department survey reflects majority of staff believe it is a more positive place to work and feel able and safe to speak up.

The improvement action plan covering the four workstreams of Training & Development, Communication, Culture & Behaviour and Integration continues to be overseen by the Finance and Procurement Skills Development (FPSD) working group and a fifth workstream focussing on financial system improvements has been created. The output of this group has resulted in two innovations being published on the ONF website as best practice for other NHS bodies to implement, those being the creation of the monthly Directorate Nomination Award Scheme and the creation of the Directorate Mental Health and Well-being Virtual Cafés. There have also been many other in-year improvements within the department and the substantive appointment to the new post of Deputy Director of Finance (Staff Development) will ensure progress made to date in supporting and developing the finance function will continue in the forthcoming years.

Policies in relation to disabled employees and equal opportunities

Equality Advisory Group

We continue to engage with the Equality Advisory Group, to support the Trust in driving forward positive outcomes for the communities that access treatment and care. There is recognition for the need to review the membership of the group to ensure it is representative of the community we serve, as well as acknowledging the contribution that members give in their free time.

The group comprises of representation from some of the diverse communities in Leicester, Leicestershire and Rutland. However, membership of the group over the past year has declined since its establishment. We will work with current members to develop and plan ways in which the Trust and the Equality Advisory Group can effectively work in collaboration to improve health outcomes for the diverse communities, we serve.

Equality, Diversity and Inclusion

We are committed to the Equality, Diversity and Inclusion (EDI) agenda and recognise the value it brings to delivering healthcare that meets the needs of the diverse communities of Leicester, Leicestershire and Rutland.

We have worked hard to embed and mainstream the agenda by engaging in initiatives that support the development of our staff and create a culture where everyone feels respected for who they are and the value they bring to the organisation. Our activities include:

- Working in collaboration with our partners and stakeholders to embed EDI across the system, through engagement and partnership working on the LLR EDI Group, EDI Committee and varies other groups;
- Collaboration on programmes that improve staff outcomes such as:
    - Developing Diverse Leadership programme – improve the representation of our workforce in higher bands;
    - Cultural Competency programme – develop an inclusive culture that ensures that all staff are valued, in line with Trust values;
    - Reverse Mentoring programme – develop an understanding of people from diverse backgrounds;
    - Active-Bystander programme – develop a culture that is respectful to all staff and addresses issues of inappropriate behaviour.
- Working with our staff Networks to improve staff experiences, which include LGBTQ+ Staff Network, BAME Staff Network and Disability Staff Network. Additionally, the Trust has also established the Women's Staff Network and an informal non-visible disabilities Staff Network to improve outcomes. The group provide an opportunity to improve working practices that enrich the experiences of staff, individually and collectively.
- Continued delivery through our Freedom to Speak Up Leads of the civility and respect programme, to improve working relationships between staff across the Trust.
- Improving the experience of staff by analysing and reporting on data against the legal requirements of:
    - Equality Act 2010 and the Public Sector Equality Duty (PSED);
    - National NHS standards such as Workforce Race Equality Standard, Workforce Disability Standard; and
    - Government Standards such as Gender Pay Gap.
- Development of the Reasonable Adjustment guidance and forms to support staff with disabilities in the workplace.

- Establishment of an EDI Board, led by our Executive Team to drive forward activities and initiatives to improve outcomes for patients and staff.
- Development and piloting our Equality Analysis process that ensures our policies, practices, functions and activities do not discriminate against groups of people.

LLR Developing Diverse Leadership programme

The aim of the LLR Developing Diverse Leadership programme is to have an approach, outcome, success and learning:

- to create learning opportunities that enable staff from under-represented groups to thrive.
- to increase diversity in leadership roles so that we have a greater propensity for addressing health inequalities and achieving better outcomes for the communities we serve.
- to deliver against the NHS 'People Promise'
- to create integrated health & care systems that offers 'choice & belonging' to our people - attracting, developing, and retaining the best.

The programme was designed and delivered in a unique setting with participants, line managers, organisational leads and executive sponsors all driving across the programme to embed change.

We have heard from the DDL participants, line managers and executive sponsors that the programme has created far-reaching learning for them around the challenges that under-represented groups face in relation to career progression. A development programme for under-represented groups is 'good', but it is not enough if we want to 'turn the dial' on representation and inclusion.

We are proud to be part of the journey to make a collective difference.

EDI Plans 2023 onwards

We are aware that we need to develop opportunities that offer fair and equitable access for all staff. We want to develop a culture where everyone feels comfortable, safe, included, and supported; aiming to be the exemplar employer in LLR and wider.

We want to be recognised as the greatest Trust, with a high performing and diverse workforce that delivers exceptional healthcare services. We want all staff to contribute to the values of the organisation that makes a difference for our patients.

To achieve this, we are going back to basics to build and deliver initiatives that helps us achieve our ambitions. We will provide tools to help staff respond to requests for help and support, and to build the knowledge of all of us in how we can best work and thrive in a diverse community. Our aim is to embed EDI in all that we do.

We recognise this will take time, however, our greatest asset will to be to work collaboratively across the organisation with our partners. This is a start to our journey to improving and endorsing a culture and ensuring all staff are recognised for their contribution.

Our key activities will include:

- strengthening our engagement and communication activities across the locally, regionally and nationally.
- reviewing and strengthening our staff networks to achieve increased membership.
- developing initiatives that reduce the gaps between staff through the development of a Gender Equality Steering Group.
- launching the 'No Excuse for Abuse campaign' (including policy, communication, training from both an internal and external lens etc.).

- meeting our Public Sector Equalities Duties (PSED), NHS contractual requirements and government requirements to understand and address gaps in our workforce profiles.
- increasing the understanding of potential bias or barriers to inclusion, as well as identifying actions to make improvements to create a fairer and more inclusive NHS.
- improving fairness and amplify voices of under-represented staff through the exploration of a Shadow Exec model.

We have developed a UHL EDI Workforce Work Programme to support our improvement ambitions and this will align to the NHSE (NHS England) NHS workforce equality, diversity and inclusion (EDI) improvement plan which was published in June 2023.

Inclusive Decision-Making Framework (IDMF)

The Trust has engaged locally on the Inclusive Decision-Making Framework (IDMF). However, we recognise that simplicity in processes aids staff in delivering positive outcomes in our services and employment practices.

We undertook a review of the process and developed a decision-making framework to take into consideration the 'due regard' requirements that full fil our legal responsibilities under the Equality Act 2010 and the Public Sector Equality Duty (PSED). Our aim is to ensure consideration of the diverse population and the wider community.

Policy Review

We are working to ensure the review of our EDI policies meet the ever-changing requirements under the various pieces of legislation. Our aim is to work collaboratively to ensure our approach is inclusive and respective of the diverse population we serve, and the people that work for us.

Improving EDI Data

We continue to review our processes on gathering, analysing and reporting of data. However, we recognise that our data systems are not always equipped to collect the information needed to make informed decisions. Therefore, we will improve our EDI data, working in collaboration with our workforce and information and systems leads to identify and address data gaps and capability.

Policies in relation to health and safety

During the final quarter of 2022/23, the strategic decision was made to repurpose the existing Health and Safety Services teams line management arrangements and key deliverables; respiratory mask fit testing returned to Infection Prevention (IP), manual handling remained within Corporate Nursing and Health, Safety and Security (LSMS) moved to the Estates and Facilities Directorate.

Since the move to Estates and Facilities, a gap analysis of the current Health and Safety Management System has been completed, revealing several areas in need of development and improvement. As a direct consequence, several strategic health and safety priorities have been highlighted for progression over the next 1 – 3 years as part of the wider Estates and Facilities Strategy.

During 2022/2023, the focus was on implementing health and safety measures in response to current situations and developing long-term strategic plans for future actions. As we look ahead to 2023/24, UHL remains committed to prioritising the health and safety of all. To achieve this, we will be reinforcing our management system processes aligned to the Plan, Do Check Act principles of HSG (65).

Health and Safety Performance

Governance, Consultation and Communication

- The UHL Health and Safety Policy are within the review window but in need of alignment with the recent structural changes.
- The UHL Health and Safety Committee continue to convene quarterly to discuss health and safety concerns at a board level with representation across all CMG / Directorates and StaffSide.

Health and Safety Management Systems

The health and safety management system requires development to ensure that the shift from reactive to proactive can be fully realised but continues to support the Trust as has been reported in previous years. The health and safety team has been devising a strategic plan to address the critical issues within the Trust, which is being progressed.

Training and Development

Mandatory Health and Safety training delivered electronically via HELM is currently showing that 91% of staff have completed below the expected target of 95%.

The Health and Safety team continue to offer General Health and Safety, COSHH (Control of Substances Hazardous to Harm) and Display Screen Equipment Risk Assessment Training. These sessions are delivered face-to-face on a quarterly basis and are open to all staff to book via HELM. The course content is reviewed and updated regularly to remain relevant.

Incident Management

This information only covers Estates and Facilities incidents within the Trust.

During the 2022-23 year, there were 161 reported accidents/incidents/near misses and dangerous occurrences reports.

- Out of the total 161 reported incidents, there were 132 reports involving employees, visitors, and patients (The breakdown of the incidents per scope groups are not available).
- 19 Near Miss
- 6 Dangerous Occurrences

40 of these incidents had to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

- There were 35 over 7-day absences related to injuries at work
- There were 3 fractures to bones
- There were 2 releases or escapes of biological agents (needle stick injuries)

Sickness Absence

A total of 199555 working days were lost due to sickness absence in the UHL based on figures held by Workforce Information Team. 907 days lost to work-related injuries and illnesses Trust-wide, noting that this figure does not include days lost due to work-related stress.

Employers Liability Claims

16 claims were made for Employer's Liability during the reporting period; 3 resolved and 13 were pending. Resultant losses thus far equate to £14,608.80 in total.

National Priorities and Changes

As we assess the health and safety performance during 2022-23 and plan for the upcoming year, it's vital to consider the national landscape and the objectives of the key regulatory and sector bodies. HSE has recognised specific priorities that hold significant relevance for NHS Trusts:

- Managing Violence and Aggression and Musculoskeletal Disorders in the NHS
- Managing risk from operations at NHS Helipad sites

The following changes in legislation have / will be taken effect in 2022-2023:

- Fire Safety Act 2021 (the Act) received Royal Assent on April 29, 2021 and came into effect on May 16, 2022. This Act strengthens the responsibilities of the "responsible person" and impacts construction practices, particularly concerning the use of fire-retardant materials in housing projects.
- Personal Protective Equipment (PPE) Regulations 2022 – extends the liability to limb (b) workers, e.g., agency workers/casuals
- Control of Substances Hazardous to Health (COSHH) Regulations (Sixth edition) L5 – changes made to Occupational Exposure Levels (OELs) result in reduced exposure levels to specific substances, potentially affecting the operations of services that utilise such substances.
- Building Safety Act 2022 – this received Royal Assent on April 28, 2022, and will be fully implemented in October 2023. This act put liability over the building owners and managers to register their building safety regime in place by this time.

The Year Ahead (2023 – 2024)

UHL remain committed to the provision of a robust health and safety management system. We will focus on reinforcing the fundamental requirements of HSG (65) and taking a proactive and pragmatic approach to address the safety needs of the Trust while also promoting a positive health and safety culture among our workforce and the public.

The Health and Safety team will collaborate with staff, management, and the Trade Unions to attain the proposed priorities:

- Re-establish Local H&S Group meeting with CMG Champions
- Improve communication channels via existing platforms
- Policy and Procedural Review
- Audit and Inspection schedule
- Evaluate, improve, and streamline the DATIX Incident / Accident Reporting System and data-gathering process
- Improve the incident investigation system where Trends are identified
- Assess the risk assessment needs of the Trust

Review the training and development arrangements and conduct a thorough health and safety training plan

Emergency Preparedness, Resilience & Response

Our Emergency Preparedness, Resilience & Response (EPRR) Team have continued to make progress against NHS England's Core Standards for EPRR, through the development of plans, training and exercising events with multi-agency partners across Leicester, Leicestershire and Rutland. In addition, the EPRR Team also supports the Trust in preparing for the national COVID-19 Inquiry through the development of a series of Investigation Reports, all while supporting the Trust in preparing for and responding to a series of Industrial Action events.

NHS England and NHS Improvement's Single Oversight Framework

NHS Trusts are subject to oversight by NHS England who use the Single Oversight Framework for this purpose. The Oversight Framework bases its oversight on the NHS provider licence. The Trust remains in "segment 4" which means there is "*actual or suspected breach of the NHS Provider Licence (or equivalent for NHS Trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support".* The Trust has been in receipt of support from the Recovery Support Programme since being placed in segment 4. An action plan has been successfully progressed throughout 2022/23 to put right issues which will lead the Trust to financial sustainability and an agreed exit criteria from segment 4.

Segmentation

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

Richard Mitchell
Chief Executive

29 August 2023

Statements of Responsibility

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

The Chief Executive of NHS England 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
29 August 2023

Statement of Directors' responsibilities 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

29 August 2023

Lorraine Hooper
Chief Financial Officer

29 August 2023

Annual Governance Statement

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of 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 2023 and up to the date of approval of the annual report and accounts.

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

The Risk Management Policy was reviewed during the year and updated to include changes to the reporting arrangements for the BAF and risk register to the Audit Committee and Trust Board. A final version of the Policy was approved through the Trust's Policy and Guideline approval process.

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

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

The Trust Board receives reports and assurance from Board Committees and discusses and notes progress with strategic risks on the Board Assurance Framework and operational risk management actions as necessary. Each of the Board Committees have responsibility for the oversight of specific risks associated with their respective remit.

On the Trust Board's Behalf, the Risk Committee, chaired by the Chief Executive or Deputy Chief Executive, has maintained, and kept under review the policy for the management of risk. In the first year of the newly established Risk Committee, the work plan included all CMGs attending to present their top risks, and these are now reflected on the Trust's Risk Register. The Risk Committee meets monthly and provides assurance to the Audit Committee that it continues to operate effectively.

Acting on feedback from the CQC Well Led inspection report, the agreed key next steps in the progress of the Risk Committee are to consistency check risk scoring and ensure appropriate controls are robust and relevant mitigating actions are in place for all new risks on the Trust Risk Register; to review and challenge risks that CMGs and corporate areas have identified where they need support to control or mitigate; and to ensure attendance is improved, recorded and quorate.

The Head of Internal Audit Opinion work programme for 2022/23 has focused on use of the BAF to support the management of strategic risk and achievement of organisational objectives and priorities. Completed actions in the year include: Board Committees Terms of Reference have been reviewed to set out expectations in relation to the BAF; Key Lines Of Enquiry have been developed for each sub-committee to encourage good conversation about risk and assurance at each meeting; BAF scoring has been updated following a Trust Board workshop to discuss risk appetite to include current, target and tolerable ratings; and Board Committee escalation reports to Trust Board include issues arising from BAF discussions.

