NHS
Nottingham
University Hospitals
NHS Trust

We Listen
We Care

Annual Report & Accounts

18/19

Contents

Section 1 – Performance Report

This section of the report is intended to give an overview of how we did against the priorities we set ourselves for 18/19 and describe our areas of focus for the year to come, reflecting the Trust's strategy and the direction of travel for the wider health and social care system in Nottinghamshire.

Introduction by the Chief Executive

It is my pleasure to introduce the 18/19 Annual Report for Nottingham University Hospitals NHS Trust (NUH).

Now in my second year at NUH, 18/19 has been a year of consolidation and further transition for NUH, as we have focused on tackling our biggest challenges and ensuring we are set up in the right way for the future so that we can achieve our vision of delivering outstanding health outcomes and patient and staff experience.

Over the last year I have truly seen what makes Team NUH special, with so many achievements and highlights we can be proud of and should celebrate, notwithstanding our challenges which we describe in this document. Our long-term strategy, which we launched in 2018, sets out six Promises to our patients, and below I have described some of the highlights in each of these domains from 18/19.

Patients

We retained our 'Good' overall rating and were rated 'Outstanding' for caring by the Care Quality Commission (CQC) following our comprehensive 18/19 inspection. This result has given our patients, their families and carers confidence in the quality of care and services provided by their local hospitals and boosted our staff who were praised for their determination to give the best possible care to patients.

Our rating in the safe domain, however, remained as 'Requires Improvement' and there is a collective determination from Team NUH to make the necessary changes in this area as quickly as possible. The CQC found that patient safety incidents were managed well and recognised much good practice, however, inspectors had some concerns about consistency of prescribing, giving, recording and storing medicines and compliance with mandatory training as well as cleanliness and staffing levels in some local areas to ensure optimal patient care. For more information about our CQC results and our associated improvement plan, please see our 18/19 Quality Account.

Notwithstanding the need to improve in response to our CQC feedback, it is important to recognise that we have made continued progress in ensuring that we provide the best possible standards of care, including achieving or exceeding the national indicators of safe care in most areas. Our Clostridium difficile infection rates are at their lowest on record, we vaccinated more frontline staff as part of our flu vaccination programme than ever before and our falls and pressure ulcer rates remain below target. Our 19/20 quality priorities, described in our Quality Account, set out our programme of work to ensure we make continued improvements to safety and quality of care in the year to come.

Over 645 lives have been saved by experts at Queen's Medical Centre's (QMC) East Midlands Major Trauma Centre, more than any other centre in the country, since major trauma centres were established in 2012 nationally. Our Major Trauma Centre is recognised as a centre of clinical excellence, with strong clinical outcomes.

People

In 2019, we launched our refreshed Team NUH values, behaviours and associated managers' standards after listening to feedback and co-designing them with our patients, partners and staff. They are: Trust, Empowering, Ambitious, Mindful, Nurturing, United and Honest.

In response to feedback from our staff in last year's staff survey, at the end of 2018, we launched a new and simplified approach to appraisals to support staff and their managers to have better quality conversations. We further strengthened our programme of work to value, reward and recognise our staff, including launching a new staff ideas scheme, hosting our first Transforming Healthcare Awards for our Allied Healthcare Professionals, Pharmacy Teams and Healthcare Scientists, a new end of week video to celebrate the achievements of Team NUH and team of the week so that celebrating excellence and our people becomes part of what we routinely do.

Our Magnet journey – which is our ambition for NUH to become the first Trust in the UK to be internationally-recognised for care excellence – continues to go from strength to strength, thanks to the fantastic ongoing support from our NUH Charity. With over 80 Councils

now in place across NUH, we have the most established Shared Governance programme in the country, and this is taking decision-making closer to the frontline and is continuing to improve morale and teamwork. We now have one of the best retention rates for nurses compared to our peers and many new and exciting developments, including our new Nursing and Midwifery Institute and Nursing Associate roles. Our close relationships with both local universities in Nottingham is similarly driving positive changes, including the introduction of an accredited frailty module in 18/19, all of which are making NUH an even more attractive place to work.

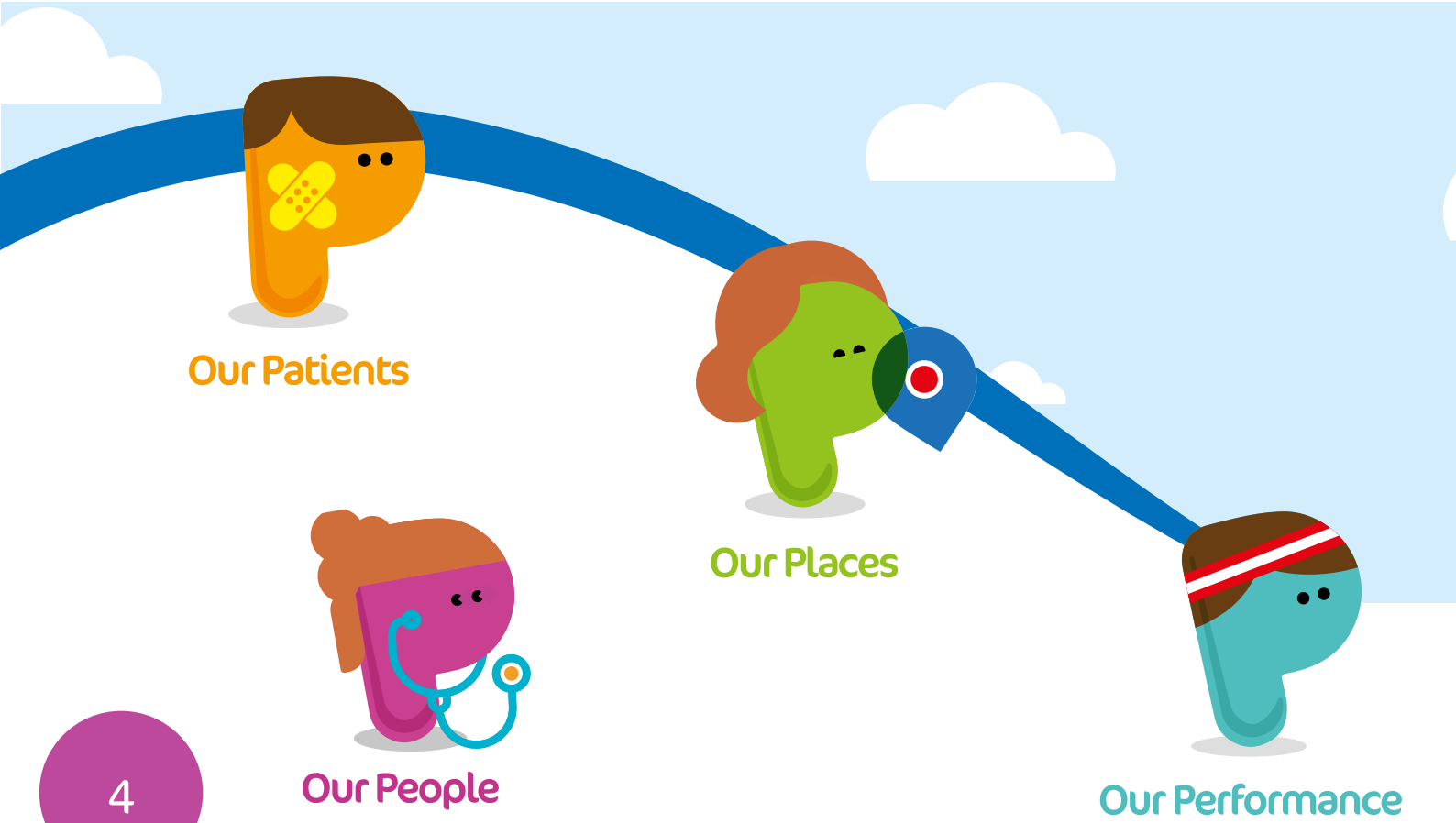
Many members of Team NUH have received significant national recognition for their innovations, care excellence and leading the way over the last year, and these include:

- Students from the University of Nottingham and NUH being shortlisted for six Student Nursing Times Awards, in a record year for entries
- Andrew Bird, our Lead Stoma Nurse, being named national Stoma Nurse of the Year at the British Journal of Nursing Awards in recognition of his exceptional care for patients and efforts in helping to implement a seven-day stoma care service
- Joseph Manning, Charge Nurse in our Paediatric Critical Care Outreach Team at our Nottingham Children's Hospital, becoming the first children's nurse in the country (and first registered nurse in the East Midlands) to be awarded a prestigious Clinical Lectureship Award from the Department of Health and Social Care
- Team NUH winning five awards at the Patient Experience Network National Awards. NUH were winners for (1) our Memory Menu, (2) our Carer2Theatre initiative, (3) our Chief Nurse Excellence in Care Fellowship Programme, (4) Best in Class NHS Trust and (5) overall winner for our Carer2Theatre entry
- Catering staff from NUH were shortlisted for two Healthcare Catering Association Awards in recognition of their exceptional commitment to improving food services for our patients, their families and staff. NUH was the only NHS Trust in the country to be shortlisted for the prestigious Catey Awards in recognition of its Memory Menu, which was also highlighted by the CQC as an example of outstanding engagement practice with our local community

Places

Our ageing estate and infrastructure continues to be a cause for concern for our Trust Board. It is well documented that NUH has the second highest critical infrastructure risks (backlog maintenance) in the NHS. Much work has been done over the last year to develop a short and longer-term plan to manage these risks, utilising our limited internally-generated capital, whilst developing an ambitious 10-year Estate Strategy which sets out our plans for QMC and Nottingham City Hospital and their use in the future, which is aligned to NUH's clinical services strategy and the direction of travel set out in the long-term plan for health and social care in Nottinghamshire.

Nottingham was awarded £4.5m winter national capital monies to develop a new Urgent and Emergency Care Centre, including a new Adult Emergency Department (ED) entrance and expanded majors' area at QMC, which



opened mid-December 2018. This development was the most significant for urgent and emergency care at Nottingham's hospitals in 15 years and aims to further improve patient and staff experience and the timeliness of emergency patient care. Alongside the increase in capacity in our ED, we have re-engineered all aspects of our urgent and emergency care pathways. This funding also supported the creation of a new 35-bedded community-run facility at Nottingham City Hospital used by patients who no longer need hospital care, which was part of a strengthened system winter plan for 18/19. See the 'Performance' section (right) and page 17 for more information.

Nottingham was awarded a further £11.9m of national monies at the end of 2018 to develop a business case to increase our critical care capacity at QMC in the years to come, and to progress the second phase of our modernisation and expansion of our Urgent and Emergency Care Centre facilities at QMC as we seek to right-size our hospitals for the future.

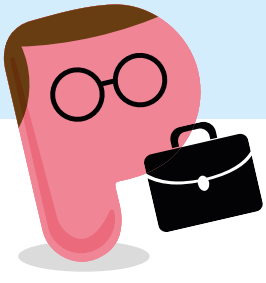
18/19 saw the beginning of a £5.7m project to upgrade the ventilation in QMC's main operating theatres. New modular operating theatres have been built at the side of QMC's West Block to enable the main operating theatres to be modernised. The suite of modular operating theatres, which opened in April 2019, will initially be used for routine surgery for a number of specialties.

There were several welcome digital developments in 18/19 also, including the news that Nottingham will benefit from £1.5m of funding to trial innovative technology that could help deliver an improved breast screening service to women across the UK. NUH, the host of the East Midlands Radiology Consortium (EMRAD), has launched an 18-month project using Artificial Intelligence (AI) to support breast screening as one of seven new NHS Test Beds, which aims to screen and treat more people to support service capacity, boost patient, public and clinical confidence in using AI technology and to improve patient care. The AI tool will specifically help radiologists to deliver more accurate and consistent results and reduce the need for recalls and biopsies.

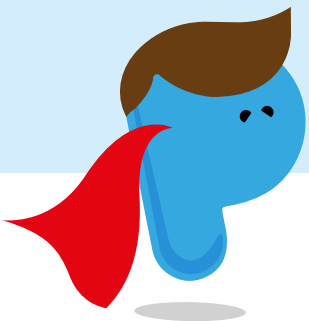
Performance

18/19 has been a challenging year with pressures across our cancer, elective and emergency pathways that have impacted on the timeliness of care. Despite these challenges, we have delivered strong performance across all of our 'Friends and Family' Tests, in our waiting times for diagnostic tests and we remain one of the top Trusts in the country for the 18-week Referral to Treatment standard, performing consistently above the 92% national target at Trust level.

Over the last year we have consistently delivered against the cancer two-week wait; 14-day referral for breast symptoms to assessment; 31-day subsequent for drug and radiotherapy cancer; and 62-day screening standards. While our 62-day referral to treatment performance has remained stable, we have been below the national standard for much of the year. 31-day diagnostic to treatment and 31-day second or subsequent surgery treatment have underperformed in 18/19. Performance has been impacted by insufficient capacity to meet demand, diagnostic wait times, complexity and patient choice. See page 18 for fuller information.



Our Partners



Our Potential

One of our biggest challenges remains achievement of the national emergency access standard. We did not admit, discharge or transfer 95% of patients from our ED within four-hours of their arrival (78.5% vs the 95% national standard). This is despite a relentless Trust-wide focus on flow, reducing discharge delays and the number of long stay patients; and significant service redesign in our ED from December 2018 onwards, as described on pages 17 and 18. A number of factors are having a detrimental impact on performance and include: higher than anticipated demand on our ED; high number of patients waiting in our ED for a hospital bed; and insufficient staffing to manage the heightened demand. Improving the timeliness of care and the overall experience of our urgent and emergency patients remains one of our top priorities in 19/20.

Despite achieving a much-improved financial outturn in the previous year, the Trust's position significantly deteriorated in 18/19. The Trust delivered a £43.5m deficit before Provider Sustainability Fund (PSF), £18.7m adverse to plan.

Due to this financial performance and the failure to meet the emergency access standard, the Trust only secured PSF funding of £3.4m against an available £32.7m, such that NUH reported an overall deficit (after PSF) at 31 March 2019 of £31.8m. This was worse than plan by £39.7m, given that the Trust had challenged itself to deliver a surplus of £7.9m, which had assumed that all of PSF funding would be received. 18/19 was year-three of our three-year plan to return the Trust to financial balance and deliver this small surplus to allow future investment in its facilities and ensure patient services remain financially sustainable.

A combination of factors contributed to this deterioration, including under-delivery against our £41m financial efficiency plan, loss of elective income and unplanned costs associated with keeping escalation beds open throughout the year to ease bed pressures, associated with higher than planned emergency admissions and increased costs above budget, and our pay costs being significantly higher than planned.

NUH delivered efficiencies of £40.3m in 18/19 against a savings plan of £41m, which means the Trust has now achieved savings of circa £40m or more for six consecutive years. Our financial challenge in 19/20 will be tougher still and will be a significant focus and priority for the Trust. More detailed information can be found on page 24 and 52 and in the Accounts on page 69 onwards.

Partners

We have continued to engage fully in the development of Nottinghamshire's Integrated Care System both at Board and workstream level. Our strategic partnership with Sherwood Forest Hospitals NHS Foundation Trust also continues to go from strength to strength with many shared pathways and posts in place across a number of specialties, including in Cancer Services, bringing significant benefits to patients across Nottinghamshire.

Work is underway – led by experts at our hospitals – to develop a world-class centre of excellence for rehabilitation in the East Midlands. In 2018, the Chancellor pledged £70m towards capital cost of National facility at the Defence and National Rehabilitation Centre (DNRC) at Stanford Hall Rehabilitation Estate, in Loughborough. The National centre will deliver rehabilitation programmes to patients who require rehabilitation after a period of illness or injury and have completed their acute hospital stay. The intention is that a new rehabilitation clinical model will deliver improved outcomes, and help more patients to get back to work and living as normal a life as possible, as quickly as possible, after their accidents. We look forward to working with our partners locally and nationally to transform the provision of rehabilitation for our patients in Nottingham and across the East Midlands in the years to come.

Potential

NUH remains a highly active research organisation with health research taking place in every clinical Division in partnership with local universities and the life sciences industry. In 18/19, we grew our research activity by 40% compared to the previous year and recruited over 14,200 patients in over 500 studies.

Biomedical Research Centres (BRC) are a measure of the quality and excellence of our research. Nottingham's BRC represents the very best of our translational research capabilities – bringing scientific developments from the research laboratory to benefit patients faster. In 18/19, we launched new trials that will offer important discoveries for people with Irritable Bowel Syndrome, severe asthma and depression. Read more about our progress in Research and Innovation on page 20.

Looking ahead

As we enter year two of our long-term strategy, we are very clear on our top priorities for 19/20, and these are:

1. **A STRENGTHENED FOCUS ON TEAM NUH – making NUH a great place to work**
   Investment in Team NUH (our people) – including development, leadership, our culture, how we reward, value and recognise our staff and how we act on concerns people raise.
2. **CAPACITY – right-sizing our hospitals (including beds, wards and theatres)**
   Seeking capital monies to allow us to create the capacity we need to meet the demand on our services, and to refurbish and renew our estate in the longer-term.
3. **VALUE FOR MONEY AND BEST USE OF RESOURCES – living within our means**
   Our current run rate of spend remains unaffordable. Many of the strengthened restrictions and financial discipline we put in place during 18/19 will remain in place moving forward, becoming 'how we do things' as we develop a long-term plan to get the Trust back into financial balance in the years to come.

For more information about our 19/20 priorities and year two of our strategy milestones, please refer to our 19/20 Annual Plan, which is available on our website.

There is so much to be proud of and to look forward to. I hope you enjoy reading about our achievements and to understanding more about our challenges and how we are addressing these in this Annual Report and I very much look forward to working with you in the coming year.

Tracy Taylor
Chief Executive

Over £3.5m
raised by NUH Charity to improve patient and staff experience

700k+
hits to our website

1.9m
meals served

107,192
emergency admissions **(4.2% increase)**

5.6m
impressions on Twitter
@nottmhospitals

1,559
volunteers

97.5%
of patients felt safe whilst in our care

5,592
compliments

683
complaints

222,567
requests for patient movements for our porters

18/19 year in numbers

241,737
theatre trays used

Overview of NUH

Our vision for the future of our hospitals is to become **"outstanding in health outcomes and patient and staff experience"**.

We're based in the heart of Nottingham, operating from three locations and provide services to over 2.5m residents of Nottingham and its surrounding communities.
We also provide specialist services for a further 4-5m people from across the region. We have 90 wards and around 1,700 beds. Our principle services are delivered from the following locations.