During the year there has also been an Internal Audit review of the Strategic Governance & Risk Management arrangements in place. Completed actions include recording quoracy within Board and Board committee minutes and recording attendance at Risk Committee meetings; changes to Trust Board meeting agendas to be aligned with Trust priorities and strategic risks on the BAF; quarterly risk management reporting to the Trust Board and Audit Committee in relation to strategic and operational risks; risk management training being included in the Organisational Development workplans; and making sure risk register reports to CMG Boards and performance review meetings include details about closed risks.

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

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

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

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

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

The risk and control framework

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

The framework supports the Trust to:

- protect our patients from harm and poor outcomes

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

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

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

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

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

The Trust's strategic risks in 2022/23 (as featured on the Board Assurance Framework) are set out below:

Risk event	Executive Lead owner	Oversight Committee
Failure to maintain and improve patient safety, clinical effectiveness and patient experience	CN / MD	Quality Committee
Failure to meet national standards for timely urgent and elective care	COO	Operations & Performance Committee
Financial transactions not carried out in accordance with the law and with Government policy and accounting standards. Lack of clarity over the financial position and plan	CFO	Finance Investment Committee
Unable to address statutory requirements such as health and safety standards and legislation, and address backlog maintenance requirements (concerning medical equipment, estate and IM&T)	CFO	Finance Investment Committee
Failure to deliver the 2023/24 financial plan and achieve long term financial sustainability	CFO	Finance Investment Committee

IT Infrastructure unfit for the future, may result in being unable to provide safe, high quality, modern healthcare services	CIO	Finance Investment Committee
Estate Infrastructure unfit for the future, may result in being unable to provide safe, high quality, modern healthcare services	DEF	Finance Investment Committee / Reconfiguration & Transformation Committee

There is an established process to add new risks and remove risks on the BAF, which involves the relevant Board Committee receiving assurance and escalation to the Trust Board to agree a change. Significant changes and movement on the BAF during the year include:

- Closure of a BAF risk regarding a culture of weak financial management, governance with longer term planning not yet embedded. The Finance Investment Committee agreed to remove the risk from the BAF and incorporate residual risk into the appropriate risk on the UHL operational risk register. This course of action was included in the Finance and Investment Committee escalation report to Trust Board in February and was subsequently approved.
- Closure of a BAF risk concerning failure to deliver the 2022/23 financial plan reforecast. The Finance Investment Committee agreed to reduce the current risk score to moderate and a summary was included in the FIC escalation report to Trust Board in February where the change was approved.

Whilst the current BAF has not been operating for the whole of the year, our Internal Auditor has acknowledged that the BAF was in development during the early part of the financial year and that the Trust Board and Audit Committee have received regular updates and been sighted on its progress and development timelines. The BAF will continue to be developed and following the update to the Trust's Strategic objectives in Summer 2023 this will lead to a further review and subsequent changes to strategic risks on the BAF as required.

Operational Risk

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

The operational risks open on the risk register are different to the strategic risks on the BAF, which relate to the delivery of the Trust's strategic objectives/themes and do not change significantly over time. The operational risk register is a repository to record all risks which relate to the organisation's on-going day-to-day business delivery, including patient and staff safety, finances and litigation activity in CMGs and corporate directorates.

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

Our significant risk themes on the organisational risk register include:

- Workforce gaps – including recruitment, retention and skill mix of clinical and non-clinical staff groups

- Patient flow – including managing demand and capacity in our urgent and emergency care services, managing the elective care backlogs, and managing cancer patients
- Estate and environment – including managing ageing infrastructure and climate
- Equipment and supplies – including managing ageing equipment and addressing IM&T infrastructure works and digital risk
- Finances – including managing capital funding and increased costs

In the coming year, we will further refresh the organisational risk register to be web-based, making it easier for staff to access and report their risks. The Risk Committee will continue to focus on the management of significant risks reported by Clinical Management Groups and Corporate Directorates.

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

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

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

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

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

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

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

Review of Effectiveness

As Accounting 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 performance information available to me.

My review is also informed by comments made by external auditors in their reports, in particular the significant weaknesses reported as part of the audit opinion with the prior period annual report. I have

been advised on the implication of the result of my review if the effectiveness of the system of internal control by the board, the audit committee and quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

Internal Audit has conducted reviews upon the Trusts control environment, governance and risk management processes, based on an audit plan approved by the Audit Committee. The work included testing the effectiveness of the controls in place with a particular focus on the basic standards of good governance and a functioning Board Assurance Framework. All recommendations which were issued in relation for core governance and risk management audits have been fully implemented and within the appropriate timeframes. There were no high risk actions identified within these audits. During the year, 5 core audits were completed, the status of those audits at the end of the year were:

Audit	Opinion
General Ledger and Financial Reporting	Limited assurance
Key Financial Systems	Limited assurance
Data Quality Framework	Significant assurance
Patient Experience – family and friends test	Limited assurance
Strategic Governance and Risk Management	*Advisory – no opinion issued

*Due to the commencement of work to review the Board committees and Board Assurance Framework, this audit was completed in an advisory capacity which was supported by 360 Assurance and the Audit Committee.

I acknowledge the response to implementing internal audit recommendations over the previous few years should have been better and this is a key area for the Trust to improve. The Audit Committee play a key role in the oversight of all outstanding actions and escalation of overdue actions where appropriate.

The Trust continues to operate its Financial Management Framework to ensure that the Trust is striving towards meeting its strategic target of financial sustainability. The Finance and Investment Committee, in particular, provides overall value for money assurance, including approving and performance monitoring of the organisation's finance, efficiency and recovery plans and reviewing Clinical Management Groups (CMGs) financial and business performance. Each month reports are prepared for the Finance & Investment Committee on the financial position, alongside monthly finance reports issued to CMGs that show performance against budget. These reports contain both financial and non-financial information. The Trust has a Project Management Office team in place to support CMGs in achieving their cost improvement plan targets. This is supported by other initiatives within the Trust such as 'Get it Right First Time' and use of relevant benchmarking, including the NHS model hospital. Assurances on the operation of financial controls are commissioned and reviewed by the Audit Committee and, where appropriate, other Committees of the Board of Directors as part of their annual cycle of business. The Trust outsources its the internal audit function to 360 Assurance, External audit is undertaken by KPMG with 2022/23 being the second year of an initial three years' contract. The implementation of recommendations made by Internal and External Audit are overseen by the Audit Committee.

The financial regime in 2022/23 reflected national policy expectations that the NHS would progress to full recovery from Covid-19, which would see transition towards a normal financial and operating regime with

overall funding levels reduce from those experienced as a result of the pandemic and elective patient care and cancer activity recovered and restored to pre-pandemic levels. While system envelopes and block arrangements remained, there was no longer a reimbursement of all reasonable costs to break even. Systems were expected to operate within these agreed financial envelopes. Consequently, achieving financial balance was always going to be a significant challenge, but the Trust did deliver the target deficit of £12.5m agreed with its system partners. The Trust achieved other statutory duties of maintaining capital spending and cash and borrowing within the limits set by DHSC.

The Trust is committed to achieving sustained financial recovery and using its resources productively to maximise patient benefit. Due to Covid, the Trust delivered a smaller than normal efficiency target of £17.1m in 2021/22, which ratcheted up substantially to £39m in 2022/23 and a plan of £56m in 2023/24, as the NHS and Trust looks to return to a 'normalised' operating regime. The Trust is working with its system partners across the LLR Integrated Care System (ICS) and engaged in the Leicester wide sustainability and transformation plan to this end. The Trust is developing a medium-term financial plan aligned with system partners spanning 5 years that focuses on return to financial balance.

Improvements to Financial Governance

Work continued throughout 2022/23 to further strengthen the financial control environment and address the accounting issues. The Trust does not currently operate a systematic and fully operational system to track and locate the plant, equipment and assets under construction held on the fixed asset register. The Trust has made improvements in this area, through a combination of physical confirmation and usage of maintenance records. However the value of the currently un-tracked fixed assets exceeds the audit materiality threshold for the Trust and the Group. The audit opinion for 2022/23 for the Trust and Group remains qualified in relation to the existence of certain fixed assets and the impact of historic matters from the previous years.

Improved governance has been achieved through progressing a Roadmap to Sustainable Financial Governance and an operational Financial Improvement Plan. The Roadmap mapped actions and outcomes to the RSP exit criteria (Recovery Support Programme – as part of being in Single Oversight Framework (SOF4)). We have agreed exit criteria in relation to sustainable financial governance. The Improvement Plan includes agreed actions from internal and external audit, advice from Deloitte and the HFMA Financial sustainability assessment.

Both these plans were developed with UHL senior responsible officers and action owners allocated and have remained as live documents, with outstanding actions was overseen at the RSP Exit Steering Group and a Financial improvement Group, both chaired by the CFO. The Roadmap originally comprised a total of 20 actions, of which now only 6 remain not completed and the Financial Improvement Plan had 138 actions, of which all but 10 (including Asset Verification) are now complete. These workstreams themselves built on the foundation work undertaken through 2020/21 and 2021/22, which included:

- **Strengthened Financial Grip and Control** – The Trust applied the NHSE/I tool for organisations and systems to use to assess their grip and control of financial management, which covered 5 core areas with over 200 individual check list items. All but 9 remaining points had been completed by end of 2021/22, which were absorbed into Financial Improvement Plan.

- **Financial Recovery Board -** In order to gain tighter oversight and scrutiny of the Trusts expenditure and investments a Finance Recovery Board was established in May 2020 and chaired by the Chief Executive, which provided assurance directly to the Finance and Investment Committee. The Financial Recovery Board was absorbed into the Trust's Executive Finance and Performance Board in late 2021 to allow for appropriate clinical engagement and oversight to financial decision making

and ultimately transitioned into the Trust's Leadership Team in 2022/23 , as the Trust began to embed and operationalise strengthened governance processes.

- **Financial Accounts –** The 2019/20, 2020/21 and 2021/22 Annual Accounts have now all been adopted and published (Disclaimer>Adverse>Qualified opinion respectively) following an intensive amount of work in a concentrated period of time, at the same time as continuing to deliver and embed improved financial governance and financial reporting processes.

Leadership and Strategy

There have been fundamental changes to the leadership over the last 18 months. In the 21/22 financial year the Trust appointed a new Chair and CEO along with 5 newly appointed Non Executive Directors, a Chief financial Officer, a Chief Operating Officer and a Director of Corporate and Legal Affairs. During 2022/23, six more key appointments were made including the Chief Nurse, Director of Estates and Facilities, Deputy CEO, Chief People Officer, Director of Communications and Engagement, and a new addition to the Board of a Director of Health, Equality and Inclusion.

Following what has been a challenging couple of years for the Trust, in particular the issues surrounding the financial management, the leadership team has been reset to enact sustainable change and improve the culture. The Board is focused on continuing to embed a leadership culture which is based on openness, transparency and integrity.

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

- Setting new priorities and staff survey
- Review of the Board Assurance Framework
- Strategy development (input from the NHS Confederation)
- Risk appetite and tolerance
- Well led self assessment
- UHL finances – including reflective journey, financial forecasting and medium-term financial planning
- Cultural competency
- Charity governance
- Health equality
- Operational pressures

Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration status following three core service inspections and a Well Led Inspection in 2022 is 'Requires Improvement', previously the Trust had received a Good rating in 2019.

The CQC completed four focused inspections in the Trust in 2022. In April there were unannounced focused inspection of Urgent and Emergency Care(UEC) and Medical Care
(Including Older People's Care) at the Leicester Royal Infirmary. In June there was an unannounced focused inspection of Surgery at Glenfield Hospital and in September there was an announced Well Led Inspection of the Trust.

Following the inspection of Urgent and Emergency Care the Trust was issued with a warning notice under section 29A of the Health and Social Care Act. Medicine (Including Older People's Care). An action plan to address the seven points within the warning notice was developed with the leadership team in Urgent and Emergency Care and has been shared with the system. The action plan is a live document

and is updated regularly. System action plans are embedded within the UEC warning notice action plan.

In 2023 Maternity Services at UHL were inspected as part of the CQC's national inspection of Maternity Services that have not been inspected and rated since April 2021. This is a national thematic review focusing on the safe and well led domains. Maternity Services at Leicester's Hospitals were inspected on 28th February (LGH) 1st March (LRI) and 2nd March (St Marys' Birth Centre). Reports and ratings are yet to be published.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

Leicester Royal Infirmary
Overall rating

Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Requires Improvement July 2022	Good July 2022	Good July 2022	Requires Improvement July 2022	Requires Improvement July 2022	Requires Improvement July 2022

2022	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Urgent and Emergency Care	Requires Improvement July 2022	Requires Improvement July2022	Good July 2022	Requires Improvement July 2022	Requires Improvement July 2022	Requires Improvement July2022
Medical Care (including older people's care)	Requires Improvement July 2022	Requires Improvement July 2022	Good July 2022	Requires Improvement July 2022	Requires Improvement July 2022	Requires Improvement July 2022

March 2023	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Maternity	TBC	TBC	TBC	TBC	TBC	TBC

Glenfield Hospital

Overall rating

Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Requires Improvement Nov 2022	Requires Improvement Nov 2022	Good Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022

2022	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Surgery	Requires Improvement Nov 2022	Good Nov 2022	Good Nov 2022	Requires Improvement Nov 2022	Good Nov 2022	Requires Improvement Nov 2022

Leicester General Hospital

Overall rating

Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Requires Improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires Improvement Feb 2020	Requires Improvement Feb 2020

March 2023	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Maternity	TBC	TBC	TBC	TBC	TBC	TBC

St Mary's Birth Centre

Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018

March 2023	Safe	Effective	Caring	Responsive	Well Led	Overall Rating
Maternity	TBC	TBC	TBC	TBC	TBC	TBC

Well led inspection

On 1 and 2 September 2022 UHL welcomed the inspection team from the CQC to conduct a Well Led inspection. The Trust's rating reduced from "good" to "requires improvement" for the well led domain. Overall, the Trust has a CQC rating of "requires improvement".

The report published in November 2022 followed a comprehensive inspection of surgery at Glenfield Hospital between June and September and the well led inspection in September. The outcome of the inspection was shared with the Trust in November 2022 and this was discussed through our public Board in December.

The CQC well led inspection followed its usual approach in assessing the organisation against the 8 KLOEs; Leadership, Vision and Strategy, Culture, Governance, Risk and Performance Management, Information Management, Engagement, and Learning, continuous improvement and innovation.

The findings within the report were fully accepted and we believe it was a fair and balanced assessment of the Trust at that point in time. At the time of issuing the report, the two main reasons for the deterioration relate to the Trust remaining in Financial Special Measures since 2020, and the increase in our elective waiting times linked to Covid. We are pleased that our progress to address the elective backlog has continued to improve throughout 2022/23. The Trust remains "good" for caring which recognises the

efforts of colleagues who continue to care for people in challenging circumstances. The report also noted the growing strength, diverse skills and experience of the Trust's Board, improved financial governance, increased visibility of the leadership team and a renewed optimism among colleagues that things are beginning to improve.

The Trust recognises that it will take time to make fundamental and long-lasting change but we are committed to making the Trust a great organisation to receive care in and a great organisation to work for. There were no "must do" actions as a result of the well led inspection, however, the Trust are focused on implementing the "should do" actions which will ensure we are operating to the expected standards of the well led framework.

Data quality

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

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

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

The Trust also has a dedicated elective care validation team comprising of a group who validate patient elective care pathways against the Referral to Treatment standards and another group that perform technical validation relating to weekly and monthly submissions against national targets. This second group also trains staff across the organisation in how to manage pathways in order to avoid incorrect outcomes that impact on performance and patient care. The team expanded in spring/summer 2022 and has therefore been able to improve accuracy of data across the acute sites within UHL.

The Trust will implement a refreshed Elective Care Training Strategy which is due to come commence in Autumn 2023. The content will include national elective care rules, the Trust's Elective Care Access Policy and standard operating procedures underpinning the policy. It will apply to both non-clinical and clinical staff and will be role based. Competency testing and compliance monitoring will be key features – which will further improve data quality across the Trust.

The NHS Digital Data Quality Maturity Index is used for benchmarking against 17 peer Trusts. Data quality and clinical coding audit is undertaken in line with Data Protection and Security Toolkit and mandatory standards are achieved. For clinical coding the Trust have several assurance processes in place to ensure that patient complexity is accurately captured. Since 2019 we have improved the

information supply chain for clinical coding which has resulted in more documentation being available for the Clinical Coding process. We are making full use of electronic systems as source documentation for Clinical Coding.

The Trust Leadership Team receive quarterly reports on the Data Quality and Clinical Coding. We will be launching an updated Elective Access Policy in 23/24 and have an elective care waiting list management plan to further improve our data quality.

Information Governance

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

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Data Security and Protection Toolkit. This contains 10 standards of good practice, spread across the domains identified below and, for 2021/22, we declared "all standards met" as our compliance:

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

We can confirm for the financial year 2022-23 – we logged no concerns with ICO that were deemed suitable for escalating. This means that the severity of the incidents we have had at the trust this far have been within organisational tolerance to manage and remediate.

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

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

Head of Internal Audit Opinion

In April 2022 360 Assurance were appointed as the Trust's Internal Audit provider. In reaching the opinion, the auditor reflected on the context in which the organisation has operated and the significant challenges facing provider organisations. An audit opinion of "limited assurance" was issued for 2022/23. This means in the opinion of the auditors, there are "*weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation objectives*". The auditors also explained that in providing their opinion for 22/23, they reflected on the "*environment in which the Trust has been required to function. There has been an emphasis on tackling waiting lists, investing in the workforce and effective use of resources*".

A moderate assurance opinion for the operation of the BAF during 2022/23 was issued. "*As a result of the changes at Board level during the year, the Trust has taken this as an opportunity to refresh its BAF to ensure that it is fit for purpose for the organisation moving forward. Whilst the BAF has not been operating effectively as a management tool for the whole of the year, it is acknowledged that the BAF was in development during the early part of the financial year and the Board and Audit Committee were sighted on its progress and timelines – a fully populated BAF has been in place since December 2022 and a plan is in place to take this forward to manage risks to the achievement of the Trust's objectives*".
A limited assurance opinion for the individual assignment outturn was issued. "*It is noted the progressive way in which the Trust engages internal audit to assist in areas of concern, however, of the five core reviews issued to date, three provided a limited assurance opinion and one provided significant assurance. In addition, we were asked to complete the core review of strategic governance and risk management on an advisory basis as the Trust was aware that improvements were required – our work identified four medium risk issues.*
Implementation of Internal Audit actions".
A limited assurance opinion was issued for the implementation of the internal audit recommendations. "*The 2022/23 first follow up implementation rate is 55% (limited assurance) and the overall implementation rate is 72%. There is one high risk action overdue which relates to asset verification exercise. In addition, 15 actions are still ongoing/in progress relating to actions brought forward from previous years, including one high risk action".*

Conclusion
I believe the 2022/23 annual governance statement has described both the challenges and improvements that have been made during this year. I am proud that we continue to make progress but I recognise that the Trust still has a long way to go, and we will continue to improve and strengthen our systems of internal control.

The Trust remains within financial special measures and is continuing to deliver a roadmap to sustainable financial improvement which sets out eventual outcomes that will demonstrate 'good' financial governance across the board and sets out the actions required to exit the Recovery Support Programme. The outcome of the well-led inspection was agreed to be fair and balanced and issued a number of "should do" actions which we are progressing. We will continue to address and embed all actions on our financial recovery plan to ensure good sustainable financial governance and the appropriate culture.

As Accountable Officer I have accepted the limited assurance opinion issued. I believe this to be a fair and balanced opinion of the control environment where the Trust has been, and continues to be, in period of transitioning.

Richard Mitchell
Chief Executive

29 August 2023

Our Parliamentary Accountability and Audit Report

Fees and Charges

Refer Note 5.2 in the Financial Statements

Remote contingent liabilities

There are no remote contingent liabilities in 2022/23

Other contingent liabilities

The Trust had contingent liabilities of £71k in 2022/23 in respect of outstanding legal claims

Losses and special payments

Refer Note 34 in the Financial Statements

Gifts

The Trust has published maintains 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 2022/23 Financial Position

There was a clear expectation that from 2022/23 that there would be a transition towards a normal financial regime, which would see overall funding levels reduce from those experienced, as a result of the Pandemic. As the Trust moved away from the Covid funding regime, managing Trust finances and achieving recurrent financial balance was clearly going to be challenging. However, with a strengthened finance team and a favourable cash position, the Trust was ready to engage in this task. To this end the Trust submitted a balanced financial plan for 2022/23, although this was subsequently revised in agreement with our System partners to a £12.5m deficit in March 2023, which the Trust delivered.

The Trust is committed to achieving sustained financial recovery and using its resources productively to maximise patient benefit. Due to Covid, the Trust delivered a smaller than normal efficiency target of £17.1m in 2021/22, but this was substantially increased to £35m in 2022/23, as the NHS and Trust look to return to a 'normalised' operating regime.

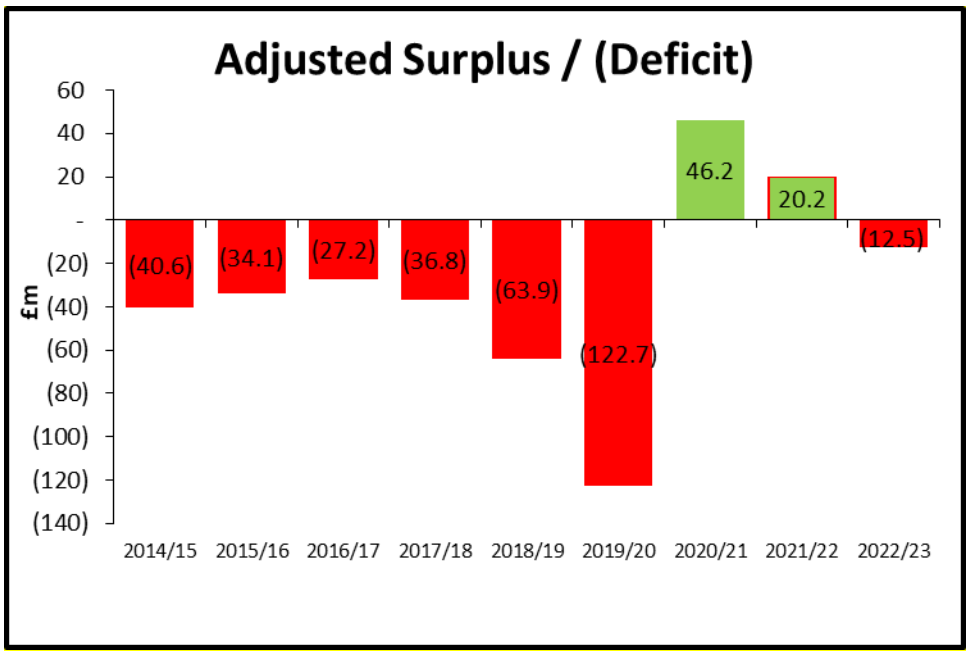
The Trust is required to meet certain financial duties, in order to provide assurance to the taxpayer on how public funds have been managed. Each NHS Trust is required to ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable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

Highlights of 2022/23 from a financial point of view are:

- a revenue deficit, after technical adjustments, of £12.5m, following a surplus of £20.2m in 2021/22
- a record level of capital investment of £96.5m (£75.3m in 2021/22).
- Delivery of a Cost Improvement of £39m (£17.1m in 2021/22).
- Reconfiguration and modernisation Programme enabling work.
- Year end cash balance of £ 103.3m (£110.0m at 31 March 22);
- Maintained high achievement against the Better Payments Practice Code for paying suppliers promptly of 93%.

Work continued throughout 2022/23 to further strengthen the financial control environment and address the accounting issues. embodied in the delivery of implementing a Financial Improvement Plan. The Trust has delivered year on year incremental improvements in its audit opinion as it has reduced the number of qualifying areas. Although the Trust has not yet achieved an overall unqualified audit opinion, this movement in opinion and reduction in qualifying elements to one component reflects the improvements in control and record keeping that have been taking place. If the Trust can demonstrate improved financial governance through 2023/24, we remain hopeful of securing an unqualified audit opinion next year.

Adjusted retained surplus/(deficit)



Income and Expenditure Summary

The Trust benefited in 2020/21 and to a lesser extent in 2021/22 from a change in the NHS funding regime and a relaxation of financial constraints during the pandemic, compared with previous years, with nationally mandated block payments replacing normal contract mechanisms to cover the cost of services. This ensured that NHS organisations had sufficient funding to respond to the pandemic and could focus on delivering safe patient care during that period. As the NHS emerged out of the pandemic during 2022/23, there was a clear expectation, nationally, that providers must transition towards business as usual which would see overall funding levels reduced from those currently experienced as a result of the pandemic.

As the Trust moved away from the Covid funding regime in 2022/23, the challenge of delivering sustainable finances was significant. However, sustainable finances remains one of the Trust's strategic goals, not least because the cash generated can be invested in subsequent years as capital expenditure to maintain and improve our estate, purchase medical equipment or develop our digital infrastructure to provide modern healthcare to our patients in safe surroundings.

The Trust delivered a deficit of £12.5m in 2022/23, after adjustment for the impact of impairments, the net impact of PPE consumables donated by Department of Health and the removal of capital donations and grants (£0.2m), following the surpluses generated in the previous two years, allowing the Trust to achieve a cumulative 3 year surplus of £53.9m.

For 2022/23 the financial agreements for the two main patient care income contracts were agreed with commissioners with the Trust agreeing a block contract with some variable elements, in line with national NHS guidance for acute providers. In addition to the fixed funding arrangement, systems had access to additional funding through the Elective Recovery Framework (ERF)

The table below illustrates the income received in 2022/23 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
NHS England	258,067	288,791	305,886	350,224	380,632	395,912	472,791
Clinical Commissioning Groups/Integrated Commissioning Board	513,658	522,902	542,245	539,952	685,583	765,772	848,594
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
Other income from Patient Care	5,993	5,766	2,894	34,491	1,515	2,131	2,702
Income from Patient Care Activities	**780,582**	**820,331**	**864,471**	**945,959**	**1,069,371**	**1,166,555**	**1,327,440**
Other operating income	143,687	127,958	129,845	144,616	212,142	68,632	69,527
Education training, and Research						84,956	93,548
Other Operating Income	**143,687**	**127,958**	**129,845**	**144,616**	**212,142**	**153,588**	**163,075**
Total Income	**924,269**	**948,289**	**994,316**	**1,090,575**	**1,281,513**	**1,320,143**	**1,490,515**

Total income from patient care activities increased by £161m (14%) as the Trust returned to more 'normal' operating regime post Covid, which saw recovery and restoration of elective patient care and cancer activity. During 2022/23 the Trust received Elective Recovery Funding of £30m, Pay Award Funding of £26m, additional Top Up Funding of £72m and additional income for new schemes, such as Ambulance Handover of £5m, and Community Diagnostic Centre (CDC) of £4m and Other inflation/growth/variations of £13m. As the Trust returned to more 'normal' operating regime post Covid, which saw recovery and restoration of elective patient care and cancer activity. There was also a £9.4m (6%) increase in other operating income, mainly relating to research and innovation and education funding. Which reflected a combination of increased research activity (commercial income, network funding, Bio-medical research and other research funding) and an increase in educational programmes and Health Education England funding for non-medical and post graduate medical placements.

Included in “Other Operating” income above are donations from a number of charities and organisations who generously support our services by funding equipment purchases, research activity, specialist staffing or environmental enhancements. The Trust is grateful to all the charities from which it receives support. The UHL Charity, is the official charity partner of the Trust. It has continued to raise funds on our behalf and worked closely with our staff to raise the profile of our services.

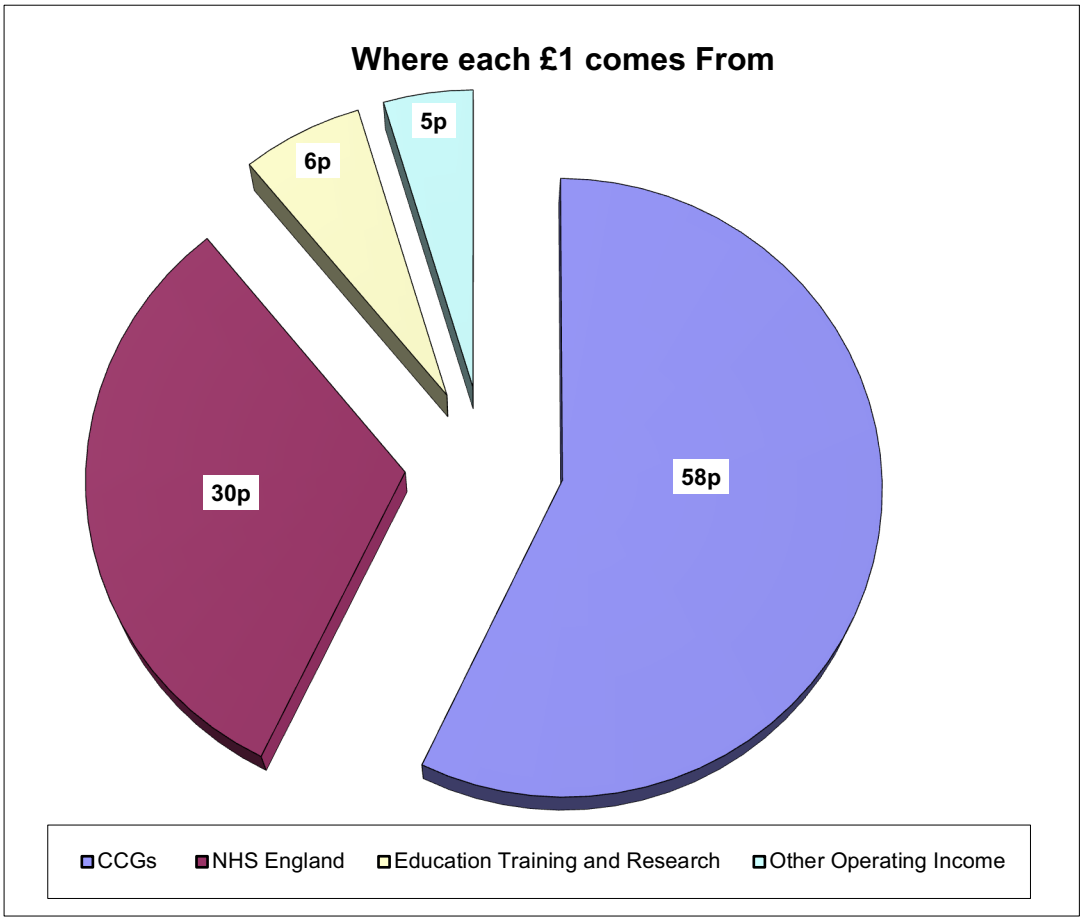
Summarised breakdown of expenditure during 2022/23	2016/17 Actual £000s	2017/18 Actual £000s	2018/19 Actual £000s	2019/20 Actual £000s	2020/21 Actual £000s	2021/22 Actual £000s	2022/23 Actual £000s
Staffing	575,895	597,876	629,537	698,996	745,371	777,761	897,482
Drugs	102,168	105,789	102,124	107,139	124,239	127,949	144,487
Clinical Supplies and Services	103,653	109,211	117,635	124,593	128,314	142,808	167,500
Depreciation and Amortisation	26,407	27,663	32,176	34,991	37,030	39,499	51,730
Clinical Negligence	23,724	27,398	30,664	31,927	34,744	38,204	38,824
Premises	33,308	33,753	43,469	54,976	48,019	52,572	58,928
Research and Development	22,932	34,376	35,763	36,124	35,254	38,680	42,610
Other Operating costs	78,216	49,535	61,262	107,866	59,020	62,098	103,220
Total Income	**966,303**	**985,601**	**1,052,630**	**1,196,612**	**1,211,991**	**1,279,571**	**1,504,781**