QMC

- Emergency Department
- East Midlands Major Trauma Centre
- Nottingham Children's Hospital
- University of Nottingham's School of Nursing and Medical School
- NHS Treatment Centre

Nottingham City Hospital

- Cancer Centre
- Heart Centre
- Stroke Services
- Cystic Fibrosis Centre
- Supports our urgent and emergency care pathway with a number of emergency admissions units – including the respiratory patient pathway

450
new Nurses and Midwives recruited to NUH

86 **lives saved by our Major Trauma Centre**

946,708
outpatient appointments
(4.8% increase)

Average 566
A&E attends to QMC a day (4.3%)

32,446
Elective and Daycase admissions

325
Nurses attended Acute Care Skills Foundation Course over 12 Cohorts

Over 90%
of patients audited treated for sepsis within 1 hour

Over 90%
of NUH patients screened for high-risk red sepsis

1.9k
new Facebook likes

We Listen We Care

Ropewalk House

- Outpatient services, including breast screening
- Our internationally-renowned hearing services

We have a national and international reputation for many of our specialist services, including Stroke, Renal, Neurosciences, Cancer and Trauma. We are also host the National Institute for Health Nottingham Biomedical Research Centre and Nottingham Clinical Research Facilities, which together are centres of excellence for clinical research, life sciences and technology industries at which Nottingham excels.

We play a vital role in the education and training of doctors, nurses and other healthcare professionals and as a teaching trust we have a strong relationship with our colleagues at the University of Nottingham and other universities across the East Midlands, including Nottingham Trent University and Loughborough University, where we are part of the Olympic Legacy project.

Our annual budget is just under £1billion.

We're one of the largest employers in the region, with over 16,000 staff based at QMC, Nottingham City Hospital and Ropewalk House and in a number of community facilities.

Performance against key strategic objectives

18/19 key strategic objectives

This is a summary of how we did against our main strategic objectives for 18/19.

Strategic objectives	Milestone	Achievement
Consistently high quality, safe care with outstanding outcomes and experience	Benchmark our current clinical outcomes and develop a programme of interventions to improve performance	**Achieved**
	Undertake a full review of our services against the CQC domains and implement any necessary improvements to maintain a 'Good' rating overall and improve our present score of 'Requires Improvement' to 'Good' in the safe domain	**Partially achieved:** Whilst we retained our 'Good' overall rating, our rating in the safe domain did not improve from 'Requires Improvement.' An action plan is in place to respond to the CQC feedback
	Identify services we consider 'Outstanding' and develop plans to achieve this rating at the CQC review in 20/21	**Achieved**
	Develop a programme to improve our patient experience metrics	**Achieved**
	Develop a single NUH Clinical Services Strategy to enable reconfiguration of services to provide a more flexible bed base across both hospitals	**Partially achieved:** The scope of our Clinical Services Strategy has significantly changed and now focuses on health outcomes and holistic patient-centred care for the population of Nottinghamshire. Phase one of the strategy was completed, however, phase two of the strategy will be completed by the end of Quarter Two in 19/20
Build on our position as an employer of choice with an engaged, developed and empowered team that puts patient care at the heart of everything it does	Improve our staff engagement through clear action plans to improve our position against other acute Trusts	**Achieved**
	Develop a robust workforce plan in line with the Clinical Services Strategy	**Achieved**
	Improve retention across the Trust and specifically for Healthcare Assistants	**Achieved**
	Development of a comprehensive career development strategy	**Achieved**
	Improve NUH's reputation as a place to work and our recruitment processes to reduce our number of vacancies	**Achieved**
	Improve accessibility of training for all staff	**Achieved**

Strategic objectives	Milestone	Achievement
Improving our estate and digitising our hospitals	Implement our Estates Strategy (March 2018) to improve building and infrastructure resilience and reduce critical infrastructure risk	**Partially achieved:** Whilst we delivered many improvements this year related to our Estates Strategy, we have not started construction on site for the City Hospital Energy project or completed the business case for the decant wards. Both delays are due to changing national requirements related to capital business cases
	Implement our plan for medical equipment replacement to support our patient objectives	**Partially achieved:** Limitations on funding this year has meant that some of our plans for medical equipment replacement have not progressed. We continue to prioritise these plans for 19/20
	Make progress towards becoming a Paperlight Hospital and implement plans for a network infrastructure refresh	**Achieved**
Consistently achieving performance standards	Improving performance in areas we are not meeting standards and further sustain our performance	**Not achieved:** We have been unable to achieve the constitutional standards in two key areas; emergency access (83.2%); adjusted 62-day cancer standard (82.8%)
	Develop and implement plans to improve patient flow by reducing unwarranted variation in service delivery	**Partially achieved:** Improvement work took place that resulted in the number of medically safe and long-stay patients in hospital being lower in 18/19 Quarter Four than the previous year. Despite these changes, the heightened demand on hospital services resulted in challenged performance against the emergency access standard
	Achieve our financial control total	**Not achieved**

Priority	Milestone	Achievement
Strong system leadership and innovative partnerships	Develop and implement a Partnership Strategy and stakeholder management plan	**Achieved**
	Refresh the Patient and Public Engagement Strategy and stakeholder engagement plan with a focus on how we will involve and listen to patients, families, carers and the local population	**Partially achieved:** The strategy has been developed and will be approved by Quarter Two of 19/20
	Build on existing partnership foundations and deliver the actions already agreed for these key partnerships	**Achieved**
	Develop and commence implementation of robust governance arrangements and a roadmap for the development of an Integrated Care System across Nottingham and Nottinghamshire	**Not achieved:** We are having continued discussions with ICS partners on how we will constructively work and interface with three ICPs moving forward
	Understand the future implications for NUH as part of an ICS	**Achieved**
	Develop a vision for acute services across Nottinghamshire through leadership of the ICS Clinical Services Strategy	**Achieved**
	Develop and implement a framework for clear decision-making for business development and potential new business opportunities	**Achieved**
	Identify potential NHS and non-NHS business development opportunities and develop a refreshed business development strategy	**Achieved**
World-class research and education	Develop an innovation plan including commercial opportunities	**Achieved**
	Agree consistent improvement and transformation methodology to be used across NUH	**Achieved**
	Develop and start implementation of a Trust-wide inter-professional education and training strategy Number of patients recruited to National Institute for Health Research (NIHR) studies > 14,000	**Achieved**

Quality priorities

Feedback from our patients, their families, carers, partners and staff from a range of sources – in addition to national standards and developments – informs our annual quality improvement priorities. This is how we did against the priorities we set ourselves in 18/19:

Quality Aim	Priority	Progress
Improve patient outcomes	Screen all in-hospital deaths	99% of all adult deaths screened
	Increase the number of completed Structured Judgement Care Reviews (SJCR)	Numbers increased from seven in Quarter One to 21 in Quarter Four
	Improve fluid balance monitoring to promote continence	Improvement goals identified to include procurement of an electronic fluid balance chart in Nervecentre
Reduce avoidable harm	Reduce the number of omitted and delayed medication doses	Omitted doses audit May 2018 established baseline Action plans in place with re-audit May 2019
	Timely observation of deteriorating patients	National Early Warning Score Two (NEWS2) implementation group established and plan developed
	Screen all patients for high risk sepsis and give antibiotics within one-hour of admission	90% of all patients screened with 90% receiving antibiotics within one-hour
	Reduce the time patients spend in the Emergency Department (ED)	**Not achieved:** work continues to improve responsiveness
Use patient feedback to improve experience	Involve patients and their relatives in discussions about their care	92% of all patients surveyed responded positively to this question
	Treat all patients with kindness and consideration	92% of all patients surveyed responded positively to this question
	Engage patients and families in discharge planning	89% of all patients surveyed responded positively to this question
	Ensure patients waiting in our ED have timely and responsive care	**Not achieved:** we have not met 95% national target

For full information, please see our 18/19 Quality Account, which is available on our website: **www.nuh.nhs.uk**

Our Long-Term Strategy

Our ambition is to become **"outstanding in health outcomes and patient and staff experience"**.

Our mission is: working together with our patients, staff and partners to deliver world class healthcare, research, education and training. A leading teaching hospital and an innovative partner, improving the health and wellbeing of the communities we serve.

To deliver this, we have committed to six Promises that will form the basis of our plans over the next 10 years:

1 **Patients**

2 **People**

3 **Places**

4 **Partners**

5 **Performance**

6 **Potential**

Underpinning each Promise, we have described key milestones for years one, two and three so that we can closely monitor our progress, which we publish quarterly. These have been developed through consultation with NUH staff, leaders and Board members. See pages 10-12 for how we did against Year One milestones. Our Year Two milestones are summarised on page seven and are available in full in our 19/20 Annual Plan.

Working with our patients, partners and staff, we have reviewed and refreshed our values, based on our principles of: We Listen. We Care. Launched in April 2019, these are as below.

CASE STUDY:

First children's nurse award for research in Nottingham

A nurse from our Nottingham's Children's Hospital at QMC has become the first children's nurse in the country to be awarded a prestigious Clinical Lectureship Award from the Department of Health and Social Care.

Joseph Manning, Charge Nurse in the Paediatric Critical Care Outreach Team at Nottingham Children's Hospital, is also the first registered nurse in the East Midlands to be awarded this accolade.

The Lectureship is a three-year award funded and administered by Health Education England (HEE) and the National Institute of Health Research (NIHR), and started in April 2019.

Dr Joseph Manning is also a Clinical Associate Professor in Children, Young People and Families at NUH, University of Nottingham, and Coventry University.

He said:

"I am extremely passionate about improving outcomes and lives for our young patients and their families. Our current understanding of the needs and how we support children and their families who have experienced critical illness is limited. This lectureship is a tremendous opportunity to develop the evidence base to inform and advance clinical care in this field, which I hope will have demonstrable impact on the long-term health and wellbeing of children and their families in Nottingham and across the NHS."

Operational performance

Operational performance at a glance

	17/18	18/19	Increase/ decrease	% change
Emergency attendances*	220,045	262,816	+42,771	+19.44%
Daycases	82,898	86,994	+4,096	+4.94%
Electives	21,790	20,966	-824	-3.78%
Non-electives	102,850	107,184	+4,334	+4.21%
Outpatients – first attendances	275,589	303,730	+28,141	+10.21%
Outpatient – follow-up attendances	627,708	649,870	+22,162	+3.53%
Outpatient – procedures	253,532	279,326	+25,794	+10.17%

*Emergency attendances includes attendances at Urgent Care Centre from 1 November 2017.

Operational performance summary

Quality measure (% unless shown)	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	NUH peer average 18/19	19/20 Target
Patients waiting < 62-days from urgent referral to treatment for all cancers	86.8	84.9	82.4	84.6	81.4	79.4	75.9	81	80.1	76.7	85
Patients waiting < 31-days from diagnosis to first treatment for all cancers	97	96.5	96.3	96.4	96.6	96.6	96.3	97	95.2	95.2	96
Patients waiting < 31-days for subsequent treatments for all cancers – surgery	95	94.9	94.5	96.5	96.7	94.7	94.3	95.5	87.8	91.7	94
Patients waiting < 31-days for subsequent treatments for all cancers – drug treatment (%)	99	99.7	99.4	99.8	99.5	99.6	99.1	99	99.2	99.4	98
Patients waiting < 31-days for subsequent treatments for all cancers – radiotherapy (%)	89.5	97.4	99.3	99	99.3	98.9	98.8	98.3	98.5	97.8	94

Quality measure (% unless shown)	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	NUH peer average 18/19	19/20 Target
Patients waiting < 2-months from referral to treatment for all cancers – referrals from national screening programmes	91	91.5	94.2	99	92.2	94.4	91.7	92	93.5	86.9	90
Patients waiting < 2-weeks from urgent GP referral to date first seen for all urgent suspected cancer referrals	94	94.8	93.6	94.7	90.7	91.9	93.8	95.5	95.4	92.2	93
Patients waiting < 2-weeks from urgent GP referral to date first seen for urgent suspected breast cancer referrals	95.6	94.6	93.2	93.9	91.3	90.8	93.9	97.4	98	84	93
Patients waiting < 18-weeks from referral to admitted treatment	94.4	90.5	95.6	96.6	98.2	97.5	95.9	92.2	93.3	87.5	92
Patients waiting longer than four-hours from arrival in ED to admission, transfer, discharge	97	93.9	93.9	93.3	86.3	86.8	76.6	79.9	78.5	83.8	95 (new clinical standards are being piloted from May 2019 – see page 17)
Breaches of the 28-day readmission guarantee as % of cancelled operations	7.92	10.15	13.31	3.2	1.9	3	2	3.8	3.5	9.3	4.6%
Midnight bed occupancy	86	83.4	85.1	84.6	88.7	83.4	85.8	87.9	87	88.8	87.3%

Operational performance overview

Urgent and emergency patient care

There has been a Trust-wide focus and determination to improve the experience of our emergency patients and flow in and through our Emergency Department (ED) and out of our hospitals. We have reduced discharge delays and the number of long stay patients and completed service redesign in our ED from December 2018 onwards.

Despite all of this hard work, we admitted, discharged or transferred just 78.5% of patients from our ED within four-hours of their arrival against the 95% national standard. A number of factors are having a detrimental impact on performance and include: higher than anticipated attendance demand to our ED (4.3% increase in QMC ED attends and 4.2% overall increase in emergency admissions compared to 17/18); high number of patients waiting in our ED for a hospital bed; and insufficient staffing to manage the heightened demand and deal with high number of patients waiting for a hospital bed. Performance and improvement plans for urgent and emergency care continue to be overseen by the A&E Delivery Board, chaired by NUH's Chief Executive, and attended by leaders from across health and social care in Nottingham. Improving performance against the emergency access standard remains one of our top priorities as we head into 19/20.

Winter preparedness

The system's strengthened winter plan, learning from 17/18, included:

- Extra 113 extra acute beds (NUH) at cost pressure – one more ward than previous winter
- Investment in community-based care, including 20 more enhanced care beds (care home)
- 35 community-run beds at St Francis at City Hospital for patients who no longer need acute care (£1.9m national funding for capital)
- QMC front door – redesigning emergency and urgent care pathways and modernising and expanding A-Floor (£4.5m national funding for capital works). 30 cubicles in majors (from 20)
- Expanding NUH's nationally-renowned Surgical Triage Unit model to wider specialties
- Focus on reducing long-stay patients (length of stay > 20 days)
- Flu campaign and infection prevention (80% frontline staff vaccinated for flu – a record year)
- Focus on staff health and wellbeing
- Joined-up, system and NHS-wide public-facing communications campaign encouraging appropriate use of services

National pilot for new urgent and emergency clinical standards

NUH has been chosen as one of 14 pilot sites to trial the new urgent and emergency care clinical standards which aim to better support frontline staff to deliver the highest quality care for patients, take into account advances in clinical practice and what patients say matter most to them.

The new standards, which will be field-tested from May 2019, include:

1. Time to initial clinical assessment in EDs and Urgent Treatment Centres: timely clinical assessment to identify those in need of immediate treatment and direct patients to those best able to meet their needs at the earliest opportunity
2. Treatment within the first hour for critically-ill and injured patients: rapid treatment for conditions such as stroke, heart attack and suspected sepsis and emergency for patients who may have mental health issues.
3. Average (total) waiting time in ED for all patients will be measured
4. Increased utilisation of same day emergency care: to avoid unnecessary overnight admissions and improve flow

This national pilot of the new clinical standards will complement the extensive transformation work that is already underway at NUH to improve the timeliness of care and the overall experience of our urgent and emergency patients. We look forward to sharing our insight and experience with NHS England and influencing the national changes to the urgent and emergency performance standards in the months to come. The first phase of NUH's Trust-wide transformation programme, which started in 2018, included:

Front Door redesign

- Expanding QMC front door – redesigning emergency and urgent care pathways and modernising and expanding A-Floor
- New Urgent Treatment Centre

Streamlining patient pathways

- Expanding NUH's nationally-renowned Surgical Triage Unit model to Head and Neck and Neuro surgery and Spines
- Streamlining pathways directly from the urgent care front door to improve the timeliness of care
- New medical admissions pathway
- New End of Life and Mental Health pathways

Capacity at NUH

- Excellence in discharge and criteria-led discharge
- Reduce long-stay patients
- Increasing number of patient discharges at the weekend

Culture and leadership

- Reviewing workforce requirements for newly-configured urgent and emergency care pathways
- Quality improvement training
- Skills training where required
- Roles and responsibility clarification
- Accountability
- Embedding new ways of working

The second phase of NUH's Trust-wide emergency pathway transformation programme, which commenced April 2019 will focus on: (1) front door and admissions units, (2) internal flow and (3) external flow (discharge).

Cancer care

Our cancer services are amongst the largest in the UK and we receive in excess of 1,600 two-week wait referrals per month. In 18/19, we have consistently delivered against the cancer two-week wait; 14-day referral for breast symptoms to assessment; 31-day subsequent for drug and radiotherapy cancer; and 62-day screening standards. Our 62-day referral to treatment performance has remained stable throughout the year and although we have remained below the national standard for much of 18/19, our adjusted performance is better than the England average. 31-day diagnostic to treatment and 31-day second or subsequent surgery treatment have underperformed in 18/19. Performance has been impacted by insufficient capacity to meet demand, diagnostic wait times, complexity and patient choice. Through dedicated and focused work of staff across our tumour sites, we have plans in place and hope to recover performance against the cancer constitutional standards in 19/20.

Referral to Treatment (RTT)

We remain one of the highest performing Trusts in the country for 18-week RTT performance, consistently remaining above the 92% national target. Pressures from cancellations in winter 17/18 continue to impact on performance with much of the headroom in the standard now diminished. Unprecedented demand for emergency care continues to impact on routine elective activity with capacity managed on a day-by-day basis. We continue to have specialty pressure points and patients waiting longer than we would wish and we proactively manage our waiting lists and work at a service-level to ensure effective management of patients waiting for elective care. With the exception for those patients waiting by choice, by the end of 18/19 we have eliminated all other 52-week wait patients.

Patients waiting below 18-weeks for planned operations (%)	
11/12	95.6
12/13	95.6
13/14	96.6
14/15	98.2
15/16	97.5
16/17	96.1
17/18	92.9
18/19	93.2

CASE STUDY:

Improving patients' discharge

Our Integrated Discharge Team is a multi-professional team of clinicians, social care workers and administrative staff who work across all the adult wards at NUH, providing assessment and support to discharge patients from the hospital out to the community.

The team works within a Discharge to Assess (D2A) model, emphasising the principle of 'Home First', returning patients to their own home for their ongoing recovery and rehabilitation. Where this is not possible, the team liaise with the community hubs to access rehabilitation beds to support patients until they can return home.