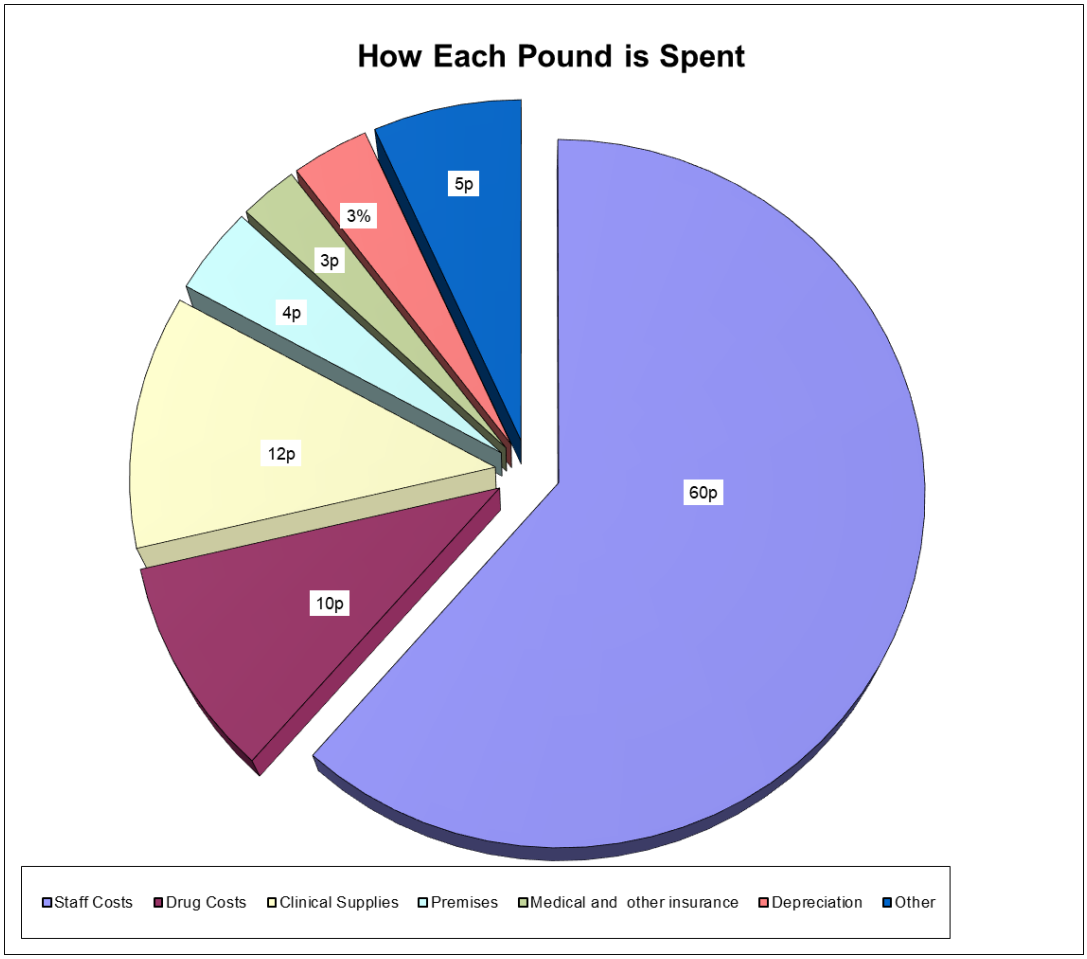
- Employment costs increased by £120m during the year. This reflected an overall increase in the workforce (average WTE worked) of 985 during 2022/2023. The Trust also incurred costs of the

national pay awards incurred in the year and additional pension contribution (£30.2m). Other cost increases were incurred across the range of non pay headings (£104m – 21%) as the Trust returned to post covid normal operating conditions and activity levels and were also impacted by inflationary pressures on the supply chain. There was also a material increase in depreciation and amortisation costs reflective of the significant capital programmes in the last 3 years (£72.5m, £77.6m and £96m) much of which has been concentrated on investment in short life medical equipment and IT infrastructure. 2022/23 was also the transitional year for the implementation of the new leasing accounting standard (IFRS16), which saw existing and new leases come onto the Trust's balance sheet with significant depreciation impact.

- In delivering its year end position, the Trust generated financial cost savings/additional income of £39m, through its efficiency programme. The Trust seeks to identify and remove wasteful practices, procedures or delays which impede great patient experience. Financial savings being a by-product of introducing improvements in the way we communicate with and treat patients in our care.

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





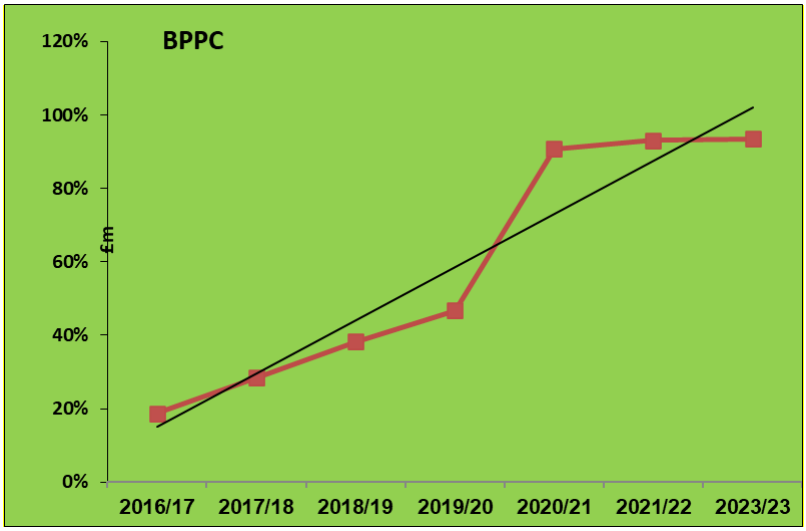
Better Payments Practice Code

The change in the NHS finance regime and the move to block contract payments, alongside better invoicing and debt collection processes has helped to improve our liquidity position. The result has been an improvement in our Better Payments Practice Code compliance percentage with 93% of valid supplier invoices now being paid within 30 days or their due date (if later).

There has been considerable work undertaken through a purchase to pay workstream, which has reduced the level of aged creditors, strengthening the financial controls and standardising system processes and improving efficiency of the transaction process through greater automation and less manual intervention. Work has now begun to make this focus business as usual and ensuring this workstream is embedded in the way we do things.

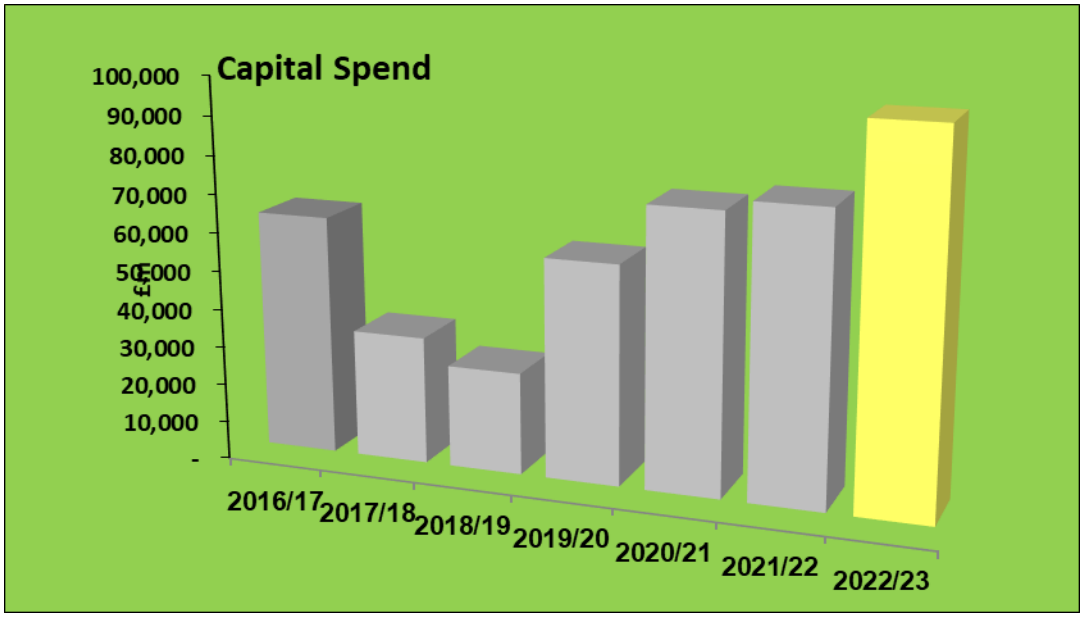
Staff Productivity

The table below shows the improvement over the past few years. In challenging economic times it is particularly important to support our suppliers and local businesses by ensuring prompt payments are made to them so it is particularly pleasing to see the improvement.



Capital Investment

In 2022/23, the Trust undertook capital investment of £96.3m. This level of expenditure on our estate, medical equipment and IT is a record for the Trust. The table and graph below show how we have been able to build our level of capital expenditure in the last five years.



The main areas of capital investment over the last 5 years are presented in the table below. In 2022/23, there was significant investment in Estates infrastructure, medical equipment, including a new linear accelerator, IT modernisation and digitisation, as well as continued investment in the Trust's reconfiguration programme. Specifically, investment in 2022/23 included expansion of facilities, in the form of the planned care centre and pre-transfer hubs, two new linear accelerators, a new surgery robot, increased ward and theatre capacity and a new Endoscopy decontamination

Capital expenditure by area

	2017/18	.2018/19	2019/20	2020/21	2021/22	2022/23
Building & Engineering	23,767	5,997	8,388	12,390	19,097	20,560
Equipment	6,558	3,542	9,860	21,165	24,277	20,724
IT	2,971	5,159	6,983	7,249	13,964	17,437
Reconfiguration		1,080	257	6,445	11,492	2,967
Children' Hospital		2,268	3,885	12,303		
Covid-19			83	6,419		
ICU		8,611	22,188	6,574		1,355
Land Purchase					6,447	
Endoscopy Decontamination						7,718
Ambulance Hub/Discharge Lounge						6,900
East Midlands Planned Care Centre						18,855
Other			5,515			
Total	**33,296**	**26,656**	**57,159**	**72,545**	**75,277**	**96,516**

Financial Outlook

The 2023/24 priorities and operational planning guidance reconfirmed the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future. UHL has already made significant progress towards eradicating two year waits for elective care and delivering urgent cancer checks. This was achieved alongside continuing to respond to the build-up of health needs during the pandemic, an ongoing high level of COVID-19 infection and capacity constraints in social care, increased costs due to inflation and reduced productivity due to the inevitable disruption caused by COVID-19.

The national NHS focus is targeted at 3 areas:

- Recovering core services and productivity;
- Making progress in delivering the key ambitions in the Long Term Plan (LTP), and
- Continuing to transform the NHS for the future.

The Government's Autumn Statement 2022 announced an extra £3.3 bn in both 2023/24 and 2024/25 for the NHS to respond to the significant pressures the NHS is facing. NHS England has issued two-year revenue allocations for 2023/24 and 2024/25.

The Health and Care Act 2022 established Integrated Care Boards (ICBs) to replace Clinical Commissioning Groups with effect from 1st July 2022. This has brought a much greater focus on health system working and collaboration across local health economies for the benefit of patients. ICBs and NHS primary and secondary care providers are now expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners.

Within Leicestershire, Leicester and Rutland (LLR) Integrated Care System, there has already been much work on Leicester wide sustainability and transformation plan, ensuring that planning and service delivery is aligned. The Trust continues to develop its medium-term financial strategy to inform the development of the annual financial plan for the Trust. The Trust actively engages commissioners, regulators (NHS Improvement) and other partners to develop and agree detailed financial and operational plans.

At national level, total ICB allocations including COVID-19 and Elective Recovery Funding (ERF) are flat in real terms with additional funding available to expand capacity. Essentially this means the NHS receives the same funding as it did in 2022/23, with the significant investment that had been provided to manage COVID-19 being largely repurposed to elective recovery and other priorities. As a result, it is clear that there is going to be huge financial pressure in the system in 2023/24. The Trust is working to deliver its deficit plan of £10m in 2023/24, on its pathway to delivering a sustainable balanced financial position. This is predicated on delivering an unprecedented cost improvement plan of £63m (4.3%) in addition to addressing a challenging underlying financial position.

Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the

foundation of capital planning for future years. Capital allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that delivered agreed budgets in 2022/23. For UHL, this translates into a capital programme for 2023/24 of £104m, which in addition to investment in the core areas, includes further investment of £16m in the Planned Care Centre and £30m in urgent and emergency care and additional bed capacity. All these initiatives will help to improve patient flow and throughput through the Trust and support the Trust in restoring activity to ensure our patients receive high quality care they need within appropriate timeframes.

For 2023/24, the contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay unit prices for activity delivered. System and provider activity targets have been agreed through planning as part of allocating ERF on a fair shares basis to systems. NHS England will cover additional costs where systems exceed agreed activity levels.

In summary, the Trust continues to face significant operational and financial pressures in 2023/24. However, strong local health community partnership working, supported by new ways of working will put us in the best possible place to meet those challenges.