The team use Nervecentre to triage, allocate and case manage their workload and use this to aid communication with the ward teams. This has allowed the team to become paperless and has created significant efficiencies in processes.

The team facilitate 270 supported complex discharges a week on average, and receive approximately 30-newly supported patient cases daily.

Achievements this year include the development of a system-wide Shared Governance group working together to improve the patient experience, the development of a patient information leaflet, and the launch of a team newsletter.

CASE STUDY:

Front door service provides better care for elderly patients

Our Healthcare of Older Persons (HCOP) service has joined with our Emergency Department (ED) to provide a 'front door' frailty service to reduce the number of unnecessary ED admissions of elderly patients, and provide an improved patient experience.

Patients can be seen and assessed by HCOP specialists as they present at our ED, enabling more patients to be discharged back into community care rather than be admitted to hospital unnecessarily. This prevents potential deconditioning and overcrowding of older patients, who would benefit from specialist community provision.

The service is available Monday to Friday during set hours, however a business case has been recently accepted to extend the provision of the service, with an opportunity to recruit a further eight clinicians to support the front door service.

Non-operational performance

Research and Innovation

Access to innovative treatments and research opportunities drive high-quality care for our patients and are highly-rated by participating staff and patients alike. NUH is a highly active research organisation with health research taking place in every clinical Division in partnership with our universities and the life sciences industry. In 18/19, we grew our research activity by 40% compared to the previous year and recruited over 14,200 patients (versus our > 14,000 target) in over 500 studies.

Commercial research performance has improved significantly, generated by our centres of research excellence including the Nottingham Biomedical Research Centre (BRC) and Clinical Research Facility.

NIHR Nottingham Biomedical Research Centre (BRC)

The Nottingham BRC represents the very best of our translational research capabilities – bringing scientific developments from the research laboratory to benefit patients faster.

In 18/19, we launched new trials that will offer important discoveries for people with Irritable Bowel Syndrome, severe asthma and depression.

We held our first Symposium, passing the learning from our research on to clinicians, students and scientists working in the NHS in Nottingham. Through our Innovation Fund we have invested over £200,000 over the last two years. This investment is pump-priming BRC-led research which capitalises on the skills and knowledge of both our post graduate and established researchers to undertake studies which will unlock the potential of future research in some of the most common diseases.

We are partnering with the NIHR Leicester BRC which hosts Cardio-vascular and Diabetes research themes to grow our capability and capacity in research addressing these two key challenges for the Nottinghamshire population.

NIHR Nottingham Clinical Research Facilities (CRF)

In June 2019, the work of the Nottingham CRF will be showcased as part of the national UK Clinical Research Facilities Network Conference, which we are hosting.

In its first year, the Nottingham CRF hosted 16 Phase One and 86 Phase Two clinical studies. By the end of 18/19, this number had risen to over 400 studies. One example of the benefits of the Nottingham CRF in managing complex and high risk studies is a trial of experimental drug, polatuzumab vedotin in combination with other drugs. The study is devised to discover the effects of polatuzumab vedotin in patients with follicular lymphoma or diffuse large B-cell lymphoma that has returned, or has not responded to treatment. The effects and potentials related to the pharmacokinetics and pharmacodynamics of these drugs in humans are currently under investigation.

Professor Steve Ryder, Clinical Director for Research and Innovation at NUH, said:

"Nottingham is benefitting from the development of world-leading centres of excellence, building on Nottingham's reputation as a centre for technology, science and clinical research. In the last year we have established the Nottingham Biomedical Research Centre and the Nottingham Clinical Research Facilities which are both funded by the NIHR and which are attracting world class research to Nottingham. Our expertise, knowledge and team working across clinical, scientific and technology research means that we are leading the way in so many areas, with the result that more and more patients are able to take part in new and exciting research here."

Angela Yates is one of those patients who is taking part in new research looking at Parkinson's Disease using Magnetic Resonance Imaging (MRI), one of the areas of research where Nottingham leads the world. She said:

"Anything that helps future medical research is so useful and so valuable, not just to patients themselves, but to their carers and their relatives."

Jennifer Deakin is a participant in research trials for osteoarthritis and says the opportunity to take part is one that everyone should consider:

"I think it's a form of giving back and it's important that we should be involved - you're doing a good thing to help, so I would encourage everybody to just try it."

Priorities for 19/20

Our research priorities were first developed in 16/17 as part of a five-year plan to enable NUH to become a national leader in clinical research and innovation. The Research for All strategy is now firmly embedded in the NUH long-term strategy as part of the "Potential" strategic objective. Embedding research at the heart of NUH supports both national and local strategic objectives, and ensures that research becomes an integral part of patient care.

The latest review of this strategy (in January 2019) introduced four additional strategic aims for development in 19/20:

1. Aligning research to the needs of the wider health system
2. Launching the Nottingham Health Science Partners as a vehicle for greater join working and alignment with our local partners in research
3. Evaluating the impact that new technology can have in driving quality and outcomes for patients. This year we will launch the Connected Ward, a live hospital ward where the impact of new technology can be tested and developed

4 Innovation Factor – encouraging more of our colleagues to develop their ideas so that they can be translated into clinical practice

Through the Cancer and Associated Specialties Division working with our academic partners ,we will develop a new Nottingham-wide cancer research strategy with the aim to bid for Experimental Cancer Medicine Centre status in 2021.

In 19/20, the Research and Innovation Plan aims to increase patient recruitment to 18,000 and achieve £26m of research income.

CASE STUDY:

Italian connection transforms Inflammatory bowel disease

International collaborations by the NIHR Nottingham BRC could transform the diagnosis and treatment of Inflammatory Bowel Disease (IBD) for patients in the UK.

Giovanni Maconi, Associate Professor of Gastroenterology, and Mirella Fraquelli, Professor of Gastroenterology, both from the University of Milan, were among leading researchers presenting the latest developments in clinical research during 2018. Their work on IBD could help the estimated 300,000 people in the UK who suffer from conditions such as ulcerative colitis and Crohn's Disease.

The first-ever Symposium organised by the Nottingham BRC, was one of two events held to mark a year of the BRC's ground-breaking work into translating scientific breakthroughs into new treatments for conditions such as asthma, arthritis and IBD. As part of spreading the new developments that Nottingham is pioneering, the Symposium provided the opportunity for researchers, clinicians and patients to learn directly from clinicians and scientists at the cutting-edge of healthcare. Associate Professor Maconi and Professor Fraquelli are internationally-recognised experts in Gastro-intestinal ultrasound, a non-invasive and accurate method to screen the presence of disease affecting the small bowel and the colon. This treatment has many advantages for patients and clinicians including detecting the localisation (small bowel or colon) and complications of disease, monitoring disease activity and detecting any recurrence of disease after surgery.

CASE STUDY:

Outstanding research in lung disease recognised

Gisli Jenkins, Consultant in Respiratory Medicine at NUH and Professor of Experimental Medicine at the University of Nottingham, was awarded a prestigious NIHR Research Professorship in 2018. NIHR Research Professors are some of the country's most outstanding research leaders.

The five-year, £1.7m award recognises Professor Jenkin's pioneering work in Idiopathic Pulmonary Fibrosis (IPF), a progressive lung disease with a worse outcome than most cancers. Professor Jenkins is leading Pulminorary Fibrosis research as part of the NHIR Nottingham BRC.

The NIHR award will allow him to extend his research by analysing genetic, biological and phenotypic data to identify biomarkers of pulmonary fibrosis. He said:

"I am so excited about receiving this award because it will enable a step change in translating my group's understanding of disease biology into better therapeutic strategies for patients with pulmonary fibrosis."

Pulmonary Fibrosis is a process that leads to progressive scarring in the lungs and ultimately death. Pulmonary Fibrosis affects over 50,000 people in the UK but early, subclinical disease is likely to affect many, many more.

Professor Jenkins added:

"This award will allow time and resource for my group to develop our understanding of molecular and cell-specific pathways to identify markers of disease activity. These can be used to personalise therapy for patients who are likely to benefit from treatment regardless of why or when they get Fibrosis. In short, it will enable us to treat the right patient, with the right drug at the right time."

CASE STUDY:

Over 4,000 patients benefit from Nottingham discovery

An innovative Nottingham research project to improve diagnosis of liver disease won national acclaim in 18/19 and benefitted over 4,500 patients.

The 'Scarred Liver Pathway' was developed by clinicians and academics in Nottingham, supported by the Research and Innovation team at NUH and the Nottingham BRC. In 2018, it was recognised nationally for its work in adopting new technology and streamlining clinical pathways to improve patient outcomes.

The team behind this project won the 2019 HSJ Values Award, in the translational research in action category.

Liver disease is the third largest cause of premature death in the UK, with an average mortality age of 59. The Scarred Liver Project combines identification of patients at risk due to lifestyle with a mobile scanner diagnostic test - Fibroscan®. The mobile scanner provides a more accurate indication of scarring than a Liver Function Test (LFT) and is painless and non-invasive - removing the need for a biopsy. Results are immediate, allowing clinicians to agree treatment with the patient during the same appointment.

This innovative approach has proven to more effectively detect chronic liver disease at an early stage when it can be halted or reversed. The project has seen:

- 338 patients referred for a scan per month (July 2018) compared to 58 per month (July 2016)
- A total of 4,612 referrals over the two-year period
- Patients making significant lifestyle changes after visiting the day clinic for fibroscanning, thereby reducing their risk of developing liver disease

Working in partnership with GPs, NHS Commissioners and the East midlands Academic Health Science Network, the new technology is now available to patients across Nottingham and Leicester. Other parts of the East Midlands are planning to commission a similar approach.

Dr Neil Guha, Clinical Associate Professor in Hepatology and who works as part of the team leading new research into liver disease at the Nottingham BRC, said:

"Our pathway is the first commissioned in the UK that enables the severity of liver disease to be directly assessed by GPs. Based on risk factors and integrated across primary and secondary care, it represents a fundamental shift in how we tackle the rising trend of premature mortality from chronic liver disease. The adoption of the pathway by several East Midlands Clinical Commissioning Groups is thanks to successful collaboration between key clinicians and academics to produce robust evidence to share with commissioners."

Dr Hugh Porter, GP and Clinical Chair at Nottingham City Clinical Commissioning Group, said:

"The benefits to patients are clear. Fibroscanning is a more accurate indicator of liver disease, removes the need for painful biopsy and can detect problems earlier so people can make lifestyle changes to reduce their risk or reverse liver damage. Detecting liver disease earlier also saves money and protects NHS resources by reducing emergency admissions and the need for specialist care."

Environmental performance

Commitment to Sustainable Development

In November 2018, the Trust Board approved the NUH Sustainable Development Strategy 2018-2023. The Strategy sets a number of goals in the areas of Carbon Mitigation and Adaptation, Water, Waste and Sustainable Travel.

Carbon and energy

18/19 was a successful year for the Trust's climate action agenda. The Trust achieved a reduction of 7.6% of its carbon footprint compared with the previous year. This was in part by continuing with the Trust's decision to switch from coal to gas as the main way to heat City Hospital. Another significant reason is that 18/19 was a warmer year compared with 17/18. However, another major contribution was the ongoing decarbonisation of the electrical grid in UK. NUH continued working on the business case to replace the heating infrastructure at Nottingham City Hospital with a sustainable solution. This will see NUH completely moving away from coal, and producing on-site electricity in 2021. The project specifies that at least 5% of energy produced on site comes from renewable sources which will be delivered via photovoltaic panels, air source heat pumps and biogas.

Sustainable food

The sustainable food programme continues delivering meals to patients, visitors and staff in the Trust from sustainable sources. The service has maintained its ethos prioritising the sourcing of most of its food ingredients from local sources, contributing to keep a low "carbon mileage" in the meals we serve, helping increase the resilience and sustainability of the NUH activities, and supporting the local economy.

Sustainable commuting

The NUH sustainable commute agenda was also very busy during 18/19. In November 2018, the Trust Board approved our Travel Plan which aims to improve access to our sites and services more sustainably, and discourage single occupancy vehicle commute.

In the area of public transport, NUH continues to promote its Travel to Work scheme, which aims to make access to NUH via public transport more attractive for staff. In 18/19, membership to the scheme grew by circa 15%, with 1,300 staff now using the scheme to commute by bus to NUH. NUH maintained its support to the Medilink Bus service which displaces circa 700 tCO2 from road emissions from patients, visitors and staff commuting between sites. NUH also promotes actively the use of park and ride sites linked to the Medilink bus service to reduce vehicles circulating within the city, and keeps supporting its car sharing platform to help staff find a car sharing partner.

Out latest staff Travel Survey suggests the number of staff commuting alone in private motor vehicles reduced by 2% compared to 2016.

In the area of active travel, NUH also continues promoting active travel via a number of initiatives including Dr Bike, Cycle to Work scheme, bike maintenance classes and roadshows aiming to promote health, wellbeing and active travel. The Cycle2Work scheme continues being a successful scheme which helps promote sustainable travel choice but also provides many health and wellbeing benefits. During 18/19, 170 staff applied to the scheme. Additional support to staff who cycle has been provided by the Dr Bike Sessions. These educational sessions provide staff with the skills in bike maintenance therefore increasing their safety awareness whilst travelling by bike. 330 staff subscribed to this initiative.

Air quality

Since August 2017, NUH has made its gas boiler house the leading heating infrastructure, making its coal-fired boiler house the backup heating infrastructure. This has reduced the emission of particulates and has reduced the Trust's carbon footprint by circa 8,000 tCO2. This has a positive impact on the local air quality. The Trust also continues engaging with its contractors to ensure its energy facility at QMC operates as efficiently as possible.

Social agenda

The Trust continues working in partnership with Nottingham City Council in a common vision of health via the County Council's Health and Wellbeing Board. The ethos of this vision is the "Happier Healthier Lives: Nottingham City Joint Health and Wellbeing Strategic Framework 2016–2020". This strategy aims to increase Healthy Life Expectancy and close the gap between the most affluent and poorest areas of the city.

Waste and finite resources consumption

The Trust continues to prioritise its waste and water agendas. In line with Department of Health and Social Care guidance, during 18/19, NUH increased the segregation of "offensive waste", by reducing the amount of waste classed as clinical. NUH continues working to reduce the impact of its waste to the environment. By recycling an ever increasing proportion of its waste, NUH contributes to minimise the impact to the environment.

See Appendix One for the full 18/19 Sustainability Report.

Emergency Planning

Following our self-assessment of annual compliance against the Emergency Preparedness, Resilience and Response (EPRR) standards we declared ourselves "substantially compliant". Our self-assessment submission underwent a "confirm and challenge" exercise carried out by the EPRR Lead for Nottinghamshire Clinical Commissioning Group and the Head of EPRR, NHS England North Midlands and the who confirmed the award based upon the supporting evidence of compliance. This status award is a positive indicator of the quality of our emergency plans including our Major Incident plans and arrangements.

In conclusion, the EPRR Lead for Nottinghamshire Clinical Commissioning Group concluded:

"We would like to thank your team for their time at the Confirm and Challenge session which demonstrated a Trust wide commitment to EPRR and as a result, to meeting the core standards".

During the year the Trust has responded effectively to a wide range of incidents ranging from significant Network outages to a potential 'no deal' EU-Exit. NUH has also continued to participate in a wide range of internal and external exercises designed to test our plans and arrangements. See below for further information.

Lessons learned from these incidents and exercises any are used to inform and improve our response plans, policies, procedures and training programmes.

As a result, the Trust's Critical and Major Incident Plan has undergone a further significant review in year in order to account for expanding national guidance and learning from internal and external incidents and external exercises. An internal exercise is being planned to test and train in the revised arrangements.

Brexit

The Trust continues to prepare for the EU exit and has plans in place to minimise disruption in the event of a 'no deal' Brexit.

We are holding regular EU Exit meetings, chaired by the Trust's Director of Corporate Governance and attended by key colleagues, including Pharmacy, HR and Workforce, Medical Equipment, Research and Innovation, Finance and Procurement and Communications. This group is working together to ensure we are as prepared as we can be, as events unfold, with a focus on making sure that our patients remain safe and unaffected by any changes and that our staff feel valued and well-informed midst the uncertainty that we face.

The Department of Health and Social Care (DHSC) is leading national NHS preparations for a 'no deal' Brexit, focussing on the following:

- Supply of medicines and vaccines
- Supply of medical devices and clinical consumables
- Supply of non-clinical consumables, goods and services
- Workforce
- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access
- Blood and Blood Products

A Trust Risk Assessment and specific Business Continuity Plan has been created and is under constant review. NUH continues to fully participate in all external meetings on the subject; working closely with system partners.

Summary of financial performance

Having achieved improving financial results in each of the previous two years, the Trust had set a plan for 18/19 aiming to bring the Trust back to financial surplus. Our target, agreed with our regulator, NHS improvement, was set at £7.9m surplus for 18/19. However, during the year the financial position worsened and the Trust's final results were that we delivered an overall deficit of £31.8m. The deficit was driven by a miss of its financial position prior to provider sustainability funding of £18.6 million and a consequent loss of Provider Sustainability Funds of £21m.

Financial performance (Pre-PSF)

Year	Plan surplus/ (deficit) £m	Plan surplus/ (deficit) £m
15/16	(47.2)	(47.2)
16/17	(46.2)	(45.7)
17/18	(34.0)	(30.8)
18/19	(24.9)	(43.5)

Financial performance (Post-PSF)

Year	Plan surplus/ (deficit) £m	Plan surplus/ (deficit) £m
15/16	(47.2)	(47.2)
16/17	(22.0)	(20.1)
17/18	(10.7)	(10.7)
18/19	7.9	(31.8)

A combination of factors contributed to this deterioration and included under-delivery against our financial efficiency plan, loss of elective income and unplanned costs associated with keeping escalation beds open throughout the year to ease bed pressures, associated with higher than planned non-elective admissions.

NUH under-performed against its elective income plan with the key reason being displacement of elective activity (due to non-elective demand pressures) and capacity constraints associated with theatres availability and staffing shortages. The drive to deliver the displaced elective activity and recover performance against operational standards meant that activity was delivered at higher cost, resulting in a lower financial contribution.

NUH delivered efficiencies of £40.3m in 18/19 (3.9% of income) against a Cost Improvement Plan (CIP) of £41m. The Trust has now achieved savings of circa £40m or more for the last six consecutive years. The shortfall of £0.7m was largely due to theatre and bed utilisation productivity schemes. Financial recovery interventions were put in place in the final quarter which included the strengthening of CIP delivery structures, more robust expenditure controls and income improvement schemes. A range of actions were undertaken to improve the income position, including improved activity capture and income billing and making use of income generating opportunities for example, pharmacy manufacturing, catering services and research and development.

With the exception of its annual break-even financial duty, the Trust also achieved its other statutory financial duties, including maintaining capital spending, cash and borrowing within the limits set by the DHSC. As was the case in the previous year, the Trust invested more than £44m in its capital infrastructure in 18/19, to meet growth in demand, improve quality standards, drive it towards achieving performance targets and ensure patients were treated in the best possible clinical environment.

The Trust operates within the NHS finance regime, which enables all providers to access deficit support through revenue support loans. Like most NHS providers, NUH does not internally generate sufficient cash and requires additional cash support to consistently meet its financial obligations and pay its staff and suppliers. The outstanding revenue and capital loan balances at 31 March 2019 were £88.9m and £10.5m respectively. New revenue loans of £21.3m were drawn in 18/19, which was driven by the Trust's financial deficit.

NUH continues its journey to advance the use of costing data and reporting across its service lines. This is used to generate financial reports that are actively used to manage speciality and divisional financial performance. Costing data is also used to drive more efficient practices across services. NUH levers its costing expertise to identify costs of cross organisational clinical pathways.

NUH built on the work in previous years by achieving a sustained reduction in premium agency spend which is maintained below the agency ceiling set by NHS Improvement. Initiatives that have contributed to this improvement include; improved retention of registered nurses, stricter controls on agency spend, use of alternative roles, local recruitment of junior doctors, effective management of sickness absences and more recently the harmonising of pay and reward benefits within the Estates Department. There has also been a positive and sustained swing away from agency to bank staff, when using temporary staffing solutions. A continued focus is however required to address the overall high non-substantive costs and reduce the pay bill.

The Trust remains committed to using its resources productively to maximise patient benefit. The CQC reported in February 2019 that the Trust has made productivity improvements within its workforce and clinical services. In particular, we have improved the utilisation of bed capacity by reducing the time patients spend in hospital waiting for procedures and out of hospital care (delayed transfers of care). Transformation work undertaken to improve utilisation of outpatient capacity has also delivered a significant reduction in the level of missed clinic appointments. However, they concluded that use of resources at NUH does 'Require Improvement', as we spend more than our peers on staff resources to deliver activity and there are several areas of improvement required in clinical support services. Readmissions also remain high and further work is required to understand and address all the relevant drivers. These findings together with the use of benchmarking tools like the Model Hospital and the Getting it Right First Time (GIRFT) approach, combined with strengthening the financial control environment (in particular in relation to appointing staff), are being used to drive the efficiency programme and generate ideas to support the level of transformation required to secure a financially sustainable position

Despite missing our control total in 18/19, we remain committed to achieving sustainable financial recovery and returning to recurrent financial balance as soon as we can. This can only be achieved by working with our partners across the integrated health and care system to make the best use of the collective resources we have at our disposal. The Trust has developed a detailed plan for 19/20 that has been built with the full engagement of our clinical leadership and is aligned to the key strategic objectives of improving our performance in the key domains of emergency care pathway and financial performance. There are risks associated with delivering an efficiency programme of £37m that will be required to meet the control total and growing our capacity to deliver the level of activity set out in system activity plans, which will require significant capital investment. However, progress had been made in developing the detail of the annual plan, particularly around understanding the capacity constraints facing the Trust and also in negotiating contracts with key commissioners. The Board agreed that, on the balance of risk, to sign off the plan and accept the pre PSF control deficit total of £27m, which if achieved would allow the Trust to access to £27m of PSF funds to secure an overall break-even position in 19/20.

Patient experience

4Cs (Compliments, Complaints, Concerns and Comments)

18/19 is the eighth year that NUH has been using the 4Cs (complaints, concerns, compliments and comments) approach to capture feedback from patients, carers and families. Patient Experience Quarterly Reports on complaint themes and examples of learning are received by our Quality Assurance Committee. The charts below describe the number of complaints received, the number of contacts from the Parliamentary Health Service Ombudsman (PHSO), the number of compliments and the five most common complaint themes for each year 15/16 to 18/19.

Number of local complaints and PHSO referrals

	15/16	16/17	17/18	18/19
Complaints	598	656	637	683
Complaints upheld	136 fully	122 fully	87 fully	104 fully
	231 partially	177 partially	129 partially	199 partially
PHSO contacts	85	76	75	70
Investigations taken up by the PHSO	30	16	15	6
Upheld PHSO referrals (in-year)	4 fully/ 6 partially	0 fully/ 12 partially	0 fully/ 3 partially	0 fully/ 5 partially

Most frequent complaint themes

15/16	16/17	17/18	18/19
Standards of care (treatment)	Standards of care (treatment)	Standards of care (treatment)	Standards of care (diagnosis)
Standards of care (diagnosis)	Standards of care (diagnosis)	Standards of care (assessment)	Standards of care (treatment)
Complications during/ after surgery	Complications during/ after surgery	Standards of care (diagnosis)	Verbal communication
Verbal communication	Lack of communications regarding discharge	Complications during/ after surgery	Complications during/ after surgery
Lack of communications regarding discharge	Standards of care (assessment)	Verbal communication	Lack of communication regarding discharge

Compliments

15/16	16/17	17/18	18/19
5,335	5,892	6,415	5,592

Re-opened complaints

Reopened complaints are reported monthly in the Integrated Performance Report. Divisions are informed of all reopened complaints on a monthly basis so they can review these and identify whether the complaint could have been handled differently in order to resolve this at the first response.

Quarter One – 18/19			Quarter Two – 18/19		
Re-opened	Total complaints	% resolved at first response	Re-opened	Total complaints	% resolved at first response
28	169	83%	21	178	88%
Quarter Three – 18/19			**Quarter Four – 18/19**		
Re-opened	Total complaints	% resolved at first response	Re-opened	Total complaints	% resolved at first response
25	158	84%	27	178	84%

Examples of learning from complaints taken from most frequent complaint themes

Reason for complaint	Quality objective	Action taken
Standards of care – diagnosis	Improve early diagnosis and communication of this to patients and their families	A review of the Histopathology Service was undertaken to improve turnaround times and as a result, an additional Head and Neck pathologist has been recruited. The complaint was tabled at the specialty governance forum and learning has been shared with all clinicians involved.
Standards of care – treatment	Improve treatment for patients and promote best practice	A shared learning document has been produced to remind medical and nursing staff of the importance of a senior review prior to patient transfer. The importance of prompt and clear escalation and improved communication has been discussed with staff concerned; this is also a focus of the learning document.
Verbal communication	Ensure robust communication between ward staff, family, carers and also between departments regarding the discharge of patients	Training in communication techniques with an emphasis on giving medications to patients with cognitive impairment. Specialty to implement a dementia admission pack that includes 'About Me' and appropriate pain assessment tool and other information relevant to the patient to further improve standards of communication and information. A pain link nurse role is to be developed with a special focus on patients with cognitive impairment.
Complications during/ after surgery	Improve care provided during/after surgery and promote best practice	Patient experience shared with all staff directly involved in the patients care for reflection. Trust guidelines on Management and Care for a Nephrostomy reviewed. The case and importance of correct nephrostomy care was discussed at the ward focus board.
Lack of communications regarding discharge	Ensure robust communication between ward staff, family, carers and also between departments regarding the discharge of patients	Specialty to implement an appointment system for relatives to meet personally with a Discharge Co-ordinator. Complaint highlighted at the specialty governance forum. Discussion held with the ward team to reflect on the complaint and how best to deliver the best care and improve communication regarding discharge.

Improving complaint handling:

In 18/19:

- NUH has continued to participate in the Peer Review process on a bi-monthly basis, reviewing the complaint process in a minimum of 25 redacted complaint files. This year we reviewed 27 complaint files
- NUH has undertaken an annual external Peer Review process 'buddying up' with the Nottingham NHS Treatment Centre. Representatives from both organisations reviewed redacted complaint files from the other's organisation
- The Complaints and PALS Team have become paper-light
- Patient stories, taken from complaints which have demonstrated learning within the organisation, are presented monthly at Trust Board
- The Complaints and PALS and Patient Safety teams meet weekly to identify any joint cases and trends from incidents, complaints and claims at the earliest opportunity
- An Effective Complaints Handling presentation for senior nurses has been developed and will be rolled-out Trust-wide in 19/20

Patient Surveys

NUH participated in two national patient surveys during 18/19 – Inpatient and Maternity.

Inpatient survey

The Trust is awaiting the publication of the national results of this survey by the CQC, which are expected Summer 2019.

Maternity survey

Women were asked a range of questions about the care they received before, during and after birth. NUH has improved on five of the questions asked, since the last survey (2017).

These included how NUH scored well for the way staff:

- Developed confidence and trust through the care they gave
- Gave women access to a midwife on a regular basis
- Made women feel listened to
- Made women feel that they had confidence and trust in the midwives they saw, after they went home

NUH has Maternity units at both QMC and Nottingham City Hospital and is one of the busiest services in the country, with just under 10,000 births over the last year. The Trust scored amongst the best in the country in three key areas, including offering choices about where a woman could have her baby (hospital, home or midwifery-led unit), making partners or other supporting family and friends feel as involved in the labour and birth as they wanted to be, and taking any concerns seriously.

Sharon Dickinson, Director of Midwifery at NUH, said:

"We're delighted that our patients feel listened to, and feel confident in our care. Our Maternity teams work extremely hard to give ladies and their families the best possible patient experience, which is demonstrated in these results. We are constantly looking for new ways to make improvements to our service by listening to and acting on feedback.

"Over the last year, improvements include introducing an intercom service at City Hospital to promote confidentiality and dignity for women in labour and introduced new elective caesarian section pathways to improve experience. We have also recruited three Professional Midwife Advocates, who offer tailored advice, support and advocacy for our frontline midwives and maternity support workers, whilst supporting women in their birth choices".

All of the areas that were assessed either saw an improvement, or remained on a par with our 2017 results. Areas that were rated as lower performing included offering women the option of where to have an antenatal and postnatal check-up, delays in discharge, and allowing partners to visit as much as they wanted during a woman's hospital stay.

Patient Friends and Family Test (FFT)

Patients are invited to give feedback on their care and experience by answering one simple question – 'How likely is it that you would recommend this service to friends and family if they needed similar treatment?'

NUH received 43,196 inpatient and day-case patient FFT responses in 18/19 with an overall recommend rate of 97.2%%. Similarly, NUH received 22,786 emergency department FFT responses with an overall recommend rate of 92.2 %.

Examples of changes prompted by feedback comments include:

- A range of actions have been put in place at Trust, Divisional and Ward level e.g. to help improve communication and dignity and respect for patients. Staff are being reminded to close curtains during ward rounds and when possible find private areas to discuss further care plans
- Memory Menus have been introduced to help promote food choices especially for patients who are elderly, frail or suffering with dementia
- Flexible visiting times have been introduced across the Trust to enable carers to visit, support mealtimes and provide emotional support
- Staff, parents, youth forum and play leaders are working together to improve privacy and activities for children and young people
- The Trust has introduced free WiFi for all patients and visitors
- The Carer2Theatre project has been introduced to promote support for vulnerable patients going to theatre and has won two Patient Experience Network National Awards (PENNA), including the 'Best in class' prize and overall winners for 2019 (see photo below)

Staff experience

NHS national staff survey

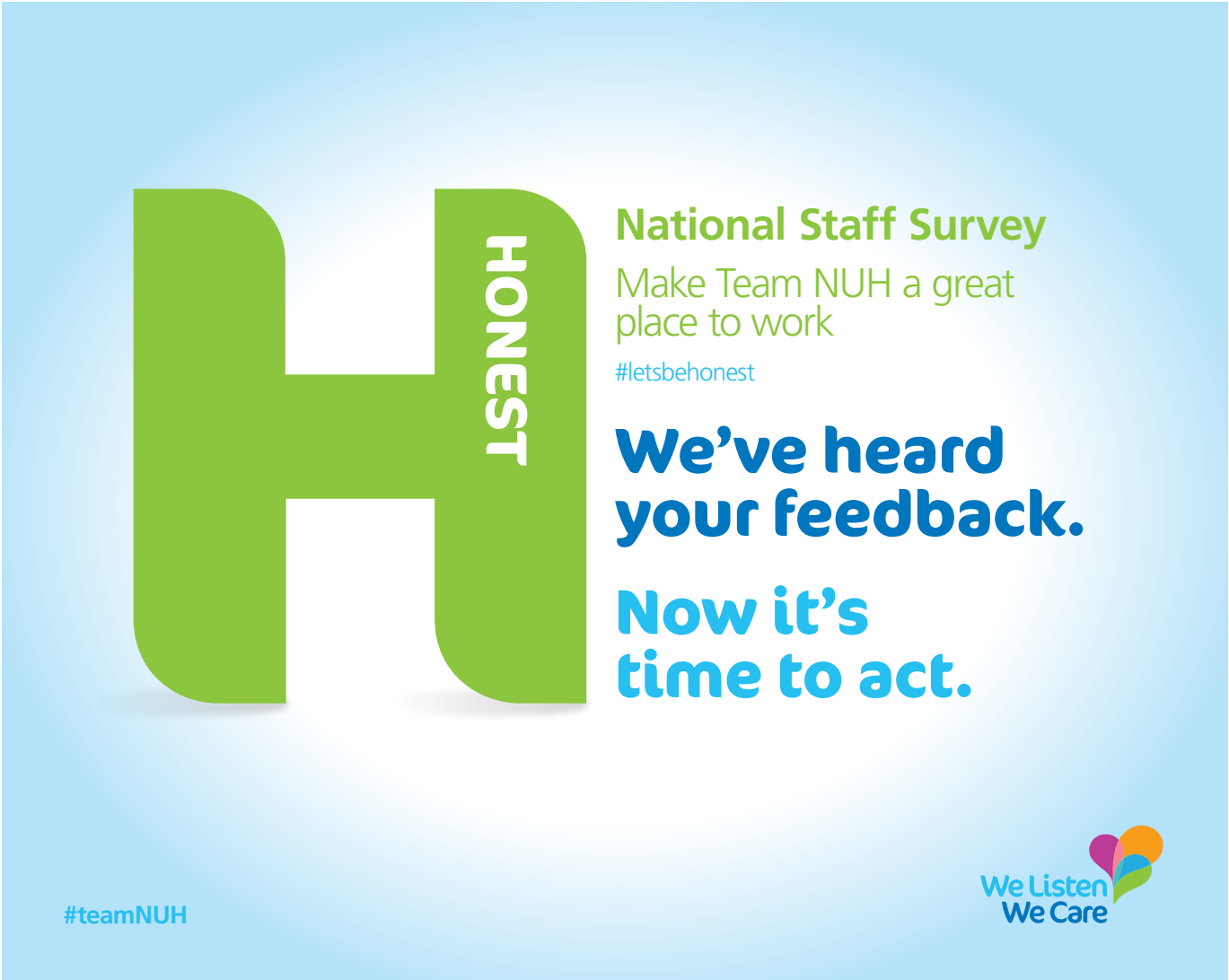
37% (5,335) of staff responded to the national staff survey. The provisional national response rate is 44%.

Highlights from our national survey results include:

- Overall staff engagement score was 3.81; demonstrating a slight increase on our 2017 score (3.80) and returning to the 2016 value
- The Trust is above average for six themes, average for three themes and below average for one (quality of Appraisals)
- Statistically significant improvements are noted for: immediate managers and equality, diversity and inclusion; with decreases in satisfaction for themes quality of care and health and wellbeing

The focus for improvement in 19/20 will be to:

- Simplify systems and processes
- Enable people to speak up
- Improve staff wellbeing, including review of the attendance management policy
- Continue the great work around value and recognition, including 'one off gestures'
- Continue with the Equality and Diversity Action Group ensuring a clear focus on protected characteristics where satisfaction has decreased
- Embed the work around managers standards, values and behaviours, appraisals and enabling our change programme within the NUH Academy Board



NHS national Staff Survey

Factor	Quarter One June 18	Quarter Two September 18	Quarter Four March 19
% of respondents would be extremely likely or likely to recommend NUH services to friends and family if they needed care or treatment	89%	85%	86%
% of respondents would be extremely likely or likely to recommend NUH as a place to work	66%	58%	60%

People Experience Group (PEG)

The four key priorities and subsequent areas of focus for PEG in 2018 (based on 2017 national staff survey results) were:

- Appraisal review – to address recurring dissatisfaction with the quality of appraisals
- Positive Action – to address concerns raised by Black and Minority Ethnic (BAME) colleagues regarding lack of equity in terms of opportunity for career progression
- Leadership development – to support line managers in ensuring the significant influence they have on staff experience is a positive one
- Values refresh – to re-engage with staff to co-design a set of values and behaviours that underpin achievement of the strategic objectives and ensure NUH is a place where staff want to work

Progress in delivering on identified key actions includes:

- Launching NUH's leadership development programme, 'Enabling our Change'
- Gaining support for implementation of a managers' induction which will be piloted from April 2019
- Implementation of the new appraisal scheme, enabling valuable conversations which make the appraise the centre of the appraisal, supported by appraiser and appraise workshops and a dedicated intranet page
- Supporting the values refresh by sense checking the proposed refreshed values with approximately 360 people from across the Trust in various roles and areas

Case studies from the Divisions/Trust-wide:

- Numerous cohorts through our Excellence in Administration Academy – now extending to Excellence in Admin and Management Academy (see photo below)
- World Kindness Day – spreading a ripple of kindness
- Roll-out of staff wellbeing boxes
- Trust has signed up to NHS Rainbow Badge project. The badge has a simple image: an NHS logo super-imposed on the rainbow pride flag, worn on NHS staff lanyards or uniforms. It is intended to send a strong message: you can talk to me, without fear of judgment or discrimination, about sexuality or gender identity. The badges reinforce that our hospital is a place of inclusion that LGBT+ children, young people, adults and families do not need to feel scared or alone here. We will roll-out the badge in 2019
- Successful #loveNUH campaign on Valentine's Day – staff nominated teams or individuals they felt should be 'shown some love' and we gave them small gifts and cards containing the words of their nominations
- Sharing of stories using #itsthelittlethings around random acts of kindness

Equality and Diversity

Highlights for 18/19 included:

- Further funding secured to provide staff with autism awareness and autism champion training over the last 12-months, delivered by Autism East Midlands
- Joining as a partner to the Nottingham Autism Champions network linked to Nottingham's Autism Strategy
- A successful completion of the third 'Future Leaders' programme, and a commitment to partner for further years. Future Leaders aims to address under representation and increase diversity at Board and senior level across Nottingham City
- The successful change over from DisabledGo to AccessAble – AccessAble is a disability access platform providing our patients and visitors with better information on accessibility including travelling to us and parking, and can be accessed as a webpage or an App. They are 100% facts, figures and photographs. The online access guides are here: **www.accessable.co.uk** (search Nottingham University Hospitals)
- We published our second year statutory Gender Pay Gap report and reported positive progress in reducing the Gap **www.nuh.nhs.uk/gender-pay-gap**
- There was a continuation of our equality partnership work with other statutory organisations including a health, wellbeing and arts conference on 29 November 2018 in recognition of Disability History Month. Over 100 members of the public attended
- In April, a team of dedicated, voluntary clinical staff undertook the annual visit to Jimma Hospital Ethiopia. The visits continue to serve as excellent developmental opportunities for NUH staff in honing skills in challenging resource poor circumstances
- We continued our commitment to address the wider detriments of health inequalities through the provision of work opportunities for young people not in education, employment or training (NEET's) through hosting further The Prince's Trust 'Get Into Hospitals' programme and 'Project Search'
- We renewed our commitment to the 'Mindful Employer' Charter, which supports employers to support mental wellbeing at work
- We successfully launched the BAME (Black, Asian, and Minority Ethnic – including international staff) Shared Governance Council. The BAME Shared Governance Council won the inaugural Equality and Diversity NUHonours Award
- BAME Shared Governance work has included a reverse mentoring programme and positive action to provide for better equality of opportunity for our internal BAME colleagues seeking development opportunities and career progression
- We promoted diversity through holding an International Nursing and staff event, opened by our Chief Nurse
- Our Chief Executive raised the rainbow flag to demonstrate the Boards commitment to inclusion raise awareness of LGBT (Lesbian, Gay, Bisexual and Trans) History Month, drawing attention to the health inequalities that adversely affect the LGBTQIA+ communities
- 17 and 18 November 2018, we welcomed Nottingham Rainbow Heritage to the Trust who provided training to staff on LGBTQIA+ awareness
- We received funding to deliver several sessions of BSL (British Sign Language) training, for front line staff in response to comments received from the Deaf Community
- NUH actively promoted the 'Time to Talk' Day, encouraging staff to have conversations about mental health to challenge prejudice and stigma
- Promoted Carers Week 11–15 June 2018 on behalf of HR to recognise the contribution and understand the challenges our staff who are carers face
- We have continued to pledge our support to the Equality and Human Rights Commission Initiative 'Working Forward', to make our workplace the best it can be for pregnant women and new parents
- Interpreting and Translation Services (ITS) continue to deliver efficiencies amid an increasing demand. The closing financial account 18/19 is approximately £400,000 with NUH increasing its business by 5% in the last twelve months (55% since 2015)

CASE STUDY:

Cavell Star Award win for Team NUH

Three members of the midwifery and maternity team at NUH were presented with a Cavell Star Award in recognition of their exceptional care to patients and families across NUH.

Aimee Summers, Community Midwife, Kirsty Rodgers, Midwife, and Emma Kelley, Transitional Care Worker, were all awarded the Cavell Star Award for providing outstanding support to patients and families.

Cavell Star Awards are a national programme for, nurses, midwives and healthcare assistants, who go above and beyond in their role, and are an important way of thanking our teams for the incredible work they do.

Kate Dutton is a mum-of-two from Keyworth; she has been friends with Aimee for the last three years and is the inspiration behind her Cavell Star Award win.

She said:

"I am entirely grateful for what Aimee did for me on that morning when I collapsed; a simple thank you will never be enough. In my eyes she's an amazing lady and I am so very glad to have her as a friend, her heart is so full of good for others and I think it is wonderful that she is being recognised in this way."

Freedom to Speak Up

Freedom to Speak Up (FTSU) guardians were introduced following Sir Robert Francis's Freedom to Speak Up Review in 2015. Their role is to work with leadership teams to create a culture where people can speak up to protect patient safety.

NUH is committed to creating a culture where staff feel empowered to speak up about any concerns they may have about patient care.

NUH appointed its first FTSU Guardian in 2016 as a three-day-per-week stand-alone role to provide independent and impartial advice to colleagues. The Guardian is supported by a network of speak up champions who promote the various channels through which concerns and other important information on quality, safety and improvement can be reported.

The Trust has a website with key contacts and information on speaking up, including frequently asked questions and speak up guidance and escalation processes. Various actions taken to contribute to a more open and supportive culture during the year include:

- Staff safe space events held in December 2018 and February 2019 to hear about experiences and for solution focussed discussion about bullying and undesirable behaviours
- The appointment of a Speak Up champion within the BAME Network to promote the channels through which to speak up and to support the staff voice
- The use of screensavers and Trust Briefing to raise awareness of FTSU and point staff to the NUH Speak Up web page that contains information and guidance

The Guardian has open door access to the Chair, Chief Executive and FTSU Non-Executive Director, supported by regular quarterly meetings.

NUH uses a variety of means to promote the Guardian role, including posters, inductions, social media and attendance by the Guardian at key staff meetings.

The total number of cases reported to the FTSU Guardian in 18/19 was 47.

Feedback has been universally positive about the support provided by the Guardian. However, it is recognised that there is more work to do on consistency of approach to understanding, investigating and feeding back on the types of concerns raised with line managers prior to contact with the Guardian.

The Board undertook a self-assessment of its FTSU arrangements in September 2018, facilitated by NHS Improvement. Following this a delivery plan was approved by the Board in November 2018. The plan lays out actions to support the cultural changes required to embed Speaking Up.

The report following an internal audit review of the robustness of the Trust's systems and processes for NUH staff to raise concerns was issued in November 2018. This review provided a significant assurance opinion to the Board.

As part of the well-led assessment during the CQC inspection in January 2019, the Trust's FTSU arrangements were assessed and were found to be 'Good'.

Trust Members and Volunteers

Our local community – which includes our public members, volunteers and patient representatives, continue to play an active and important part in our continuous improvement, both as ambassadors for NUH and as our 'critical friends.'

During 18/19, we started to develop an integrated patient and public engagement strategy which, when launched in 19/20, will simplify our 'offer' for all of the ways in which our local community can get involved in life at NUH.

Led by a recruitment charge from the Helpforce Charity, which coincided with the NHS's 70th birthday in 2018, the prominence of volunteering in the NHS has risen significantly over the last year.

NUH remains a popular place for volunteering placements, reaffirming the hospitals' excellent local and national reputation, with 1,559 volunteers who are vital and valued members of Team NUH, each supporting our ambition of delivering outstanding patient care.

Highlights from 18/19 included:

- In a series of one-off sessions co-ordinated by Therapy Services, poetry student volunteers attended our Healthcare of Older People wards in April, May and early June 2018 to sit and recite poetry to patients to enhance their stay in hospital
- Our Estates and Facilities Team took on a volunteers this year to support our uniform review meetings so that we could listen carefully to the views of our patients
- Volunteers now support on Wards A23, C5, C6 and D10 at QMC to offer support to patients and staff at mealtimes
- A volunteer has been recruited to the EMRAD Breast Screening Artificial Intelligence project (see page five), and is supporting the effective implementation of this exciting project
- Volunteers supported the moves as part of phase one of our Emergency Pathway Transformation Programme, including the Fracture and Spinal Clinic moves, notably providing patients, visitors and staff wayfinding advice and information. Volunteers continue to support patients and visitors in the recently relocated Fracture Clinic
- As part of our Winter Plan, volunteers have supported the redeveloped St Francis Unit at Nottingham City Hospital, including providing support to patients at mealtimes
- The vital role of volunteers featured in a 30-minute winter preparedness programme that was aired in January 2019 on BBC Inside Out about our winter plans, with a focus on our Emergency Department volunteers
- Voluntary services are now working in partnership with the new Pear's Project Lead Liz Charalambous, to build on the existing hospital voluntary services infrastructure to create a sustainable programme which provides flexible opportunities and overcomes barriers to recruit young/disadvantaged volunteers from a range of schools in Nottingham. This project is supported by our NUH Charity

101 volunteers were recognised for their contributions to NUH at our annual Long Service Awards in 2018, which were held at the Crowne Plaza Hotel in Nottingham and hosted by our Chief Executive Tracy Taylor and Chair Eric Morton. Volunteers were recognised for service ranging from five to 35-years.

The winner of the 2018 Volunteer of the Year Award at our annual NUHonours Awards was Mickey Lewis, Nottingham Hospital radio volunteer, and shortlisted were Andy Warren, Emergency Department volunteer (below), and Annie Dexter, one of our Breast Institute volunteers.

Very many thanks to our QMC and Nottingham City Hospital League of Friends for all they do to support our hospitals throughout the year, including making our Long Service Awards for both staff and volunteers possible.

NUH Charity

We want to thank our many generous supporters who have helped us continue to improve the facilities and care for patients, both young and old, at our hospitals in Nottingham over the last year.

More individuals, schools, businesses and local community groups than ever have wanted to support their local NHS. As the official charity for Nottingham's hospitals we are proud to be able to ensure that donations go directly to help those areas within our amazing hospitals that are close to peoples hearts, providing over £3.5m funding in total last year.

Highlights:

- **Children**
  Our £3m Big Appeal for Nottingham Children's Hospital successfully achieved its first target of refurbishing the vital accommodation for parents to stay near to sick children onsite. We are delighted to have also met our next fundraising target to provide a ground-breaking MRI for paediatric neurosurgeons to use during delicate surgery on children with brain cancer and other diseases. This should be operational by the end of this year
- **End of life**
  We celebrated giving over £340,000 to services such as the incredible Hayward House which provides end of life care. The centre offers a warm and welcoming environment for patients and their families in a bright and joyful setting that gives them much-needed respite. It was wonderful to see patients there cheer leading our celebrations to mark the 70th Anniversary of the NHS last year
- **Breast cancer**
  Breast Cancer has also been at the forefront of our charitable fundraising over the last year. Many individuals and families are immensely grateful for the care received at the Nottingham Breast Institute, which thanks to our donors now includes a new digital mammography machine. Across our hospitals we have provided over £120,000 of funding for new breast cancer equipment in the last year
- **Research**
  At our first ever Nottingham Hospitals Charity Research Event we were joined by some of the country's leading researchers – based here in Nottingham. Together they showcased the incredible outcomes achieved as a result of our £8m research funding programme. This is part of our commitment to achieving life-changing improvements for the care and treatment of patients

Nottingham Hospitals Charity
At the heart of your care

Nottingham Children's Hospital THE BIG APPEAL #RobinsBigWorldRecord

To find out more about Nottingham Hospitals Charity, visit:
www.nottinghamhospitalscharity.org.uk
or follow **@NUHCharity** on Twitter.

Section 2 – Accountability Report

Summary of Governance Statement

We want to make sure that our patients receive the highest quality care possible and are always working to ensure this, looking at our internal systems and learning from national assessments, which examine the services we provide and how we handle our resources.

Accountability

NHS Improvement is responsible for appointing trust chairs and other Non-Executive Directors. All these appointments are subject to annual review and appraisal. The remuneration of Non-Executive Directors is determined nationally.

All substantive Executive Directors and Advisors to the Board are appointed through national advertisement, on permanent contracts. The contract may be terminated by their retirement, resignation or dismissal. Performance of the Chief Executive is evaluated by the Chair and is reported to the Remuneration and Terms of Service Committee. The performance of other Executive Directors and senior managers is evaluated by the Chief Executive and is reported to the Remuneration and Terms of Service Committee.

Any changes in remuneration for executive directors or advisors to the Board are agreed by the Remuneration and Terms of Service Committee.

Board meetings

The Board meets eight times a year and these meetings are open to the public, subject to the proviso that the Board may go into confidential session as appropriate. Information about Board meetings, including agendas and papers, is posted on the Trust's website: **www.nuh.nhs.uk**.

It is also available from:

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Nottingham, NG5 1PB

Tel: **0115 969 1169**

E-mail: **michelle.rogan@nuh.nhs.uk**

Annual Public Meeting

The Trust's annual public meeting for the year ending 31 March 2018 was held on 5 July 2018 in the Postgraduate Education Centre at City Hospital. We shared with our patients, public members and partners our responsibilities and good stewardship of public funds in the previous financial year.

We celebrated a number of our achievements and recognised the hard work of our staff. Executive colleagues asked a range of questions about the way we run the Trust and our plans for the future.

There were presentations on:

- BBC Two's 'Hospital' documentary
- End of Life care improvements
- Building relationships with our Junior Doctor workforce
- Focus on improving rehabilitation services for patients and their families

Full details of the Board members, Board and its subcommittees are available online at: www.nuh.nhs.uk

The Board and its Committees

The Board discharges its responsibilities through monthly Board meetings, an Annual Public Meeting and a number of formal committees. For details of attendance at Board and committee meetings, please refer to the Annual Governance Statement in Appendix Two.

There have been some changes in the senior team in the last year, summarised as below.

- Mrs Michelle Rogan was appointed as Director of Corporate Governance on 2 April 2018
- Ms Christine Reed stepped down as Associate Non-Executive Director on 31 July 2018
- Miss Natalie Sigona was appointed as Associate Non-Executive Director (non-voting) on 27 September 2018
- Ms Alison Wynne was appointed as Director of Strategy and Transformation on 1 October 2018
- Ms Edwina Grant stepped down as Non-Executive Director on 30 November 2018
- Ms Rachel Eddie has been formally acting up into the role of Chief Operating Officer since 14 January 2019 when Ms Caroline Shaw, the existing post-holder, went on secondment

Fit and Proper Person Test

In 18/19, the directors individually updated their declarations to confirm continuing compliance with the Fit and Proper Person Test.

Staff Report

Health and wellbeing

NUH's Staff Wellbeing programme has gone from strength to strength in 18/19, providing a range of services to support the physical, emotional and financial wellbeing of our staff. Staff wellbeing in its widest sense is critical to providing an engaged, supported workforce and contributes to patient satisfaction.

Early in 2018, the Staff Wellbeing strategic group renewed the Staff Wellbeing Strategy and identified key aims and actions for the next three years. This has included an increased emphasis on supporting staff mental health, improving the uptake of the flu vaccination and improving the food offer for staff.

Key areas of work/action have been:

- A reduction in high salt, fat and sugar foods in our catering outlets
- Improving access to food out-of-hours including trialling hot vending machines and extended opening hours to some of our catering outlets
- Strengthening our flu vaccination programme, achieving over 80% of frontline staff being vaccinated
- Introducing a new telephone support line through Health Assured, offering staff a wide range of support and access to counselling services – in the first 12 months, over 1,257 calls were registered
- Introducing a new financial wellbeing service through Neyber, providing an educational hub to help our staff deal with any personal financial issues
- Establishing a Staff Mental Health Shared Governance Council to support and develop more initiatives to support the mental health of our staff
- Securing funding support from our NUH Charity to develop and deliver local health events to reach even more of our staff
- Introducing the Inspiring Staff Wellbeing award category as part of the newly refreshed NUHonours Awards – over 30 nominations were received

Throughout the year the team delivered:

- A wide range of physical activity initiatives including walking challenges and events, onsite fitness classes and Couch to 5k programmes – 500 staff took part in our walking challenges and events, 31 staff completed a couch to 5k programme
- Support to staff cycling to work– 144 bikes were accessed through our Cycle to Work salary sacrifice scheme, 240 bikes were serviced by our Dr Bike initiative
- Mental health initiatives including 16 Coping with Stress workshops attended by 225 staff, nine local department stress workshops with 99 attendees, two eight week mindfulness courses with 18 staff benefitting
- Support to staff to improve their overall wellbeing through the provision of 11 health check events, completing health checks for 780 staff
- Over 700 physiotherapy appointments to staff to address musculo-skeletal problems which were affecting their work
- Two menopause workshops, attended by 25 staff
- Six training sessions for line managers aimed specifically at how to look after the wellbeing of staff – 85 line managers attended. 51% of those attending saw significant improvements in their confidence in dealing with members of staff experiencing mental health concerns
- 16 eating for wellbeing seminars, attended by 82 staff

Comments from staff accessing the Staff Wellbeing programme include:

"I felt lonely and unwanted. Joining the Couch to 5k group made me feel like part of a team"

"I just wanted to let you know that what you do really makes a difference"

"I am much more able to cope with stress at work and interacting with colleagues. I also feel able to cope with emotional challenges at home."

"What a fantastic service Dr Bike is. My bike is kept in much better condition, making me a much safer cyclist. It is an excellent service and I really appreciate it."

Staff policies applied during 18/19

All new and refreshed Trust policies are Equality Impact Assessed (EIA). An EIA is a tool for identifying the potential impact of our policies, services and functions on our patients and staff. It helps us provide and deliver excellent services by making sure that all services reflect the needs of our patients and staff. This includes giving full and fair consideration to applications for employment to the Trust, training, career development and promotion for people with a disability.

Remuneration & Staff Report

Our Staff

The CQC's Use of Resources assessment (January 2019) concluded that in overall terms, our workforce productivity metrics compare well with our peers. Sickness absence is well-managed, and we have maintained high staff retention rates.

We have embedded the use of alternative roles in our services to increase capacity and provide resilience within clinical teams and reduced agency spend. Examples of the new roles established include; reporting radiographers who provide additional capacity for plain film reporting, and advanced clinical practitioners (ACPs) who provide cover for junior doctors' gaps and support implementation of improved clinical pathways.

Existence of these roles has also provided career development opportunities for existing staff, which has supported staff retention. NUH has one of the largest trainee Nurse Associate programmes in the region and has also participated in a regional pilot of a medical team administrator role, to reduce the administrative burden on medical staffing.

Workforce summary

At the end of March 2019, the workforce at NUH was 16,208 (14,541 Full-Time Equivalents).

STAFF GROUPS	HEADCOUNT	%
Add Prof Scientific and Technical	761	5
Additional Clinical Services	2,764	17
Administrative and Clerical	3,086	19
Allied Health Professionals	858	5
Estates and Ancillary	1,434	9
Healthcare Scientists	583	4
Medical and Dental	1,967	12
Nursing and Midwifery (Registered)	4,755	29
Total	**16,208**	**100**

Numbers of staff (Average WTE in 18/19)

	Total 18/19	Permanently employed	Other	Total 17/18	Permanently employed	Other
Average staff numbers	**No.**	**No.**	**No.**	**No.**	**No.**	**No.**
Medical and Dental	1,913	1,710	203	1,952	1,704	248
Administration and Estates	2,986	2,894	92	2,976	2,889	87
Healthcare Assistants and other support staff	3,130	3,049	81	2,871	2,793	78
Nursing, Midwifery and Health Visiting staff	4,575	4,065	510	4,506	3,961	545
Scientific, Therapeutic and Technical staff	1,418	1,381	37	1,353	1,321	32
Other	519	504	15	497	483	14
Total	**14,541**	**13,603**	**938**	**14,155**	**13,151**	**1,004**

Mandatory training attendance

86.7% versus 90% target.