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 2022/23 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 2022/23 Group Accounting Manual issued by the Department of Health and Social Care. They represent a "true and fair view" of our activity in 2022/23, 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 Codes 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 securing economy, efficiency and effectiveness in our use of resources (value for money).

KPMG charged audit-related fees of £300k (excluding VAT) for The Trust and £20k (excluding VAT) for TGH. We did not receive any non-audit services from KPMG in 2022/23.

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 2023 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.

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Qualified opinion

We have audited the financial statements of the University Hospitals of Leicester NHS Trust ("the Trust") for the year ended 31 March 2023 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion, except for the effects and the possible effects of the matters described in the *Basis for qualified opinion* section of our report, the financial statements:

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2023 and of the Group's and 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 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for qualified opinion

Existence of certain Group and Trust plant, equipment and assets under construction assets included in property, plant and equipment

The Group and Trust have no system of control over tracking the location of physical assets, on which we could rely for our audit, for plant, equipment and assets under construction with a total net book value at 31 March 2023 of £110.8 million (2022: £128.1 million) for the Group and Trust. Due to the nature of the Group's and Trust's records there were no other satisfactory audit procedures that we could adopt and therefore we have been unable to obtain sufficient appropriate audit evidence regarding the existence of these assets as at the balance sheet date. Any adjustments would have a consequential effect on the Group's and Trust's net assets as at 31 March 2022 and 31 March 2023 and their income and expenditure for the years then ended.

Comparative figures

As at 31 March 2021, the Group's and Trust's £46.3 million net book value of assets under construction included:

- £7.0 million of capital additions which were also included in the revaluation of land and buildings; and
- £6.0 million of capital additions that were completed as at 31 March 2021 and therefore which should have been reclassified to land and buildings and revalued.

Accordingly, the assets under construction balance was overstated by £13 million as at 31 March 2021 for both the Trust and the Group. The £7.0m overstatement at 31 March 2021 was released to the statement of comprehensive income in the year ended 31 March 2022 ("the comparative period") and accordingly the total comprehensive income for the comparative period is understated by £7.0m. In relation to the £6.0m million, as no assessment of the impact of this matter on the valuation of land and buildings as at 31 March 2021 has been performed by management, it is not practicable for us to quantify the consequential effect of this matter on the Group and Trust's income and expenditure for the comparative period.

In addition, we have not been provided with sufficient appropriate audit evidence over trade payables and accruals for the Group or the Trust as at 31 March 2021, or over their non-payroll operating expenses and property, plant and equipment additions for the year ended 31 March 2021. Errors had been identified in the amounts and period of items recorded. The Directors

have not provided evidence to enable us to quantify the extent of these errors or the consequential effects of any adjustments on the Group's and Trust's income and expenditure and Statements of Cash Flows for the comparative period.

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 qualified opinion.

Going concern

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

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

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and 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 Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of

controls in particular the risk that Group management may be in a position to make inappropriate accounting entries.

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

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

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals posted to cash or revenue with an unexpected account pairing and those posted as part of the year end close procedures that reduced the level of expenditure recorded, in order to critically assess whether there was an appropriate basis for posting the journal.
- Inspecting a sample of invoices of expenditure, in the period around 31 March 2023, to determine whether expenditure has been recognised in the appropriate accounting period.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.

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

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

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

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

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

The *Qualified opinion* section of our report explains the implications of the matter described in the *Basis for qualified opinion* on compliance with the requirements of the National Health Service Act 2006 (as amended).

We are also required to make a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 if we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which 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.

As outlined in the *Report on Other Legal and Regulatory Matters* section of our report, we made a Section 30 referral to the Secretary of State on 1 July 2023.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following

areas as those most likely to have such an effect: health and safety, data protection , anti-bribery, employment, food and drug administration, contract and anti-money laundering legislation, recognising the regulated nature of the Group's and Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

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

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

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

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

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

- except for the consequential effects of the matters described in the *Basis for qualified opinion* section of our report on the related disclosures in the other information, we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 80, 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 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 Trust or dissolve the Group and Trust without the transfer of their services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 79 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

In our audit report for the year ended 31 March 2022 we reported that we had identified four significant weaknesses, and associated recommendations, in relation to Financial Resilience, Governance and Arrangements to Improve Economy, Efficiency and Effectiveness. We draw attention to Review of Effectiveness in the Annual Governance Statement on page 85 which states that whilst the Trust has taken actions in respect of these significant weaknesses and the recommendations made, further work is required in order to address each of these issues reported.

Except for the matter noted above, we have nothing else to report in this respect.

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

As explained in the statement set out on page79, 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 have planned our work and undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful

expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We made a Section 30 referral to the Secretary of State on 1 July 2023 as the Trust continues to be in breach of its 'breakeven duty' set out at paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of University Hospitals of Leicester NHS Trust for the year ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

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

31 August 2023

University Hospitals of Leicester NHS Trust

Annual accounts for the year ended 31 March 2023

Consolidated Statement of Comprehensive Income

	Note	Group 2022/23 £000	2021/22 £000
Operating income from patient care activities	3	1,327,440	1,166,555
Other operating income	4	163,075	153,588
Operating expenses	7, 9	(1,504,781)	(1,279,571)
Operating surplus/(deficit) from continuing operations		**(14,266)**	**40,572**
Finance income	11	2,048	180
Finance expenses	12	(1,834)	(1,133)
PDC dividends payable		(18,982)	(16,912)
Net finance costs		**(18,768)**	**(17,865)**
Other gains / (losses)	13	(624)	321
Corporation tax expense		(41)	(25)
Surplus / (deficit) for the year		**(33,699)**	**23,003**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	18	19,434	12,125
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	(396)	196
Total comprehensive income / (expense) for the period		**(14,661)**	**35,324**
Surplus/ (deficit) for the period attributable to:			
University Hospitals of Leicester NHS Trust		**(33,699)**	**23,003**
Total comprehensive income/ (expense) for the period attributable to:			
University Hospitals of Leicester NHS Trust		**(14,661)**	**35,324**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(33,699)	23,003
Remove impact of consolidating NHS charitable fund		(2,427)	553
Remove net impairments not scoring to the Departmental expenditure limit		12,958	(3,042)
Remove I&E impact of capital grants and donations		243	(1,114)
Gains on disposal of assets			(450)
Remove net impact of inventories received from DHSC group bodies for COVID response		185	1,224
Adjusted financial performance surplus / (deficit)		**(22,740)**	**20,174**

Statements of Financial Position

	Note	Group 31 March 2023 £000	Group 31 March 2022 £000	Trust 31 March 2023 £000	Trust 31 March 2022 £000
Non-current assets					
Intangible assets	15	15,507	16,122	15,507	16,122
Property, plant and equipment	16	667,682	655,056	667,668	655,041
Right of use assets	18	51,703		51,703	
Other investments / financial assets	20	4,964	5,362	4,000	4,000
Receivables	23	3,099	3,445	3,099	3,445
Total non-current assets		**742,955**	**679,985**	**741,977**	**678,608**
Current assets					
Inventories	22	22,663	21,126	20,650	19,530
Receivables	23	62,928	33,614	61,737	32,496
Cash and cash equivalents	25	107,980	112,417	101,080	108,442
Total current assets		**193,571**	**167,157**	**183,467**	**160,468**
Current liabilities					
Trade and other payables	26	(187,250)	(145,348)	(186,070)	(145,304)
Borrowings	28	(12,231)	(7,658)	(14,146)	(7,658)
Provisions	29	(12,958)	(8,153)	(12,900)	(8,116)
Other liabilities	27	(4,196)	(3,799)	(4,196)	(3,799)
Total current liabilities		**(216,635)**	**(164,958)**	**(217,312)**	**(164,877)**
Total assets less current liabilities		**719,891**	**682,184**	**708,132**	**674,199**
Non-current liabilities					
Borrowings	28	(29,514)	(12,586)	(27,596)	(12,586)
Provisions	29	(4,032)	(4,902)	(4,032)	(4,902)
Total non-current liabilities		**(33,546)**	**(17,488)**	**(31,628)**	**(17,488)**
Total assets employed		**686,345**	**664,696**	**676,504**	**656,711**
Financed by					
Public dividend capital		797,141	760,831	797,141	760,831
Revaluation reserve		202,796	188,573	201,349	188,573
Income and expenditure reserve		(323,314)	(292,399)	(321,986)	(292,693)
Charitable fund reserves	21	9,722	7,691	-	-
Total taxpayers' equity		**686,345**	**664,696**	**676,504**	**656,711**

The notes form part of these accounts.

Name **Richard Mitchell**

Position **Chief Executive**

Date **29 August 2023**

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

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

Consolidated Statement of Changes in Equity for the year ended 31 March 2022

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**742,817**	**189,145**	**(328,652)**	**8,048**	**611,358**
Surplus/(deficit) for the year	-	-	21,490	1,513	**23,003**
Revaluations	-	12,125	-	-	**12,125**
Transfer to retained earnings on disposal of assets	-	(7,090)	7,090	-	**-**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	196	**196**
Public dividend capital received	18,014	-	-	-	**18,014**
Other reserve movements	-	(5,607)	7,673	(2,066)	**-**
Taxpayers' and others' equity at 31 March 2022	**760,831**	**188,573**	**(292,399)**	**7,691**	**664,696**

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

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**760,831**	**188,573**	**(292,693)**	**656,711**
Surplus/(deficit) for the year			(34,504)	**(34,504)**
Other transfers between reserves		(5,211)	5,211	
Revaluations		17,987		**17,987**
Public dividend capital received	36,310			**36,310**
Taxpayers' and others' equity at 31 March 2023	**797,141**	**201,349**	**(321,986)**	**676,504**

Statement of Changes in Equity for the year ended 31 March 2022

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**742,817**	**189,145**	**(328,840)**	**603,122**
Surplus/(deficit) for the year			23,450	**23,450**
Revaluations		12,125		**12,125**
Transfer to retained earnings on disposal of assets		(7,090)	7,090	**-**
Public dividend capital received	18,014			**18,014**
Other reserve movements		(5,607)	5,607	**-**
Taxpayers' and others' equity at 31 March 2022	**760,831**	**188,573**	**(292,693)**	**656,711**

Information on reserves

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

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

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

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

Statements of Cash Flows

	Note	Group 2022/23 £000	Group 2021/22 £000	Trust 2022/23 £000	Trust 2021/22 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(14,266)	40,572	(15,243)	41,115
Non-cash income and expense:					
Depreciation and amortisation	7.1	51,730	39,499	51,726	39,497
Net impairments	8	12,958	(3,042)	11,511	(3,042)
Income recognised in respect of capital donations	4	-	(504)	(1,061)	(2,570)
(Increase) / decrease in receivables and other assets		(29,314)	(8,396)	(29,454)	(6,738)
(Increase) / decrease in inventories		(1,537)	(289)	(1,120)	98
Increase / (decrease) in payables and other liabilities		39,515	21,042	38,777	9,187
Increase / (decrease) in provisions		4,087	(9,119)	4,067	(9,121)
Movements in charitable fund working capital		(133)	(214)	-	-
Tax (paid) / received		(25)	(6)	-	-
Other movements in operating cash flows		2	(540)	(10)	-
Net cash flows from / (used in) operating activities		**63,017**	**79,003**	**59,193**	**68,426**
Cash flows from investing activities					
Interest received		1,886	59	1,886	59
Purchase of intangible assets		(4,776)	(7,460)	(4,776)	(7,460)
Purchase of PPE and investment property		(66,024)	(55,861)	(66,024)	(44,030)
Sales of PPE and investment property		-	10,550	-	10,550
Receipt of cash donations to purchase assets		-	342	1,061	1,849
Net cash flows from charitable fund investing activities		162	121	-	-
Net cash flows from / (used in) investing activities		**(68,752)**	**(52,249)**	**(67,853)**	**(39,032)**
Cash flows from financing activities					
Public dividend capital received		36,310	18,014	36,310	18,014
Capital element of lease liability repayments		(16,866)	(7,731)	(15,307)	(7,731)
Other interest		(128)	(90)	(128)	(91)
Interest paid on lease liability repayments		(204)	(1,773)	(1,763)	(1,773)
PDC dividend (paid) / refunded		(17,814)	(17,013)	(17,814)	(17,013)
Net cash flows from / (used in) financing activities		**1,298**	**(8,593)**	**1,298**	**(8,594)**
Increase / (decrease) in cash and cash equivalents		**(4,437)**	**18,161**	**(7,362)**	**20,800**
Cash and cash equivalents at 1 April - brought forward		**112,417**	**94,256**	**108,442**	**87,642**
Cash and cash equivalents at 31 March	25.1	**107,980**	**112,417**	**101,080**	**108,442**

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 2022/23 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.

Note 1.3 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

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

Valuation of the Trust's estate
The Trust engaged its valuers, Gerald Eve LLP, to revalue its estate as at the 31st March 2023. This revaluation applied a Modern Equivalent Asset (MEA) valuation methodology, which took into account the Trust's long term reconfiguration strategy. The Trust provided the valuers with the latest iteration of the Estates Strategy to inform the MEA valuation.

Sale of land
The Trust has sold a portion of land under an arrangement which gives the purchaser an option to oblige the Trust to repurchase the land. The Directors consider that this option would not be exercised unless planning permission is refused for the land. As the Directors believe that planning permission is likely to be granted, no provision has been made for the cost of repurchasing the land.

In addition, the sale agreement allowed for a contribution by the Trust to costs under section 106 of the of the Town and Country Planning Act 1990 of up to £2.2m. The Directors consider that the actual exposure is likely to be much less, and have made provision of £500k in the accounts.

Income recognition
Income is recognised in the period to which it relates. Where we have received payment in advance of a service being provided we treat this receipt as deferred income - where the counter party who has paid us agrees that the amount can be deferred. This can be the case with R&D income. Such income is released to revenue in future periods as the service is provided

Note 1.4 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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

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

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

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

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

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

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

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

Note 1.5 Consolidation

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

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

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

Other subsidiaries
Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The amounts consolidated are drawn from the draft financial statements of the subsidiaries for the year.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

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.

Note 1.6 Revenue from contracts with customers

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

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

The Trust receives income from its subsidiary, Trust Group Holdings, in relation to the provision of administrative services provided by the Trust to the subsidiary. This income is adjusted out of the group position upon consolidation of the group accounts position.

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 income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. These are termed 'aligned payment and incentive' contracts.

Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

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

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

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

Note 1.7 Other forms of income

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

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

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

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

Note 1.8 Expenditure on employee benefits

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

Pension costs
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 1.9 Expenditure on other goods and services

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

Note 1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

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

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

The Trust has revalued its assets with an effective date of revaluation of 31st March 2023.