Appraisal rate (medical and non-medical)

Medical 98.6% (target 95%, non-medical 87.5% (target >90%).

Turnover

10.8% (target <11%).

Staff retention

The Trust's overall retention rate, which is better than the national average and sits in the second-best quartile nationally, has also improved over the last twelve months from 85.6% to 86.8%. Improved retention rates for registered nurses and health support workers are the drivers for the favourable movement. This has been achieved through various initiatives including; engagement with the NHS Improvement retention schemes for nursing staff, NUH's own Magnet (retention) programme and introduction of targeted training and career development opportunities for the non-qualified nursing workforce. NUH also directly employs Junior Doctors to its local NHS Trust grade programme which has helped reduce gaps in its Junior Doctor workforce.

Sickness absence data

Our sickness absence rate for 18/19 was 4% (versus our < 3.6% target). This compares to 3.7% in the previous year and,3.64% in 16/17, 3.3% in 15/16, 3.34% in 14/15, 3.29% in 13/14, 3.77% in 12/13 and 3.79% in 11/12. NUH's sickness rate remains one of the lowest in the region (vs other NHS hospitals) and below the national average of 4.44% for acute teaching hospitals and 4.8% for all Trusts.

The sickness performance of the Trust is summarised in the table below:

	Sickness %
17/18	4.0
16/17	3.7
15/16	3.30
14/15	3.34
13/14	3.29
12/13	3.77
11/12	3.79

The staff sickness absence data is stated for the calendar year as being the latest available data at the time of preparation of the Annual Report and Accounts. The Department of Health and Social Care considers these as a reasonable proxy for the financial year.

Total days lost through sickness increased slightly in 17/18 compared with 16/17, resulting in an average working days lost per whole-time equivalent of 13.31 (13.94 in 16/17). This was 14.57 in 18/19.

Gender pay gap

We published our statutory Gender Pay Gap report in March 2017.

The gender pay gap differs from equal pay as it is concerned with the differences in the average pay between men and women over a period of time no matter what their role is. Equal pay deals with the pay differences between men and women who carry out the same or similar jobs.

Gender	Average Hourly Rate	Median Hourly Rate
Male	21.89	17.16
Female	17.16	14.05
Difference	15.27	3.10
Pay Gap %	14.05	18.11

Quartile		Male	Female %	Male %
1	2661.00	561.00	82.59	17.41
2	2678.00	552.00	82.91	17.09
3	2730.00	500.00	84.52	15.48
4	2007.00	1224.00	62.12	37.88

Gender	Average Pay	Median Pay
Male	15,439.47	11,835.02
Female	8,503.20	5,967.20
Difference	6,936.27	5,867.82
Pay Gap %	44.93	49.58

We have taken a lot of time to understand the reasons behind the pay gap at NUH. These reasons include:

- Consultants earning the highest salary within this staff group are at the moment predominantly male (61.3%). Historically the medical profession has attracted more male than female candidates although this is changing as years progress. However the dominance within this staff group currently gives some indication as to the difference in pay rates. Those consultants who have a higher annual salary and therefore hourly rate are also more likely to be male given they have been in post for longer
- Only Consultants can receive pay that is classified as bonus pay. Bonus pay elements are awarded as a result of recognition of excellent practice over and above contractual requirements and have no gender bias. However, it is important to consider that the opportunity to develop excellent practice over and above contractual requirement is linked to the amount of time the consultant has been in post. Again, this makes the awarding of bonus pay more likely for male employees in this staff group
- For non-medical staff there is a predominantly female workforce (80%) which has a direct impact on our profile

We are committed to ensuring that we take all the steps we can to address the gap over time. These include:

- Talent management schemes and succession planning to ensure those with potential (regardless of gender) have the opportunity to progress. It is important to note that we already have female employees in senior management positions
- Working with the Less than Full-Time (LTFT) champion (a female Consultant) for trainee doctors to ensure that time away from work does not affect career progression
- We have already provided guidance within our recruitment process regarding unconscious bias
- Working with schools and higher education providers to ensure students have an awareness of all of the careers available to them in the NHS
- Extending our apprenticeship opportunities to ensure we offer access to a wide range of frameworks

The full Gender Pay Gap report is available on the NUH website: **www.nuh.nhs.uk/gender-pay-gap**

Workforce management

E-rostering is used by NUH to support effective deployment of its nursing, midwifery and junior medical workforce, and an acuity model is used to ensure the nursing staffing levels meet patient need. NUH demonstrates that rotas are agreed six weeks in advance to ensure that gaps are identified and addressed promptly, avoiding the use of premium agency staffing. 90% of Consultants also have an active job plan held electronically. We are working to align job plans to service requirements thereby reducing the need for additional medical hour payments. There is also been some progress in developing partnership with other NHS Trusts within some of the hard to recruit services. NUH is working with other neighbouring NHS trusts to streamline and provide more sustainable clinical services in areas such as Urology, Stroke, Vascular and Oncology.

Consultancy

The Trust spent £1.5m on consultancy costs in 18/19, an increase of £0.5m compared with 17/18, associated with advice provided by EY in support of the Trust's financial recovery plan.

Remuneration Report

The remuneration and staff report sets out the organisation's Remuneration Policy for Directors and senior managers, reports on how that Policy has been implemented, sets out the amounts awarded to directors and senior managers and, where relevant, the link between performance and remuneration. In addition, the report provides details on remuneration and staff that users of the accounts see as key to accountability. There are no expected changes to the terms and conditions of the Remuneration Policy in the future, so it should be read as being the current and future Policy of the Trust.

All disclosures in the Remuneration Report are consistent with identifiable information of those individuals included in the financial statements. No information about these individuals has been withheld or not disclosed.

The figures presented in this report relate to all those individuals who hold or have held the office of a Director of NUH during the reporting year or in the prior period.

Salary and Pension Entitlements of Senior Managers

The definition of "Senior Managers" is 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.' For NUH this is defined as the Trust's Executive and Non-Executive directors.

The 18/19, remuneration and pension entitlement for these Senior Managers is disclosed in the tables below.

Remuneration levels are set by the Board's Remuneration Committee, based on benchmarked information obtained via the Association of UK University Hospitals salary surveys, supplemented by advice, where appropriate, from external agencies. All Non-Executive Directors are members of the Committee. Reviews of the performance of each Executive Director are presented to the Remuneration Committee for their assessment in each year. No performance-related or bonus schemes are in place for the Executive Team.

The Trust uses permanent appointments with six-month notice periods for Directors, with a longer notice period for the Chief Executive.

There is no entitlement to any payment on termination or resignation outside of these payments, other than in the case of redundancy or ill-health retirement when standard NHS terms apply. No awards have been made to previous members of the Executive Team in the financial year in question.

There were no payments to past directors or payments for loss of office.

Remuneration

Salary and pension entitlements of senior managers

Name	18/19				17/18			
	Salary (bands of £5,000) £000	Performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000) £000	Salary (bands of £5,000) £000	Performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000) £000
Executives								
Mrs T Taylor, Chief Executive	225-230	0	202.5-205	430-435	95-100	0	102.5-105	195-200
Ms M Sunderland, Chief Nurse	160-165	0	0	160-165	155-160	0	27.5-30	185-190
Dr K Girling, Medical Director	195-200	0	575-577.5	770-775	160-165	0	22.5-25	185-190
Mr R Egginton, Chief Financial Officer	180-185	0	0	180-185	170-175	5-10	2.5-5	185-190
Ms C Shaw, Chief Operating Officer	145-150	0	92.5-95	240-245	180-185	0	27.5-30	205-210
Ms R Eddie, Acting Chief Operating Officer	25-30	0	7.5-10	35-40	0	0	0	0
Non-Executives								
Mr E Morton (Chair)	35-40	0	0	35-40	35-40	0	0	35-40
Mrs J Pomeroy	5-10	0	0	5-10	5-10	0	0	5-10
Prof H Sewell	5-10	0	0	5-10	5-10	0	0	5-10
Mr S Thomas	5-10	0	0	5-10	5-10	0	0	5-10
Mr D Cartwright	5-10	0	0	5-10	5-10	0	0	5-10
Mrs E Grant	0-5	0	0	0-5	5-10	0	0	5-10

Notes

1. Tracy Taylor was appointed Chief Executive on 30 October 2017

2. Rupert Egginton was appointed Deputy Chief Executive Officer on 14 January 2019

3. Caroline Shaw went on secondment on 14 January 2019

4. Rachel Eddie was appointed Acting Chief Operating Officer on 14 January 2019

5. Professor Herbert Sewell retired on 31 March 2019

6. Edwina Grant resigned on 30 November 2018

There are no performance pay, long-term performance pay or bonuses for Directors in 18/19. All pension related benefits is defined as twenty times the real annual increase in pension plus the real increase in lump sum less employee contributions introduced by the Department of Health and Social Care in 13/14.

Pension Entitlement

Salary and pension entitlements of senior managers

Name	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accured pension at pension age at 31 March 2019 (bands of £5,000) £000	Lump sum at pension age related to accured pension at 31 March 2019 (bands of £5,000) £000	Cash Equivalent Transfer Value at April 2018 £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Real increase in Cash Equivalent Transfer Value £000
Mrs T Taylor, Chief Executive	10-12.5	30-32.5	90-95	275-280	1,469	1,905	361
Ms M Sunderland, Chief Nurse	0-2.5	0-2.5	60-65	190-195	1,260	1,446	125
Dr K Girling, Medical Director	25-27.5	67.5-70	75-80	215-220	981	1,678	639
Mr R Egginton, Chief Financial Officer	0	0	65-70	195-200	1,284	1,448	126
Ms R Eddie, Acting Chief Operating Officer	2.5-5.0	2.5-5.0	25-30	60-65	412	520	17

Notes

The Trust has no employer contributions for Partnership pension accounts.

Pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at **www.nhsbsa.nhs.uk/pensions**. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The scheme is subject to a full actuarial valuation every four years (until 2004, every five-years) and an accounting valuation every year.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's 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 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.

Pay Multiples

The reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director of the Trust in the financial year 18/19 was £225,000-£230,000 (17/18, £225,000-£230,000). This was 7.8 times (17/18, 8.3 times) the median remuneration of the workforce, which was £29,059 (17/18, £27,308). In 18/19, four (17/18, one) employees received remuneration in excess of the highest paid director. Remuneration ranged from £6,157 to £281,662 (17/18 £6,091 to £309,334). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the CETV of pensions. Where there is a sharing arrangement, the cost of an individual to the Trust is shown and not the total of that individual's remuneration. Termination benefits have been excluded from the calculation of the highest paid director's/ member's salary to avoid distorting the ratio.

The Chief Executive was the highest paid director and a Consultant was the highest paid member of staff in 18/19.

Severance and Exit Packages

Actual redundancy and other departure payments in the year were £175,000.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension's scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the tab.

Reporting of other compensation schemes – exit packages	No of compulsory redundancies	Cost of compulsory redundancies	No. of other departures agreed	Cost of other departures agreed	Total no. of exit packages		No. of departures where special payments have been made	Cost of special payment element incl. in exit packages
	No.	£000	No.	£000	No.	£000	No.	£000
18/19								
Less than £10,000	0	0	5	11	5	11	0	0
£10,000-£25,000	0	0	3	56	3	56	0	0
£25,001-£50,000	0	0	2	54	2	54	0	0
£50,001-£100,000	0	0	1	54	1	54	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**11**	**175**	**11**	**175**	**0**	**0**

Reporting of other compensation schemes – exit packages	No of compulsory redundancies	Cost of compulsory redundancies	No. of other departures agreed	Cost of other departures agreed	Total no. of exit packages		No. of departures where special payments have been made	Cost of special payment element incl. in exit packages
	No.	£000	No.	£000	No.	£000	No.	£000
17/18								
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	0	0	1	17	1	17	0	0
£25,001-£50,000	0	0	1	42	1	42	0	0
£50,001-£100,000	0	0	2	167	2	167	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**4**	**226**	**4**	**226**	**0**	**0**

Other exit packages	18/19 no. of exit package agreements	18/19 total value of agreements	17/18 no. of exit package agreements	17/18 total value of agreements
	No.	£000	No.	£000
Voluntary redundancies incl. early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of service contractual costs	0	0	0	0
Contractual payments in lieu of notice	11	175	4	226
Exit payments following employment tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval	0	0	0	0
Total	**11**	**175**	**4**	**226**
Non-contractual payments made to individuals where the payment value was more than 12-months of their annual salary	0	0	0	0

Tracy Taylor
Chief Executive
23 May 2019

Section 3 – Financial performance

18/19 financial headlines

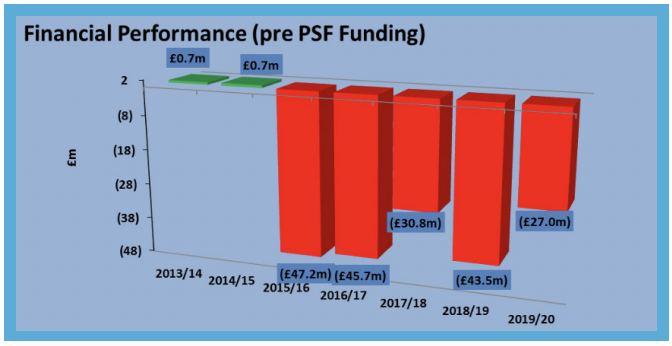
The Trust is required to meet certain financial duties in order to provide assurance to the taxpayer of how public funds have been managed. The performance of these is shown in the table below:

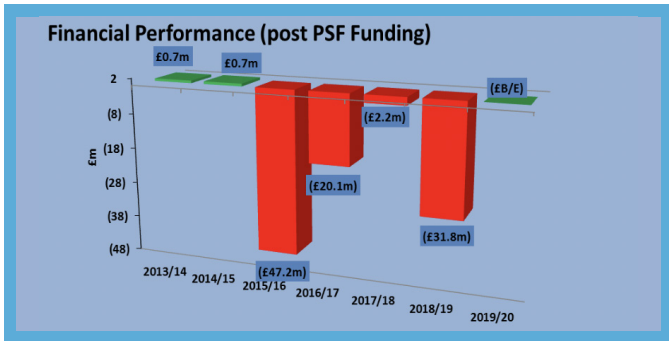
Statutory duty	Notes	Target	Performance	Variance	Duty
Break-even	Expenditure does not exceed income	(£24.9m)	(£43.5m)	(£18.6m)	Not met
External Finance Limit (EFL)	Specifies how much more (or less) cash NUH can spend over that which it generates from its activities	£36.3m	£13.2m	£23.1m	Met
Capital Absorption Rate	NUH is required to pay a dividend to Department of Health and Social Care (DHSC) of 3.5% of its average relevant net assets (Cost of Capital)	3.5%	3.5%		Met
Capital Resource Limit (CRL)	NUH must not spend more than the limit set	£43.7m	£43.6m	£0.1m	Met

18/19 represented the third year of a three-year plan to return the Trust to financial balance. However, the Trust delivered a £43.5m deficit (before Provider and Sustainability Funding) (PSF), representing a miss against its financial control total (a deficit of £24.9m) of £18.6m. Due to this financial performance and the failure to meet the emergency access national standard target, the Trust was only able to secure PSF funding of £11.7m against an available pot of £32.7m, such that NUH reported an overall deficit (after PSF) at 31 March 2019 of £31.8m.

Since being established, NUH has had a history of strong financial performance, delivering annual surpluses up to 14/15. Over the course of the last four years, like most acute providers, nationally, the Trust has been exposed to unprecedented operational and financial pressures, such that the Trust incurred losses in of £47.2m in 15/16, £20.1m in 16/17, £2.2m in 17/18 and now £31.8m in 18/19. Until this year, the Trust had also delivered its financial control total agreed with NHS Improvement (NHSI).

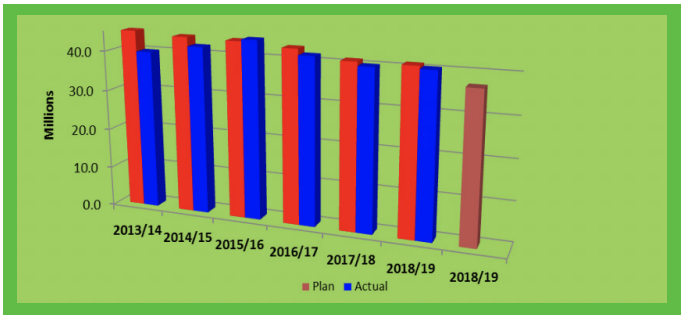
The Trust's underlying (pre PSF/STF) financial position and its financial position after the distribution of PSF funds are shown below. The target set for 19/20 is to achieve a break-even position.





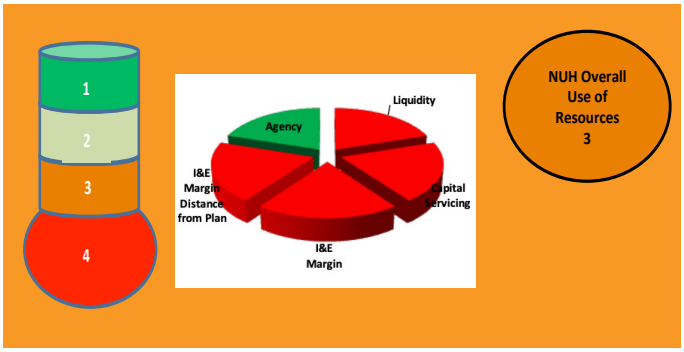
The Trust's consolidated financial position includes the operating surplus of its private subsidiary, Hospital Pharmacy Services Nottingham (HPSN) Ltd (£0.1m), in accordance with the Group accounting standards.

FINANCIAL EFFICIENCY



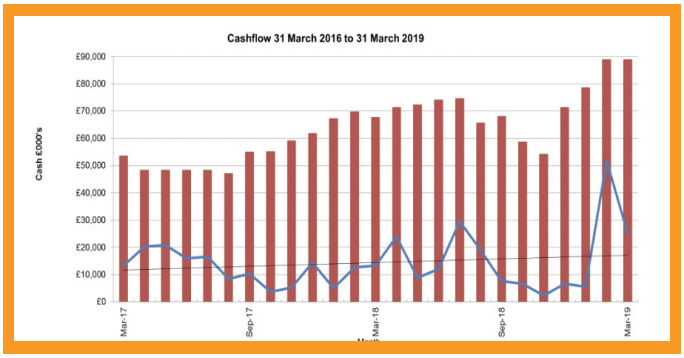
- NUH delivered efficiencies of £40.3m in 18/19 (4.0% of income) against a Cost Improvement Plan (CIP) plan of £41m. The Trust has now achieved savings of circa £40m or more for the last six consecutive years.

USE OF RESOURCES



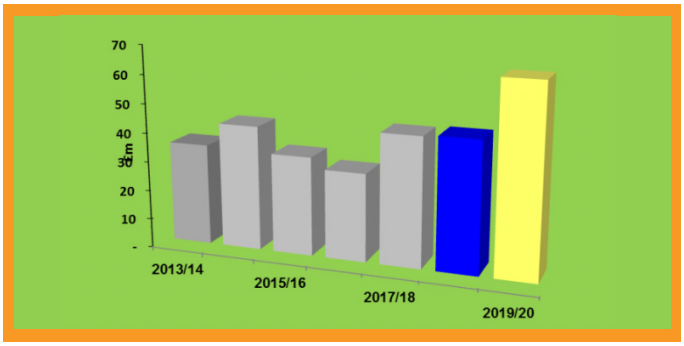
- NHSI measures use of resources through the Single Oversight Framework (SOF). The Trust achieved a score of three, which represents the best possible score that it could have achieved, given scoring a four on any component of the metric triggers an override to the calculation (as a result of the financial deficit achieved). The Trust delivered a score of one for spending less on agency staffing than its cap.

CASH



- The Trust's cash position of £25.1m at 31 March 2019, was supported by new revenue deficit support loans of £21.3m in 18/19. The Trust operates within the NHS finance regime, which enables all providers to access deficit through revenue support loans. NUH is like the vast majority of NHS bodies in that it does not internally generate sufficient cash to consistently meet its financial obligations and therefore requires additional cash support to pay its staff and suppliers.

CAPITAL INVESTMENT



- The Trust invested more than £44m in its capital infrastructure in 18/19, to meet growth in demand, improve quality standards, drive it towards achieving performance targets and ensure patients were treated in best possible clinical environment.

Income

The Trust's turnover exceeded one billion pound for the first time (£1.022bn compared with £987.5m in 17/18) – an increase of £34.5m (3.5%), generated mainly from the delivery of acute and specialised patient care activities.

Patient Care Income (£891m)

The largest component of the Trust's clinical activity related income was received from the Clinical Commissioning Group (CCG) Commissioning Consortia (£479.8m) and local authorities (£5.2m) for acute services, and NHS England (£384.7m) for specialised services. This represented a £50.7m (6%) increase on the levels received in 17/18, attributable to national and local tariff pricing increases, delivery of additional elective and non-elective care and high cost drugs income.

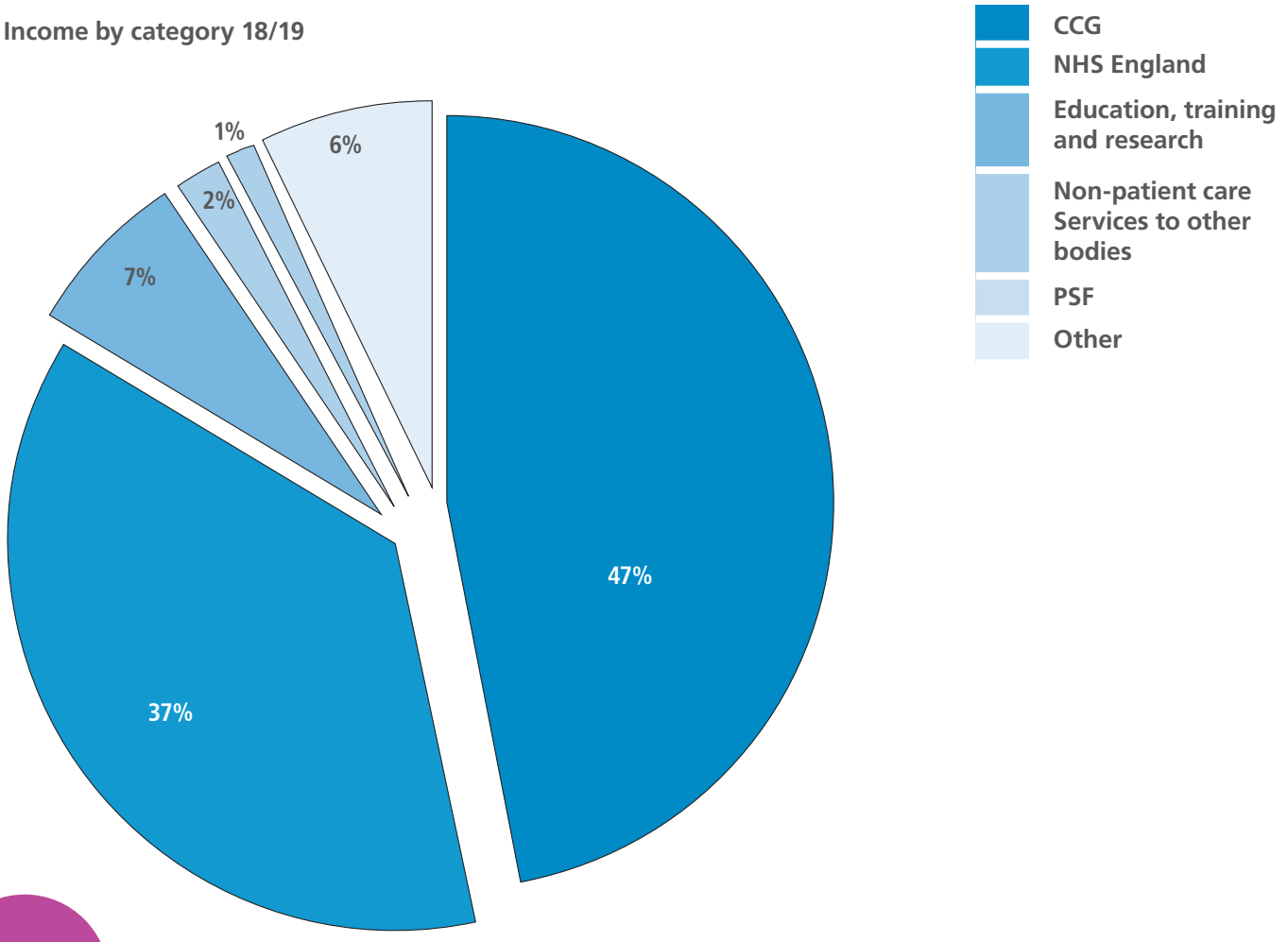
Whilst overall patient income levels have grown with increasing tariff rates and higher patient volumes, the disproportionate increase in emergency activity has displaced planned patient care. This in turn has led to the need to provide some activity through sub-contracts to the private sector and to inefficiency within our planned care services.

Non-Patient Care Income (£131m)

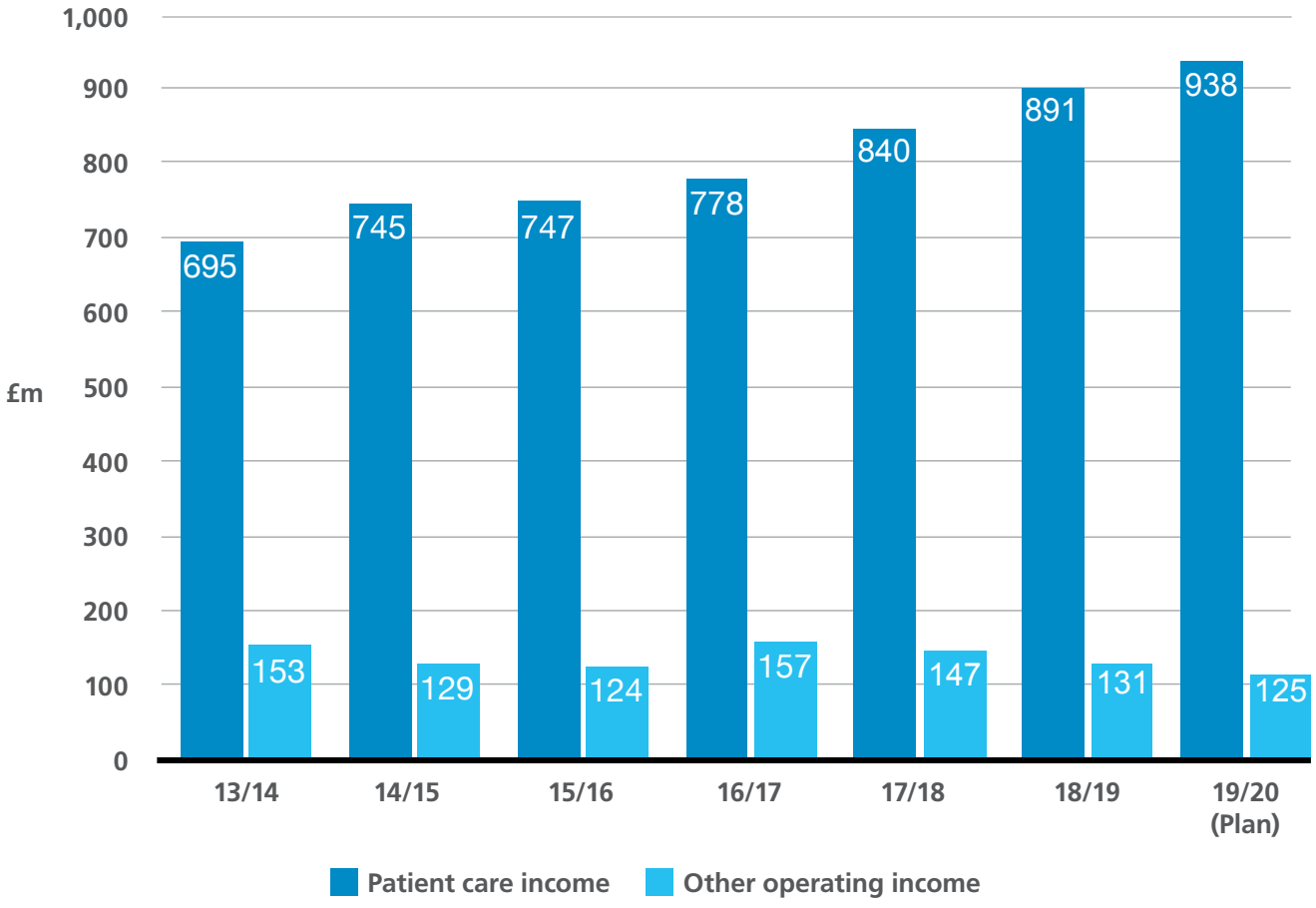
Other operating income is received to fund education, training and research activities and generated from trading and commercial activities. As a teaching hospital and centre of excellence for teaching, education and research, the Trust receives significant investment for these services. Other operating income reduced by £17m in 18/19, mainly in relation to the reduction in PSF funding received, as a result of failing to hit financial control total and operational (ED) targets.

An analysis of the sources of income by type and trend analysis in 18/19 is shown in the graph on page 55.

Income by category 18/19



Trust income (13/14 – 19/20)

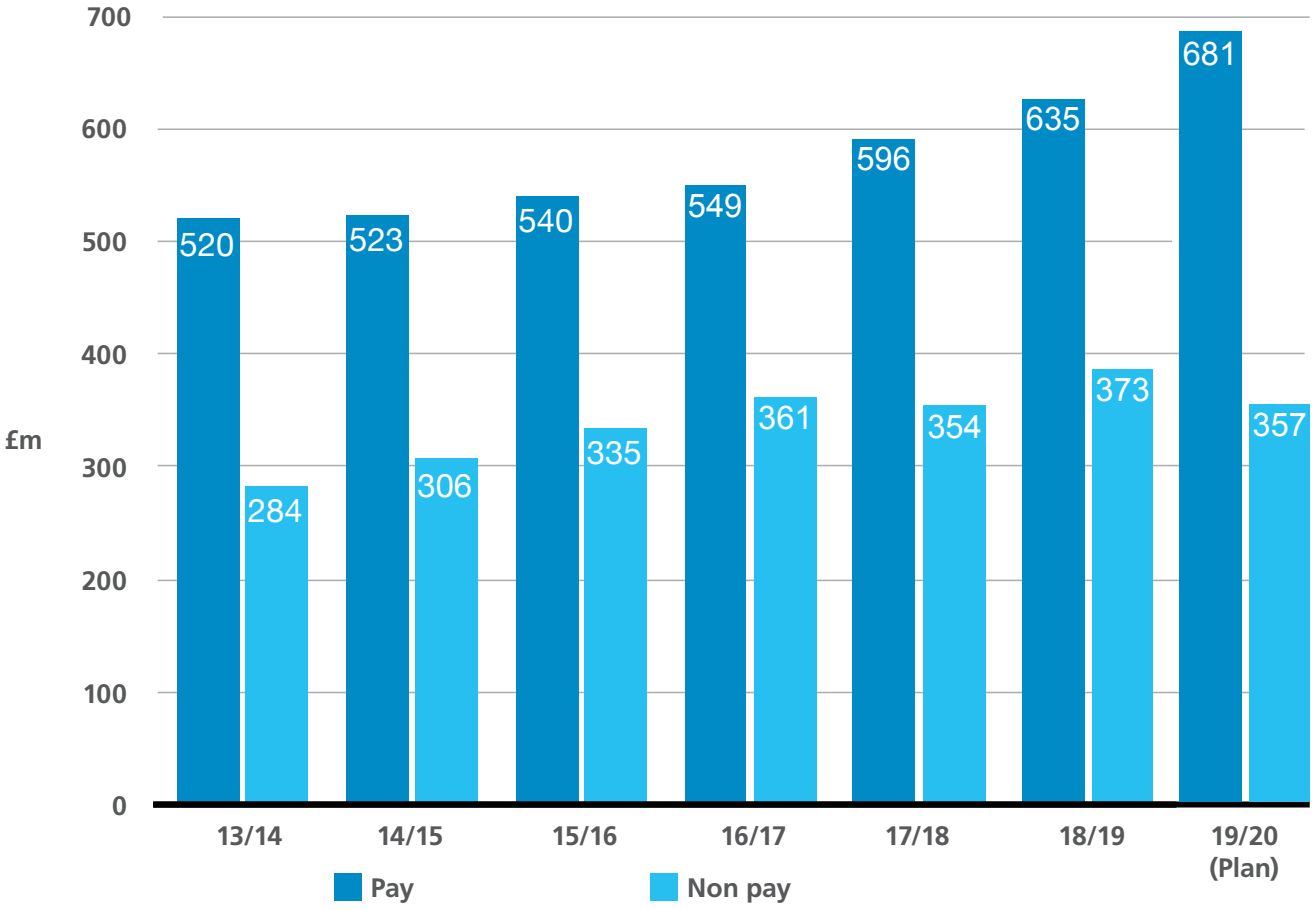


Expenditure

Expenditure (including non-operating items) of £1.06bn were incurred in delivering Trust services in 18/19, compared with £983.3m in 17/18; an increase of £77.4m (7.9%).

A trend analysis of operating expenses is shown in the graph below:

Trust operating expenditure (13/14–19/20)



NUH built on the work in previous years by achieving a sustained reduction in premium agency spend which it maintained below the agency ceiling set by NHS Improvement. Initiatives that have contributed to this improvement include; improved retention of registered nurses, stricter controls on agency spend, use of alternative roles, local recruitment of junior doctors, effective management of sickness absences and more recently the harmonising of pay and reward benefits within the Estates Department.

The overall size of the Trust's workforce increased by 386 WTE to 14,541 employees in 18/19, mainly healthcare assistants and other support staff (259 WTE).

Benchmarking information indicates that there is still an opportunity to improve the efficiencies in the use of staff resources, although there has been a positive and sustained swing away from agency to bank staff, when using temporary staffing solutions. A continued focus is however required to address the overall high non-substantive costs. Medical Staffing is higher primarily due to additional medical hours payment paid to substantive staff to cover service gaps and undertake extra activity to reduce waiting lists. As a large teaching Trust, academic and teaching costs also contribute to this higher pay bill.

The Trust is strengthening the financial pay control environment through the implementation of a new process called establishment control, which involves formally matching, at post level, funded posts to staff currently employed, to ensure that the Trust can only recruit into a budgeted post when it becomes vacant.

The Trust's underlying non-pay expenditure position increased year on year by £19.3m (excluding non-operating items), representing an increase of 5.4%, mainly associated with delivering front-line care (clinical supplies and services, including medicines - £10.6m), research and development (£2.5m), education and training (£2.5m) and premises expenses (£2.4m).

Although NUH's overall non-pay cost are below the national average. NUH is actively working to reduce the supplies and services costs by securing best value prices on purchases and securing volume discounts by collaborating with other NHS providers using regional procurement hubs. A clinical procurement specialist team is established within the Trust which includes three experienced nurses to develop clinical engagement and provide clinical expertise to support procurement activity. The group has reduced the range of products available in the Trust's procurement catalogue, to support bulk purchasing discounts. There have been successes, for example, in orthopaedics, where primary hip implants are now provided by just one supplier. NUH has increased the use of contract purchases with 93% of the non-pay spending on contract, which is in the best quartile nationally.