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

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

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

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

The Key Factors Impacting on the Land and Property Valuation

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

· **Obsolescence**

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

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

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

· **Indexation**

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

Site	2021/22	2022/23	National Factor	Local Factor	Combined Factor
TPI	349	379	1.086		
LRI/LGH/Glenfield	103	102		0.99	1.075
Lincoln	100	98		0.98	1.064
Loughborough	102	101		0.99	1.075

· **Floor Areas**

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

Site	Baseline GIA m2	New Build GIA m2	Disposals GIA m2	2023 Estate MEA GIA m2
Leicester Royal Infirmary	169,951	27,398	(7,838)	189,512
Leicester General Hospital	90,946	-	(74,758)	16,188
Glenfield Hospital	77,848	26,733	-	104,581
All main sites	338,745	54,131	(82,595)	310,281

· **Land Values**

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

To guide the land values adopted in the valuation, the valuer considered recent land sales of NHS sites, whilst also taking account of the size of the MEA hospital sites. There have been limited new land transactions over the last year in the locality, so the Valuer therefore has to consider the wider trends in land values at a national level, market sentiment and the impact of the factors identified above on residual land value. The assessment has been necessarily judgement led and has concluded that it would be appropriate to make a c10% reduction in land values generally adopted within DRC valuations as against positions taken at March 2022. This reflected a widely reported *softening* of the industrial and commercial land value market, which until last year had been performing quite strongly.

· **Sensitivity of Assumptions**

A sensitivity analysis of these assumptions allows the Trust to understand the impact on materiality, given the estimation uncertainty implicit in the valuation. The table below setting out at a high level the sensitivity of the valuation of the main hospital sites to movements in each of these key assumptions, using a 5% tolerance. 31 March 2022 balances have been used as the baseline to derive these values, as the valuation indices were applied to these balances in arriving at the 31 March 2023 valuation.

Assumption	**Baseline Adjustment Factor**	**Assumption value (£m)**	**Sensitivity (+ 5%) (£m)**	**Sensitivity (- 5%) (£m)**
Build Cost Index	1.075	34.3	24.6	(24.6)
Obsolescence Factor	(1.038)	(17.4)	(23.7)	23.7
Land value / acre	(1.092)	(4.7)	(2.8)	2.8

Depreciation

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

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

Donated and grant funded assets

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

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

This includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

The majority of donated assets have been purchased on behalf of the Trust by the Leicester Hospitals Charity.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	8	90
Dwellings	8	51
Plant & machinery	7	20
Transport equipment	8	15
Information technology	4	11
Furniture & fittings	8	31

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.11 Intangible assets

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

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

	Min life Years	Max life Years
Software licences	2	10
Internally generated information technology	2	10

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. Physical stock counts are performed as close to 31 March as possible and the exact timing takes into account the disruption to clinical areas. For example, theatre stock is counted at weekends close to 31 March when the theatres are not in operation.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Inventories held by the Trust Subsidiary - TrustMed Pharmacy
Inventories are stated at the lower of cost and net realisable value. Cost includes all costs incurred in bringing each product to its present location and condition, as follows:

Note 1.13 Cash and cash equivalents

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

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

Note 1.14 Carbon Reduction Commitment Scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

Note 1.15 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, except for charitable fund investments measured at 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 1.15 Leases

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

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

The Trust as a lessee

Recognition and initial measurement

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

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

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

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

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

Subsequent measurement

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

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

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

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

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been 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 has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line or other systematic basis.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2023.

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.27%	0.47%
Medium-term	After 5 years up to 10 years	3.20%	0.70%
Long-term	After 10 years up to 40 years	3.51%	0.95%
	Exceeding 40 years	3.00%	0.66%

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 2022:

	Inflation rate	Prior year rate
Year 1	7.40%	4.00%
Year 2	0.60%	2.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.7% in real terms (prior year: minus 1.3%).

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 29.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.17 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

Note 1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Value added tax

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

Note 1.20 Corporation tax

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

Note 1.21 Climate change levy

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

Note 1.22 Third party assets

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

Note 1.23 Losses and special payments

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

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

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

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

There are no standards relevant to the Trust awaiting adoption.

Note 2 Operating Segments

The Trust operates in one segment, which is the provision of healthcare.
The Trust subsidiary TGH operates a pharmacy service for the Trust and Leicester Hospitals Charity raises and disburses funds for the benefit of the Trust. Neither subsidiary is material to the operations of the Trust.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6

Note 3.1 Income from patient care activities (by nature)	**2022/23**	**2021/22**
	£000	**£000**
Block contract income*	1,117,809	1,059,233
High cost drugs income from commissioners (excluding pass-through costs)	113,785	72,558
Private patient income	3,353	3,281
Elective recovery fund	29,631	-
Agenda for change pay offer central funding	27,571	-
Additional pension contribution central funding**	32,589	29,893
Other clinical income	2,702	1,590
Total income from activities	**1,327,440**	**1,166,555**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National tariff payments system documentation.

https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2022/23	**2021/22**
Income from patient care activities received from:	**£000**	**£000**
NHS England	472,791	395,912
Clinical commissioning groups	202,713	765,772
Integrated care boards	645,881	-
Non-NHS: private patients	3,353	2,740
Non-NHS: overseas patients (chargeable to patient)	1,382	541
Injury cost recovery scheme	1,320	1,365
Non NHS: other	-	225
Total income from activities	**1,327,440**	**1,166,555**
Of which:		
Related to continuing operations	1,327,440	1,166,555

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

	2022/23	2021/22
	£000	£000
Income recognised this year	1,382	541
Cash payments received in-year	339	185

Note 4 Other operating income (Group)

	2022/23			2021/22		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	43,086	-	**43,086**	37,504	-	**37,504**
Education and training	50,462	-	**50,462**	47,452	-	**47,452**
Non-patient care services to other bodies	9,742		**9,742**	6,885		**6,885**
Reimbursement and top up funding	5,392		**5,392**	13,786		**13,786**
Income in respect of employee benefits accounted on a gross basis	9,464		**9,464**	8,299		**8,299**
Receipt of capital grants and donations and peppercorn leases		-	**-**		504	**504**
Charitable and other contributions to expenditure		2,355	**2,355**		3,552	**3,552**
Revenue from operating leases		275	**275**		459	**459**
Charitable fund incoming resources		5,351	**5,351**		3,233	**3,233**
Other income	36,948	-	**36,948**	31,914	-	**31,914**
Total other operating income	**155,094**	**7,981**	**163,075**	**145,840**	**7,748**	**153,588**
Of which:						
Related to continuing operations			163,075			153,588

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period (Group and Trust)

No revenue was recognised in the reporting period that was included in within contract liabilities at the previous period end (2021/22 - £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 5.2 Fees and charges (Group)

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from 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.

	2022/23	2021/22
	£000	£000
Income	3,010	-
Full cost	(1,562)	-
Surplus / (deficit)	**1,448**	**-**

Note 6 Operating leases - University Hospitals of Leicester NHS Trust as lessor

This note discloses income generated in operating lease agreements where the 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)

	2022/23	2021/22
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	275	459
Total in-year operating lease income	**275**	**459**

Note 6.2 Future lease receipts (Group)

	31 March 2023
	£000
Future minimum lease receipts due at 31 March 2023:	
- not later than one year	198
Total	**198**

	31 March 2022
	£000
Future minimum lease receipts due at 31 March 2022:	
- not later than one year;	463
- later than one year and not later than five years;	2,251
Total	**2,714**

Note 7.1 Operating expenses (Group)

	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,438	1,529
Purchase of healthcare from non-NHS and non-DHSC bodies	14,309	10,889
Staff and executive directors costs	897,213	777,540
Remuneration of non-executive directors	269	221
Supplies and services - clinical (excluding drugs costs)	167,500	142,808
Supplies and services - general	14,997	14,172
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	144,487	127,949
Inventories written down	-	26
Consultancy costs	2,613	3,297
Establishment	7,801	7,783
Premises	58,928	52,572
Transport (including patient travel)	7,104	6,356
Depreciation on property, plant and equipment	46,339	36,243
Amortisation on intangible assets	5,391	3,256
Net impairments	12,958	(3,042)
Movement in credit loss allowance: contract receivables / contract assets	1,697	(252)
Increase/(decrease) in other provisions	3,390	(8,598)
Change in provisions discount rate(s)	(526)	70
Fees payable to the external auditor		
audit services- statutory audit	334	929
Internal audit costs	112	257
Clinical negligence	38,824	38,204
Legal fees	740	489
Insurance	709	807
Research and development	42,610	38,680
Education and training	3,002	3,315
Expenditure on short term leases (current year only)	1,679	
Operating leases expenditure (comparative only)		3,131
Car parking & security	4,658	3,586
Hospitality	1	-
Losses, ex gratia & special payments	56	43
Other NHS charitable fund resources expended	2,011	1,825
Other	22,137	15,486
Total	**1,504,781**	**1,279,571**
Of which:		
Related to continuing operations	1,504,781	1,279,571

Note 7.2 Other auditor remuneration (Group)

Other auditor remuneration paid to the external auditor:

The Trust has not paid any remuneration to the auditor in respect of non-audit services (2021-22 - £Nil).

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2021/22: £1 million).

Note 8 Impairment of assets (Group)

	2022/23	2021/22
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	12,958	(3,042)
Total net impairments charged to operating surplus / deficit	**12,958**	**(3,042)**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**12,958**	**(3,042)**

Note 9 Employee benefits (Group)

	2022/23	2021/22
	Total	Total
	£000	£000
Salaries and wages	711,147	615,554
Social security costs	68,006	61,998
Apprenticeship levy	3,274	2,992
Employer's contributions to NHS pensions	107,116	98,669
Pension cost - other	126	-
Temporary staff (including agency)	28,370	20,698
Total gross staff costs	**918,039**	**799,911**
Of which		
Costs capitalised as part of assets	3,124	5,915

Note 9.1 Retirements due to ill-health (Group)

During 2022/23 there were 2 early retirements from the Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £21k (£302k in 2021/22).

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 two 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 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 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 11 Finance income (Group)

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

	2022/23	2021/22
	£000	£000
Interest on bank accounts	1,886	59
Interest on other investments / financial assets	-	-
NHS charitable fund investment income	162	121
Other finance income	-	-
Total finance income	**2,048**	**180**

Note 12.1 Finance expenditure (Group)

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

	2022/23	2021/22
	£000	£000
Interest expense:		
Interest on lease obligations	1,860	1,178
Interest on late payment of commercial debt	126	90
Total interest expense	**1,986**	**1,268**
Unwinding of discount on provisions	(152)	(135)
Other finance costs	-	-
Total finance costs	**1,834**	**1,133**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2022/23	2021/22
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	1	89
Amounts included within interest payable arising from claims made under this	126	90

Note 13 Other gains / (losses) (Group)

	2022/23	2021/22
	£000	£000
Gains on disposal of assets	-	450
Losses on disposal of assets	(624)	(129)
Total gains / (losses) on disposal of assets	**(624)**	**321**

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's deficit for the period was £34.5 million (2021/22: surplus £23.4 million). The Trust's total comprehensive expense for the period was £16.8 million (2021/22: income £35.7 million).

Note 15.1 Intangible assets - 2022/23

Group and Trust	Software licences	IT (Internally Generated and Third Party)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**36,624**	**-**	**36,624**
Additions	4,764	12	**4,776**
Disposals / derecognition	(9)	-	**(9)**
Valuation / gross cost at 31 March 2023	**41,379**	**12**	**41,391**
Amortisation at 1 April 2022 - brought forward	**20,502**	**-**	**20,502**
Provided during the year	5,391	-	**5,391**
Disposals / derecognition	(9)	-	**(9)**
Amortisation at 31 March 2023	**25,884**	**-**	**25,884**
Net book value at 31 March 2023	**15,495**	**12**	**15,507**
Net book value at 1 April 2022	**16,122**	**-**	**16,122**

Note 15.2 Intangible assets - 2021/22

Group and Trust	Software licences	IT (Internally Generated and Third Party)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**26,508**	**-**	**26,508**
Additions	7,460	-	**7,460**
Reclassifications	2,656	-	**2,656**
Valuation / gross cost at 31 March 2022	**36,624**	**-**	**36,624**
Amortisation at 1 April 2021 - brought forward	**17,246**	**-**	**17,246**
Provided during the year	3,256	-	**3,256**
Amortisation at 31 March 2022	**20,502**	**-**	**20,502**
Net book value at 31 March 2022	**16,122**	**-**	**16,122**
Net book value at 1 April 2021	**9,262**	**-**	**9,262**

Note 16.1 Property, plant and equipment - 2022/23

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2022 - brought forward	**60,128**	**467,471**	**5,555**	**39,912**	**170,624**	**338**	**55,537**	**2,693**	**802,258**
IFRS 16 implementation - reclassification to right of use assets	-	(3,675)	-	-	(59,693)	-	(10,863)	-	**(74,231)**
Additions	-	8,245	-	39,672	9,738	-	9,541	907	**68,103**
Impairments	(3,207)	(16,910)	-	-	-	-	-	-	**(20,117)**
Reversals of impairments	-	7,159	-	-	-	-	-	-	**7,159**
Revaluations	(1,501)	3,077	624	-	-	-	-	-	**2,200**
Reclassifications	-	29,809	131	(47,948)	12,640	-	5,368	-	**-**
Disposals / derecognition	-	-	-	-	(1,988)	-	(2,022)	(4)	**(4,014)**
Valuation/gross cost at 31 March 2023	**55,420**	**495,176**	**6,310**	**31,636**	**131,321**	**338**	**57,561**	**3,596**	**781,358**
Accumulated depreciation at 1 April 2022 - brought forward	**-**	**649**	**-**	**-**	**113,470**	**177**	**30,769**	**2,137**	**147,202**
IFRS 16 implementation - reclassification to right of use assets	-	(760)	-	-	(39,246)	-	(5,904)	-	**(45,910)**
Provided during the year	-	16,994	351	-	6,845	6	8,710	104	**33,010**
Revaluations	-	(16,883)	(351)	-	-	-	-	-	**(17,234)**
Disposals / derecognition	-	-	-	-	(1,888)	-	(1,500)	(4)	**(3,392)**
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**79,181**	**183**	**32,075**	**2,237**	**113,676**
Net book value at 31 March 2023	**55,420**	**495,176**	**6,310**	**31,636**	**52,140**	**155**	**25,486**	**1,359**	**667,682**
Net book value at 1 April 2022	**60,128**	**466,822**	**5,555**	**39,912**	**57,154**	**161**	**24,768**	**556**	**655,056**

Note 16.2 Property, plant and equipment - 2021/22

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 2021 - brought forward	**49,967**	**432,152**	**5,199**	**46,291**	**159,792**	**330**	**45,725**	**2,630**	**742,086**
Additions	6,447	10,416	205	35,828	9,324	-	5,597	-	**67,817**
Impairments	-	(13,279)	(2)	-	-	-	-	-	**(13,281)**
Reversals of impairments	1,590	5,933	-	-	-	-	-	-	**7,523**
Revaluations	2,124	967	153	-	-	-	-	-	**3,244**
Reclassifications	-	31,282	-	(42,207)	3,983	8	4,215	63	**(2,656)**
Disposals / derecognition	-	-	-	-	(2,475)	-	-	-	**(2,475)**
Valuation/gross cost at 31 March 2022	**60,128**	**467,471**	**5,555**	**39,912**	**170,624**	**338**	**55,537**	**2,693**	**802,258**
Accumulated depreciation at 1 April 2021 -	**-**	**564**	**-**	**-**	**104,981**	**149**	**23,276**	**2,016**	**130,986**
Provided during the year	-	17,460	306	-	10,835	28	7,493	121	**36,243**
Impairments	-	(8,796)	(4)	-	-	-	-	-	**(8,800)**
Revaluations	-	(8,579)	(302)	-	-	-	-	-	**(8,881)**
Disposals / derecognition	-	-	-	-	(2,346)	-	-	-	**(2,346)**
Accumulated depreciation at 31 March 2022	**-**	**649**	**-**	**-**	**113,470**	**177**	**30,769**	**2,137**	**147,202**
Net book value at 31 March 2022	**60,128**	**466,822**	**5,555**	**39,912**	**57,154**	**161**	**24,768**	**556**	**655,056**
Net book value at 1 April 2021	**49,967**	**431,588**	**5,199**	**46,291**	**54,811**	**181**	**22,449**	**614**	**611,100**

With the exception of equipment valued at £14k which belongs to TGH, Property, plant and equipment held by the Trust matches that of the Group.

Note 16.3 Property, plant and equipment financing - 31 March 2023

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	55,420	494,978	6,310	31,636	48,109	155	25,486	1,326	**663,420**
Owned - donated/granted	-	198	-	-	4,031	-	-	33	**4,262**
NBV total at 31 March 2023	**55,420**	**495,176**	**6,310**	**31,636**	**52,140**	**155**	**25,486**	**1,359**	**667,682**

Note 16.4 Property, plant and equipment financing - 31 March 2022

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
Owned - purchased	60,128	450,376	5,555	39,556	30,669	141	23,378	469	**610,272**
Finance leased	-	2,961	-	-	19,954	-	1,281	-	**24,196**
Owned - donated/granted	-	13,485	-	356	6,531	20	109	87	**20,588**
NBV total at 31 March 2022	**60,128**	**466,822**	**5,555**	**39,912**	**57,154**	**161**	**24,768**	**556**	**655,056**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	500	-	-	-	-	-	-	**500**
Not subject to an operating lease	55,420	494,676	6,310	31,636	52,140	155	25,486	1,359	**667,182**
NBV total at 31 March 2023	**55,420**	**495,176**	**6,310**	**31,636**	**52,140**	**155**	**25,486**	**1,359**	**667,682**

Note 17 Donations of property, plant and equipment

	Group and Trust	
	2022/23	2021/22
	£000	£000
Assets purchased with donations from the Trust's charitable fund	1,061	559
Assets received from DHSC relating to Covid treatment	-	162
Other	-	1,849
	1,061	**2,570**

Note 18 Revaluations of property, plant and equipment

The Trust's land and buildings are held at valuation. Details are disclosed in note 1.10

Note 19 Leases - University Hospitals of Leicester NHS Trust as a lessee

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

Payment for the fair value of the services received

The annual unitary payment is applied to meet the annual finance cost and to repay the lease liabilities over the contract term.

Interest costs charged to revenue

An annual finance cost is calculated by applying the implicit interest rate in the leases to the opening lease liabilities for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

Property plant and equipment assets recognised on the balance sheet

The finance lease assets are recognised as property, plant and equipment. The asset values, life and depreciation for the scheme are provided to the Trust by the Lessors.

Depreciation on the property, plant and equipment is charged to revenue.

Liability

Lease liabilities are recognised at the same time as the assets are recognised. The liabilities are measured initially at the same amount as the fair value of the assets and are subsequently measured as finance lease liabilities in accordance with IAS 17 Leases.

Asset replacement

Any assets, or asset components provided by the lessor during the contract are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the lessor and are measured initially at their fair value.

Assets contributed by the Trust to the operator for use in the scheme (MES only).

Assets contributed for use in the scheme are recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Note 19.1 Right of use assets - 2022/23

Group and Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**-**	**-**	**-**	**-**	**-**	**-**
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	3,675	59,269	-	11,287	**74,231**	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	10,738	2,278	58	-	**13,074**	8,431
Additions	3,494	9,243	-	2,970	**15,707**	-
Remeasurements of the lease liability	3,958	3,972	-	-	**7,930**	-
Valuation/gross cost at 31 March 2023	**21,865**	**74,762**	**58**	**14,257**	**110,942**	**8,431**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	-	**-**	-
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	760	39,574	-	5,576	**45,910**	-
Provided during the year	2,791	8,060	40	2,438	**13,329**	1,229
Accumulated depreciation at 31 March 2023	**3,551**	**47,634**	**40**	**8,014**	**59,239**	**1,229**
Net book value at 31 March 2023	**18,314**	**27,128**	**18**	**6,243**	**51,703**	**7,202**

Carrying value of right of use assets by counter party

	31 March 2023
	£000
Net book value of right of use assets leased from other DHSC group bodies	7,202
Net book value of right of use assets leased from local authorities	1,490
Net book value of right of use assets leased from bodies external to government	43,011
	51,703

Note 19.2 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 28.

	Group and Trust
	2022/23
	£000
Carrying value at 31 March 2022	**20,244**
IFRS 16 implementation - adjustments for existing operating leases	13,074
At start of period for new FTs	-
Lease additions	15,707
Lease liability remeasurements	7,930
Interest charge arising in year	1,860
Lease payments (cash outflows)	(17,070)
Carrying value at 31 March 2023	**41,745**

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

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

Note 19.3 Maturity analysis of future lease payments at 31 March 2023

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2023	**31 March 2023**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	12,799	1,000
- later than one year and not later than five years;	25,813	5,386
- later than five years.	8,238	1,128
Total gross future lease payments	**46,850**	**7,514**
Finance charges allocated to future periods	(5,105)	(246)
Net lease liabilities at 31 March 2023	**41,745**	**7,268**
Of which:		
- Current	12,231	940
- Non-Current	29,514	6,328

Note 19.4 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the Trust previously determined to be finance leases under IAS 17 at 31 March 2022.

	Group and Trust 31 March 2022 £000
Undiscounted future lease payments payable in:	
- not later than one year;	7,849
- later than one year and not later than five years;	11,280
- later than five years.	3,755
Total gross future lease payments	**22,884**
Finance charges allocated to future periods	(2,640)
Net finance lease liabilities at 31 March 2022	**20,244**
of which payable:	
- not later than one year;	7,658
- later than one year and not later than five years;	9,863
- later than five years.	2,723
Total of future minimum sublease payments to be received at the reporting date	-

Note 19.5 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the Trust previously determined to be operating leases under IAS 17.

	Group and Trust 2021/22 £000
Operating lease expense	
Minimum lease payments	3,131
Total	**3,131**

	31 March £000
Future minimum lease payments due:	
- not later than one year;	2,234
- later than one year and not later than five years;	6,824
- later than five years.	3,377
Total	**12,435**
Future minimum sublease payments to be received	-

Note 19.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 15.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	Group and Trust
	1 April 2022
	£000
Operating lease commitments under IAS 17 at 31 March 2022	**12,435**
Impact of discounting at the incremental borrowing rate	
IAS 17 operating lease commitment discounted at incremental borrowing rate	**12,323**
Finance lease liabilities under IAS 17 as at 31 March 2022	20,243
Other adjustments	752
Total lease liabilities under IFRS 16 as at 1 April 2022	**33,318**

Note 20 Other investments / financial assets (non-current)

	Group	
	2022/23	2021/22
	£000	£000
Carrying value at 1 April - brought forward	**5,362**	**5,185**
Acquisitions in year	959	655
Movement in fair value through OCI	(396)	196
Disposals	(961)	(674)
Carrying value at 31 March	**4,964**	**5,362**

	Trust	
	2022/23	2021/22
	£000	£000
Carrying value at of investments		
Investment in subsidiary	4,000	4,000
Carrying value at 31 March	**4,000**	**4,000**

Note 21 Analysis of charitable fund reserves

The Leicester Hospital Charity has been consolidated within this set of accounts.

	31 March 2023	31 March 2022
	£000	£000
Unrestricted funds:		
Unrestricted income funds	6,043	5,984
Restricted funds:		
Other restricted income funds	3,679	1,707
	9,722	**7,691**

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 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
Drugs	8,081	6,541	6,068	4,945
Consumables	14,154	14,300	14,154	14,300
Energy	428	285	428	285
Total inventories	**22,663**	**21,126**	**20,650**	**19,530**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £2,540k (2021/22: £233,071k). Write-down of inventories recognised as expenses for the year were £0k (2021/22: £26k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2022/23 the Trust received £2,355k of items purchased by DHSC (2021/22: £3,552k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 23.1 Receivables

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Current				
Contract receivables	58,116	23,194	58,116	23,188
Allowance for impaired contract receivables / assets	(4,370)	(2,617)	(4,370)	(2,617)
Prepayments (non-PFI)	4,693	7,552	4,676	7,545
PDC dividend receivable	-	559	-	559
VAT receivable	2,899	3,098	2,246	2,024
Corporation and other taxes receivable	24	32	24	32
Other receivables	1,242	1,685	1,045	1,765
NHS charitable funds receivables	324	111	-	-
Total current receivables	**62,928**	**33,614**	**61,737**	**32,496**
Non-current				
Contract receivables	1,891	2,208	1,891	2,208
Allowance for impaired contract receivables / assets	(452)	(508)	(452)	(508)
Other receivables	1,660	1,745	1,660	1,745
Total non-current receivables	**3,099**	**3,445**	**3,099**	**3,445**
Of which receivable from NHS and DHSC group bodies:				
Current	43,922	13,449	43,922	13,449
Non-current	1,660	1,745	1,660	1,745

Note 23.2 Allowances for credit losses - 2022/23

	Group and Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2022 - brought forward	**3,125**	**-**
Changes in existing allowances	1,697	-
Allowances as at 31 Mar 2023	**4,822**	**-**

Note 23.3 Allowances for credit losses - 2021/22

	Group and Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2021 - brought forward	**3,377**	**-**
Reversals of allowances	(252)	-
Allowances as at 31 Mar 2022	**3,125**	**-**

Note 24 Non-current assets held for sale and assets in disposal groups

	Group and Trust	
	2022/23	2021/22
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**10,100**
Assets sold in year	-	(10,100)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 25.1 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	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
At 1 April	**112,417**	**106,423**	**108,442**	**99,809**
Net change in year	(4,437)	5,994	(7,362)	8,633
At 31 March	**107,980**	**112,417**	**101,080**	**108,442**
Broken down into:				
Cash at commercial banks and in hand	6,948	2,497	48	289
Cash with the Government Banking Service	101,032	109,920	101,032	108,153
Total cash and cash equivalents	**107,980**	**112,417**	**101,080**	**108,442**

Note 26.1 Trade and other payables

	Group		Trust	
	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
Current				
Trade payables	44,297	57,637	59,805	59,280
Capital payables	10,882	8,803	10,882	8,803
Accruals	101,823	50,900	85,387	49,418
Receipts in advance and payments on account	-	-		
PFI lifecycle replacement received in advance	-	-		
Social security costs	9,229	9,117	9,216	9,100
VAT payables	-	-		
Other taxes payable	8,908	7,744	8,895	7,728
PDC dividend payable	609	-	609	
Pension contributions payable	10,471	10,210	10,471	10,210
Other payables	888	874	805	765
NHS charitable funds: trade and other payables	143	63		
Total current trade and other payables	**187,250**	**145,348**	**186,070**	**145,304**
Of which payables from NHS and DHSC group bodies:				
Current	9,105	5,816	9,105	5,816
Non-current	-	-		

Note 26.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2023	31 March 2023	31 March 2022	31 March 2022
	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	-		302	
- number of cases involved		-		5

Note 27 Other liabilities

	Group and Trust	
	31 March 2023	31 March 2022
	£000	£000
Current		
Deferred income: contract liabilities	4,196	3,799
Total other current liabilities	**4,196**	**3,799**

Note 28 Borrowings

	Group and Trust	
	31 March 2023	31 March 2022
	£000	£000
Current		
Lease liabilities*	12,231	7,658
Total current borrowings	**12,231**	**7,658**
Non-current		
Lease liabilities*	29,514	12,586
Total non-current borrowings	**29,514**	**12,586**

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 18.

Lease Liabilities split by counter party

	31 March 2023
	£000
Other DHSC group bodies	7,268
Local Authorities	1,026
Bodies external to government	33,451
	41,745

Note 28.1 Reconciliation of liabilities arising from financing activities

Group and Trust - 2022/23	Lease liabilities £000	Total £000
Carrying value at 1 April 2022	**20,244**	**20,244**
Cash movements:		
Financing cash flows - payments and receipts of principal	(16,866)	**(16,866)**
Financing cash flows - payments of interest	(204)	**(204)**
Non-cash movements:		
IFRS 16 implementation - adjustments for existing operating	13,074	**13,074**
Additions	15,707	**15,707**
Lease liability remeasurements	7,930	**7,930**
Application of effective interest rate	1,860	**1,860**
Carrying value at 31 March 2023	**41,745**	**41,745**

Group and Trust - 2021/22	Finance leases £000	Total £000
Carrying value at 1 April 2021	**19,162**	**19,162**
Cash movements:		
Financing cash flows - payments and receipts of principal	(7,731)	**(7,731)**
Financing cash flows - payments of interest	(1,772)	**(1,772)**
Non-cash movements:		
Additions	9,407	**9,407**
Application of effective interest rate	1,178	**1,178**
Carrying value at 31 March 2022	**20,244**	**20,244**

Note 29.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Other	Total
	£000	£000	£000	£000
At 1 April 2022	**2,177**	**1,244**	**9,634**	**13,055**
At start of period for new FTs	-	-	**-**	**-**
Change in the discount rate	(270)	(256)	(1,481)	**(2,007)**
Arising during the year	186	101	9,815	**10,102**
Utilised during the year	(211)	(47)	(1,038)	**(1,296)**
Reversed unused	(131)	-	(2,615)	**(2,746)**
Unwinding of discount	(28)	(124)	34	**(118)**
At 31 March 2023	**1,723**	**918**	**14,349**	**16,990**
Expected timing of cash flows:				
- not later than one year;	208	61	12,689	**12,958**
- later than one year and not later than five years;	1,515	857	1,660	**4,032**
- later than five years.	-	-	-	**-**
Total	**1,723**	**918**	**14,349**	**16,990**

Note 29.2 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Pensions: injury benefits	Other	Total
	£000	£000	£000	£000
At 1 April 2022	**2,177**	**1,244**	**9,597**	**13,018**
At start of period for new FTs				**-**
Change in the discount rate	(270)	(256)	(1,481)	**(2,007)**
Arising during the year	186	101	9,794	**10,081**
Utilised during the year	(211)	(47)	(1,038)	**(1,296)**
Reversed unused	(131)	-	(2,615)	**(2,746)**
Unwinding of discount	(28)	(124)	34	**(118)**
At 31 March 2023	**1,723**	**918**	**14,291**	**16,932**
Expected timing of cash flows:				
- not later than one year;	208	61	12,631	**12,900**
- later than one year and not later than five years;	1,515	857	1,660	**4,032**
- later than five years.				**-**
Total	**1,723**	**918**	**14,291**	**16,932**

Note 29.3 Clinical negligence liabilities

At 31 March 2023, £307,297k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals of Leicester NHS Trust (31 March 2022: £302,778k).

Note 30 Contingent assets and liabilities

	Group and Trust	
	31 March 2023	31 March 2022
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	71	130
Gross value of contingent liabilities	**71**	**130**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**71**	**130**
Net value of contingent assets	**-**	**-**

Note 31 Contractual capital commitments

	Group and Trust	
	31 March 2023	31 March 2022
	£000	£000
Property, plant and equipment	15,692	24,543
Intangible assets	-	-
Total	**15,692**	**24,543**

Note 32 Other financial commitments

The Group and Trust have no other financial commitments.

Note 33 Financial assets and liabilities

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Note 33.1 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	56,427	-	**56,427**
Cash and cash equivalents	103,345	-	**103,345**
Consolidated NHS Charitable fund financial assets	4,959	4,964	**9,923**
Total at 31 March 2023	**164,731**	**4,964**	**169,695**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	22,388	-	**22,388**
Cash and cash equivalents	109,960	-	**109,960**
Consolidated NHS Charitable fund financial assets	7,819	-	**7,819**
Total at 31 March 2022	**140,167**	**-**	**140,167**

Note 33.2 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	56,230	-	**56,230**
Other investments / financial assets	4,000	-	**4,000**
Cash and cash equivalents	101,080	-	**101,080**
Total at 31 March 2023	**161,310**	**-**	**161,310**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	22,250	-	**22,250**
Other investments / financial assets	4,000	-	**4,000**
Cash and cash equivalents	108,442	-	**108,442**
Total at 31 March 2022	**134,692**	**-**	**134,692**

Note 33.3 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost £000	Total book value £000
Obligations under leases	41,745	**41,745**
Trade and other payables excluding non financial liabilities	152,306	**152,306**
Consolidated NHS charitable fund financial liabilities	143	**143**
Total at 31 March 2023	**194,194**	**194,194**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost £000	Total book value £000
Obligations under finance leases	20,244	**20,244**
Trade and other payables excluding non financial liabilities	124,353	**124,353**
Total at 31 March 2022	**144,597**	**144,597**

Note 33.4 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost £000	Total book value £000
Obligations under leases	41,745	**41,745**
Trade and other payables excluding non financial liabilities	151,348	**151,348**
Total at 31 March 2023	**193,093**	**193,093**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost £000	Total book value £000
Obligations under finance leases	20,244	**20,244**
Trade and other payables excluding non financial liabilities	124,308	**124,308**
Total at 31 March 2022	**144,552**	**144,552**

Note 33.5 Fair values of financial assets and liabilities

The book value of financial liabilities is a reasonable approximation of fair value.

Note 33.6 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
In one year or less	165,248	132,202	165,798	132,157
In more than one year but not more than five years	25,813	11,280	28,315	11,280
In more than five years	8,238	3,755	8,154	3,755
Total	**199,299**	**147,237**	**202,267**	**147,192**

Note 34 Losses and special payments

	2022/23		2021/22	
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	-	-	190	117
Total losses	**-**	**-**	**190**	**117**
Special payments				
Ex-gratia payments	130	307	86	2,836
Total special payments	**130**	**307**	**86**	**2,836**
Total losses and special payments	**130**	**307**	**276**	**2,952**

No loss was indiviually in excess of £300k

Note 35 Gifts

The Group and Trust made no gifts in 2022/23 (2021/22 - none)

Note 36 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 (DHSC) is regarded as a related party. During the year the **University Hospitals of Leicester NHS Trus**t has had a significant number of material transactions with the DHSC and with other entities for which the DHSC is regarded as the parent Department. These entities are listed below:

Cambridge University Hospitals NHS Foundation Trust
Health Education England
Kettering General Hospital NHS Foundation Trust
Leicestershire Partnership NHS Trust
NHS Cambridgeshire and Peterborough ICB
NHS Coventry and Warwickshire ICB
NHS Derby and Derbyshire ICB
NHS East Leicestershire and Rutland CCG (demised 01/07/22)
NHS England
NHS Leicester City CCG (demised 01/07/22)
NHS Leicester, Leicestershire and Rutland ICB
NHS Lincolnshire CCG (demised 01/07/22)
NHS Lincolnshire ICB
NHS Northamptonshire CCG (demised 01/07/22)
NHS Northamptonshire ICB
NHS Nottingham and Nottinghamshire ICB
NHS Property Services
NHS Resolution
NHS West Leicestershire CCG (demised 01/07/22)
North West Anglia NHS Foundation Trust
Northampton General Hospital NHS Trust
Nottingham University Hospitals NHS Trust
Sherwood Forest Hospitals NHS Foundation Trust
United Lincolnshire Hospitals NHS Trust
University Hospitals of Derby and Burton NHS Foundation Trust

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the following organisations:

HM Revenue and Customs - Other Taxes and Duties
HM Revenue and Customs - VAT
Leicester City Council
NHS Blood and Transplant
NHS Pension Scheme

Note 37 Better Payment Practice code

	2022/23	2022/23	2021/22	2021/22
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	170,393	800,530	166,903	866,582
Total non-NHS trade invoices paid within target	160,023	748,718	155,844	817,964
Percentage of non-NHS trade invoices paid within target	93.9%	93.5%	93.4%	94.4%
NHS Payables				
Total NHS trade invoices paid in the year	3,811	110,398	3,989	128,116
Total NHS trade invoices paid within target	2,799	93,482	3,131	115,181
Percentage of NHS trade invoices paid within target	73.4%	84.7%	78.5%	89.9%

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

Note 38 External financing

The Trust is given an external financing limit against which it is permitted to underspend

	2022/23	2021/22
	£000	**£000**
Cash flow financing	26,059	(9,645)
External financing requirement	**26,059**	**(9,645)**
External financing limit (EFL)	26,059	(9,645)
Under / (over) spend against EFL	**-**	**-**

Note 39 Capital Resource Limit

	2022/23	2021/22
	£000	**£000**
Gross capital expenditure	96,516	75,277
Less: Disposals	(622)	(10,229)
Less: Donated, granted and peppercorn leased capital additions	(1,061)	(2,570)
Charge against Capital Resource Limit	**94,833**	**62,478**
Capital Resource Limit	94,938	64,858
Under / (over) spend against CRL	**105**	**2,380**

Note 40 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		51	1,013	88	91	(39,655)	(40,648)	(34,051)
Breakeven duty cumulative position	3,910	3,961	4,974	5,062	5,153	(34,502)	(75,150)	(109,201)
Operating income		697,692	696,257	719,154	758,665	770,393	834,376	866,036
Cumulative breakeven position as a percentage of operating income		0.6%	0.7%	0.7%	0.7%	(4.5%)	(9.0%)	(12.6%)

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(27,152)	(34,455)	(44,879)	(154,380)	46,161	20,624	(22,736)
Breakeven duty cumulative position	(136,353)	(170,808)	(215,687)	(370,067)	(323,906)	(303,282)	(326,018)
Operating income	924,269	960,790	992,246	1,086,035	1,282,199	1,318,976	1,486,225
Cumulative breakeven position as a percentage of operating income	(14.8%)	(17.8%)	(21.7%)	(34.1%)	(25.3%)	(23.0%)	(21.9%)

Glossary of terms

Acute Care is specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

Acuity The measurement of the intensity of care required for a patient delivered by a registered nurse. There are six categories ranging from minimal care to intensive care.

Admission the point at which a person begins an episode of care, e.g. arriving at an inpatient ward.

Ambulatory care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

A&E (Accident & Emergency) see Emergency Department.

Board Assurance Framework (BAF) is a key mechanism which Trust Boards should be using to reinforce strategic focus and better management of risk.

Cannulation intravenous cannulation involves putting a “tube” into a patient’s vein so that infusions can be inserted directly into the patient’s bloodstream.

Care Plan a plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy.

Care Quality Commission the organisation that make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

Carbapenem resistant organisms are a group of germs which can live harmlessly inside the bowel and, except for their resistance to antibiotics, are identical to our normal gut bacteria. Carrying them in the bowel is not a direct risk to patients. They are only a danger if they cause infections.

CCG (Clinical Commissioning Group) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

CIP (Cost Improvement Programme) a Cost Improvement Programme (CIP) is the identification of schemes to increase efficiency/ or reduce expenditure. CIPs can include both recurrent (year on year) and non- recurrent (one-off) savings. A CIP is not simply a scheme that saves money. The most successful CIPs are often those based on long-term plans to transform clinical and non-clinical services that not only result in a permanent cost savings, but also improve patient care, satisfaction and safety.
Clinical Governance is a framework that ensures that NHS organisations monitor and improve the quality of services provided and that they are accountable for the care they provide.

Clinical Management Groups (CMG) we have seven Clinical Management Groups: CHUGGS (Cancer, Haematology, Urology, Gastroenterology and General Surgery); CSI (Clinical Support and Imaging); ESM (Emergency and Specialist Medicine); ITAPS (Critical Care, Theatres, Anaesthesia, Pain and Sleep); MSS (Musculoskeletal and Specialist Surgery); RRCV (Renal, Respiratory and Cardiovascular); W&C (Women’s and Children’s).

Clinical Negligence Scheme for Trust (CNST) is a scheme for assessing a Trust's arrangements to minimise clinical risk for service users and staff. Trusts need to pay 'insurance' which can offset the costs

of legal claims against the Trust. Achieving CNST Levels (1, 2 or 3) shows the Trust's success in minimising clinical risk and reduces the premium that the Trust must pay.

Clinician is a person who provides direct care to a patient such as a doctor, nurse, therapist, pharmacist, psychologist etc.)

Commissioner is responsible for getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc.

Commissioning is the process of identifying a community's social and/or health care needs and finding services to meet them.

Community Care aims to provide health and social care services in the community to enable people live as independently as possible in their own homes or in other accommodation in the community.

Co-morbidity is the presence of two or more disorders at the same time. For example, a person with depression may also have diabetes.

CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. This means that a proportion of our income depends on achieving quality improvement and innovation goals, agreed between the Trust and its commissioners. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients, a principle fully supported at all levels of the hospital.

Diagnosis is identifying an illness or problem by its symptoms and signs.

Discharge is the point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan (see Care plan).

Emergency Admission when a patient admitted to hospital at short notice because of clinical need or because alternative care is not available.

Emergency Department is a hospital department that assesses and treats people with serious and life-threatening injuries and those in need of emergency treatment. Also sometimes called A&E (Accident & Emergency).

Friends and Family Test (FFT) launched in April 2013, the FFT question asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

General Medical Council: The General Medical Council (GMC) works to protect patient safety and support medical education and practice across the UK. They do this by working with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems.

General Practitioner (GP) is a family doctor, usually patient's first point of contact with the health service.

GIRFT (Getting it Right First Time): Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT

identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing.

Health Care Assistants (can also be referred to as Health Care Support Workers) are non-qualified nursing staff who carry out assigned tasks involving direct care in support of a registered/qualified nurse. There are two grades of Health Care Assistants, A and B grade. A grades would expect to be more closely supervised, while B grades may regularly work without supervision for all or most of their shift, or lead on A grade.

Human Resources is a department found in most organisations that works to recruit staff, assist in their development (e.g. providing training) and ensure that staff work in good conditions.

Information Management and Technology (IM&T) refers to the use of information held by the Trust, in particular computerised information and the department that manages those services.

Intermediate Care Services are services that promote independence, prevent hospital admission and/or enable early discharge. Intermediate care typically provides community-based alternatives to traditional hospital care.

Model Hospital: The Model Hospital is a free digital tool from NHS Improvement available to all NHS provider trusts. It supports the NHS to provide the best patient care in the most efficient way. It allows trusts to compare their productivity and identify opportunities to improve.

Mortality means death rate. In the NHS it is used when referring to the expected death rate for conditions or procedures.

Multidisciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.

NICE is the National Institute for Health and Clinical Excellence, an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Non-Executive Director is a member of the Trust Board. They act a two way representative. They bring the experiences, views and wishes of the community and patients to the Trust Board. They also represent the interests of the NHS organisation to the Community.

NHS England leads the NHS in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

NHS Improvement is responsible for overseeing foundation trusts and NHS provider trusts, as well as independent providers that provide NHS-funded care. They offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, they help the NHS to meet its short-term challenges and secure its future.

Nursing and Midwifery Council: The Nursing and Midwifery Council, NMC, make sure nurses, midwives and nursing associate have the skills they need to care for people safely, with integrity, expertise, respect and compassion, from the moment they step into their first job.

Out of Hours (OOH) is the provision of GP services when your local surgery is closed, usually during the night, at weekends and Bank Holidays.

Palliative care is an area of healthcare that focuses on relieving and preventing the suffering of patients.

Peri-natal mortality is the number of stillbirths and deaths in the first week of life per 1,000 live births, after 24 weeks gestation.

Primary Care is the care will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

QIPP (Quality Innovation Productivity and Prevention) In July 2010, the White Paper 'Equity and excellence: Liberating the NHS' set out the government's vision for the future of the NHS. The White Paper outlined the government's commitment to ensuring that QIPP supports the NHS to make efficiency savings, which can be reinvested back into the service to continually improve quality of care.

Risk assessment identifies aspects of a service which could lead to injury to a patient or staff member and/or to financial loss for an individual or Trust.

Royal College of Nursing: The Royal College of Nursing is the world's largest nursing union and professional body.

Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).

Serious Untoward Incidents (SUI) is to describe a serious incident or event which led, or may have led, to the harm of patients or staff. Members of staff who were not involved in the incident investigate these and the lessons learned from each incident are used to improve care in the future.

SHMI (Summary Hospital-level Mortality Indicator) The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Stakeholders are a range of people and organisations that are affected by or have an interest in, the services offered by an organisation.

Tertiary Care is when a hospital consultant decides that more specialist care is needed. Mental Health Services are included in this (see also Secondary care).

TTO (To-take-out) are medicines supplied by the hospital pharmacy for patients to take with them when they are discharged (see discharge) from hospital.

Triage a system which sorts medical cases in order of urgency to determine how quickly patients receive treatment.

Urgent Care Centre is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent care centres primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency department visit.

Urgent care centres are distinguished from similar ambulatory healthcare centres such as emergency departments and walk in centres by their scope of conditions treated and available facilities on-site.

Walk-in-Centre (WiC) is a medical centre offering free and fast access to health-care advice and treatment. Centres provide advice and treatment for minor injuries and illnesses and guidance on how to use NHS services.

Whistle-blowing is the act of informing a relevant person in an organisation of instances or services in which patients are at risk.

If you would like this information in another language or format such as EasyRead or Braille, please telephone **0116 250 2959** or email **equality@uhl-tr.nhs.uk**

اگر آپ کو یہ معلومات کسی اور زبان میں درکار ہیں، تو براہِ کرم مندرجہ ذیل نمبر پر ٹیلی فون کریں۔

ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਨੰਬਰ 'ਤੇ ਟੈਲੀਫ਼ੋਨ ਕਰੋ।

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