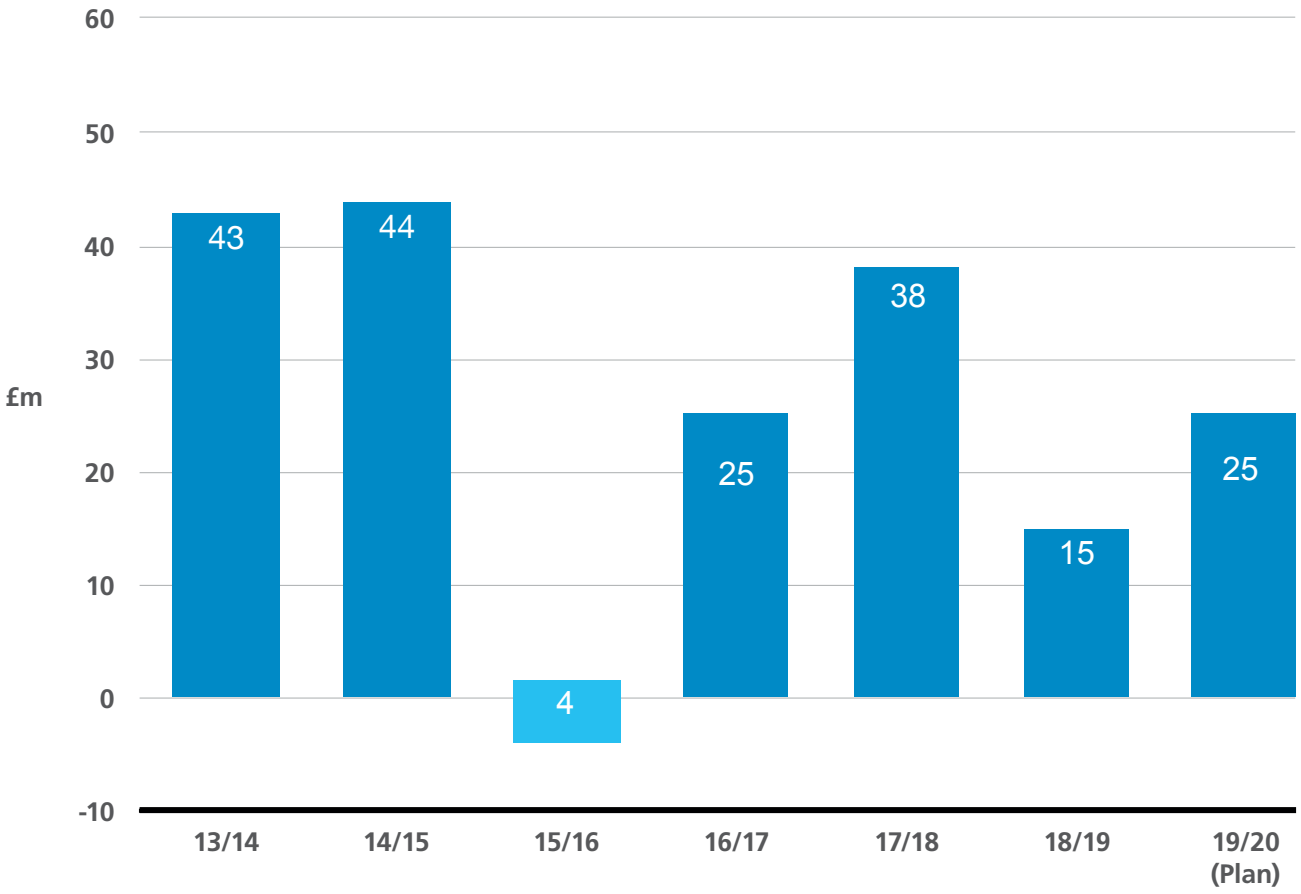
New procurement initiatives have been introduced this year such as running electronic auctions, and steps have been taken to market test estates and facilities contracts. There has been engagement with the national procurement initiatives such as use of the NHS Improvement Purchasing Price Index Benchmark tool, to inform negotiations with suppliers and obtain more competitive prices. However, NUH is not complacent and recognises that there are further opportunities to review its procedures in place to drive down its non-pay costs further.

Overall, the Trust has an ageing estate with a high level of backlog maintenance. This in turn can lead to disruption from plant and asset failure. The Trust has increased its annual capital and revenue expenditure on maintaining and improving its estate and is developing a long-term strategy to renew and modernise its estate.

EBITDA

EBITDA is defined as earnings before interest, tax and dividend. The Trust returned a surplus EBITDA of £14.6m in 18/19, albeit at a lower level than 16/17 and 17/18. It is planned to grow to £25m in 19/20 reflecting a planned financial recovery.

EBITDA (13/14–19/20)

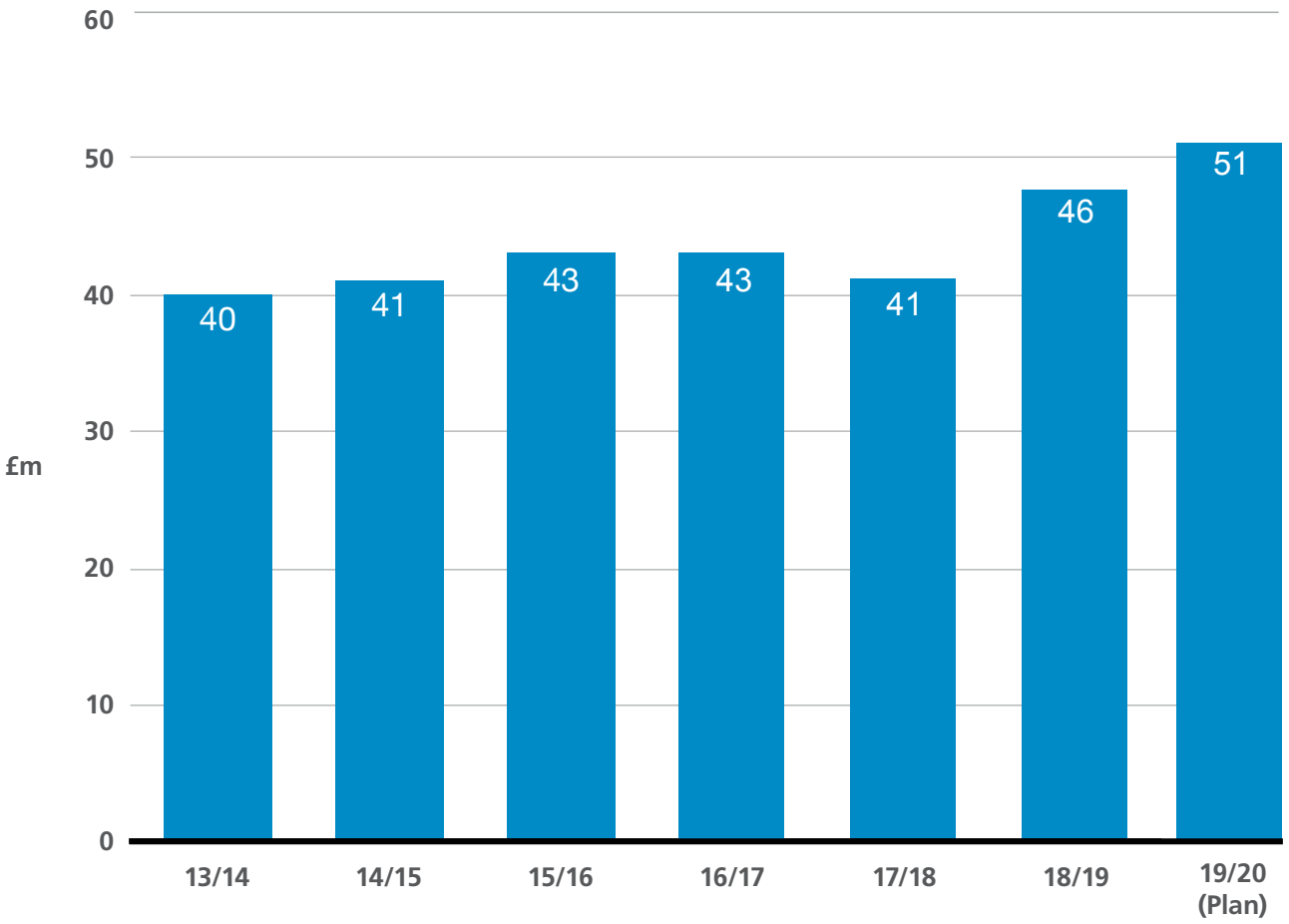


Non-operating items

Non-operating items are an accounting term used to describe those items of income or expenditure that occur outside a company's core day-to-day activities. These types of expenses include depreciation and amortisation charges, dividends, interest payments and interest receipts, corporation tax and profit or loss on the disposal of assets.

Depreciation charges increased by £5.2m mainly as a result of capital investment in recent years being disproportionately weighted towards short life assets (IT and medical equipment in particular), which consequently attract a higher annual depreciation charge. Depreciation provides a fund for asset replacement when they reach the end of their economic life.

Trust non-operating items (13/14–19/20)



Financial efficiency plans

The Trust achieved £40.3m savings against a £41m target, although this included a significant element of non-recurrent schemes (£18.3m).

The table below sets out the savings delivered across the key work streams and divisions.

Work stream	M12 YTD Plan	M12 YTD Actual	M12 YTD Variance
Bed efficiency	3,542	853	-2,689
Medical pay & productivity	2,811	2,795	-16
Medicines management	891	699	-192
Nursing & Midwifery	1,894	2,201	307
Other income	9,871	16,504	6,633
Other non-pay	5,875	2,010	-3,865
Outpatient efficiency	252	136	-117
Procurement	7,055	7,021	-33
Technology	938	924	-14
Theatres efficiency	3,643	745	-2,897
Workforce other	4,220	6,432	2,212
Total	**40,992**	**40,321**	**-671**

Division	M12 YTD Plan	M12 YTD Actual	M12 YTD Variance
Cancer & Associated Specialties	6,513	6,567	54
Clinical Support	7,899	6,619	-1,280
Corporate	2,081	3,726	1,645
Estates and Facilities	2,536	2,823	288
Family Health	6,363	5,553	-810
Medicine	7,954	10,968	3,014
Surgery	7,648	4,065	-3,583
Total	**40,992**	**40,321**	**-671**

NUH has actively engaged with 'Getting It Right First Time' (GIRFT) programme and is looking to identify and secure opportunities for further productivity improvements. Examples highlighted in orthopaedics included a reduction in length of stay for joint replacement procedures, rationalisation of suppliers for joint implants (with cost savings realised) and better utilisation of theatre capacity. NUH hosts a GIRFT clinical Ambassador who provides implementation support and advice to other NHS Trusts within the East Midlands and East of England GIRFT Hub.

The Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 2019 and remains committed to making best use of resources, working with its partners across the health and care system. The CQC undertook a use of resources assessment in December 2018 to understand how effectively the Trust is uses its resources to provide high quality, efficient and sustainable care for its patients.

They concluded that whilst the Trust has made productivity improvements within its workforce and clinical services (for example through improved utilisation of its bed and outpatient capacity), it spends more on pay to deliver activity, and there are several areas for improvement and modernisation of its clinical support services. As a consequence, it rated NUH as 'Requiring Improvement' in its overall use of resources. A number of these issues have been highlighted in more detail elsewhere in this Report.

Corporate Services

The cost of running NUH Corporate Services is relatively lower than most other NHS Trusts. Human Resources and Finance costs are below the national medians and suggest that the NUH has a higher level of efficiency in these back-office functions. There is a two-year partnership agreement in place with Nottingham City Council and Leicestershire County Council for some of the financial transactional services, with a view to share staffing costs and achieves economies of scale in future.

Service line reporting

NUH is also well-advanced in the use of costing data and service line reporting across its service lines. This is used to generate financial reports that are actively used to manage speciality and Divisional financial performance. Costing data is also used to drive more efficient practices across services. NUH is leveraging its costing expertise to identify costs of cross organisational clinical pathways.

The table below presents a summary of the margins achieved by each of the Trust's service lines in 18/19. All frontline clinical service lines delivered financial deficits in 18/19. Despite an expansion and development of the Emergency Department (ED) in 18/19, the key challenge for the Trust continues to be one of capacity (infrastructure and beds) both in terms of optimising the flow of patients through the hospital and accommodating the growing volume and complexity of patients presenting at ED. Both these issues impact upon the Trust's ability to meet the four-hour emergency access standard itself and maximise the use of its bed stock to ensure that specialties have an appropriate bed-base to meet demand.

Service line	18/19 Margin – Surplus (Loss) £m	17/18 Margin – Surplus (Loss) £m	16/17 Margin – Surplus (Loss) £m	15/16 Margin – Surplus (Loss) £m	14/15 Margin – Surplus (Loss) £m
Emergency pathway	(23.1)	(14.1)	(25.0)	(29.1)	(22.7)
Cancer	(1.2)	(2.6)	4.5	(1.6)	(2.1)
Planned care	(20.7)	(13.8)	(11.4)	(10.2)	(2.4)
Family Health	(5.9)	(8.2)	(11.5)	(12.5)	(1.7)
Support services (Diagnostics, Theatres and Critical Care)	5.5	2.5	0.6	3.8	2.0
Central and Corporate (includes non-recurrent funding)	13.5	33.5	22.3	1.6	26.9
Pharmacy Company (HPSN)	0.1	0.5	0.4	0.8	0.8
Total	**(31.8)**	**(2.2)**	**(20.1)**	**(47.2)**	**0.8**

The use of this margin information for each service line is critical in signposting the way to a more sustainable financial future for the Trust, alongside the use of benchmarking tools like the Model Hospital.

Property valuation

A full site revaluation of Trust property was been completed by its valuers, Gerald Eve, which resulted in land and building values increasing by 6.2% in 18/19.

Capital investment programme

As one of its core financial statutory duties, the Trust is not allowed to incur more capital expenditure than its capital resource limit set by the Department of Health and Social Care.

During the year, the Trust completed over £44m of capital investments which ensured that delivery of care continued to take place in the best possible clinical environment using the modern equipment and facilities.

A summary of the capital investment undertaken in the year is provided in the table below:

Capital investment scheme	Benefits	Value in 18/19 (£m)
Minor medical equipment replacement	Replacement of medical equipment that has reached the end of its useful life to modernise services	5.3
Major medical equipment schemes	X-ray rooms, Cath Lab replacement, Gamma Camera, MRI, etc	3.6
iOS devices	Replacement of ageing incompliant devices to continue to drive the clinical benefits of the Nervecentre products. To reduce issues around incompliant iOS devices and improve security; better control can be applied to mobile devices that are compatable, which means less compliancy issues for core mobile applications and reduces the risk of security vulnerabilities for considered legacy operating items	2.0
ICT – SAN replacement	Planned replacement of SAN storage and backup solutions.	1.8
Other IT investment	Hardware and software additions improving clinical and corporate information and services	4.4
Estates regulatory compliance	Improvements to buildings and infrastructure, patient environments and health and safety compliance	13.4
City – Brachytherapy Facility	Relocation of brachytherapy at City Hospital to release a spare bunker for the Linac replacement programme	0.5
Seedcom developments	Capital investment to improve services and save revenue monies	0.6
Modular theatres	Decant theatres used for theatre modernisation programme, including Theatres 18-19 to incorporate the inter-operative MRI and the upgrade of the ventilation to Theatres 1-17	4.1
City – St Francis step down beds	Developing two wards within the empty St Francis unit at City Hospital to provide step down accommodation for patients medically safe for transfer requiring further assessment	1.9
QMC – ED expansion	Front Door redesign project, including the creation of dedicated Children's ED entrance, additional works to current Fracture Clinic waiting area to turn it into new ED entrance and First Contact area, improvements to medicine and surgery wards to support the winter bed capacity ward moves, etc	4.5
Other developments	Small schemes, including those funded from charitable donations	2.8
Total capital expenditure		**44.9**
Book value of assets disposed of		(0.1)
Charitable income		(1.2)
Total capital expenditure		**43.6**
Capital Resource Limit (CRL)		**43.7**
CRL underspend		**0.1**

Better payments performance (BPPC)

All providers are required to pay their suppliers promptly, by ensuring that payments are made within 30 days of receipt of each invoice for 95% of invoices. The Trust achieved 84% of the value of invoices processed, which still benchmarks in the upper quartile of all providers.

Post balance sheet events

The Trust has agreed a contract with CCGs to run the Nottingham NHS Treatment Centre for five years from 29 July 2019.

Financial outlook

Despite achieving an improvement in the previous year, NUH's deficit position worsened in 18/19 to £31.8m, which was £39.7m worse than the planned annual surplus of £7.9m. NUH has previously demonstrated a record of strong financial performance, delivering balanced financial positions or better in the nine years up to 14/15. Over the course of the last four years, like all acute providers, the Trust has faced a much tougher trading environment, as the NHS been exposed to unprecedented operational and financial pressures, such that the Trust has incurred cumulative losses over this period of £101.3m (15/16 to 18/19). However, the underlying pre-STF financial performance has remained relatively stable over the last four years, with an expected improvement in 19/20 comparable with the level of performance attained in 17/18. In each of these years (with the exception of 18/19), the Trust has also delivered its financial control total agreed with NHS Improvement (NHSI).

The Trust has undergone a period of financial recovery. 18/19 had represented the third year of a three-year plan to return the Trust to financial balance, but a combination of factors contributed to the deficit, including under delivery and loss of elective income and unplanned costs associated with keeping escalation beds open throughout the year to ease bed pressures, associated with higher than planned non elective admissions.

A range of financial recovery interventions were put in place in the final quarter of 18/19 which included strengthening of CIP delivery structures, a more robust expenditure control environment and income improvement schemes. These included improved activity capture and income billing, and making use of income generating opportunities for example, pharmacy manufacturing, catering services and research and development.

One of the main issues for the Trust to address in 19/20 is the imbalance in the growth in expenditure relative to income growth. In simple terms the Trust spent more money delivering additional work than it earned to pay for it. The need for greater control of pay and non-pay costs has been signposted by the CQC use of resources assessment and other benchmarking tools. The requirement to deliver an efficiency plan of 337m and have sufficient capacity (beds and staffing) to meet its contract with its commissioners, which is able to support delivery of the control total, present the key strategic performance and financial challenges for 19/20.

The Trust has developed a detailed plan in 19/20 that has been built with the full engagement with clinical leadership and is aligned to the key strategic objectives of improving our performance in the key domains of emergency care pathway and financial performance

The Trust has been set a control total (before conditional funding) of £27m deficit.

Significant progress had been made in developing the detail of the annual plan, particularly around understanding the capacity constraints facing the Trust and also in negotiating contracts with key commissioners. There are still inherent risks to delivery of the plan in particular creating additional capacity (and the associated workforce) and delivering an efficiency programme sufficient to meet the financial control total.

However, having reviewed the detail plan and following discussions with partners in the healthcare system who agreed to the release of transformation funding to the Trust, the Board agreed to sign off the plan and accept the pre-PSF control deficit total of £27m, which if achieved would allow the Trust to access to £27m of PSF funds to secure an overall break-even position in 19/20.

By working with its ICS partners and agreeing to accept the control total, this in turn has allowed the Nottinghamshire ICS financial plan to be triangulated and the system control total to be accepted in totality, which will allow the ICS access to national ICS transformation funds (circa £6m allocated to the Nottinghamshire system).

The Board has agreed to a contract with local commissioners that moves away from payment by results and introduces more financial certainty for both parties, while trying to incentivise action that avoids emergency admissions to the Trust. Heads of Terms have been agreed, but further work is required on the detailed risk share agreement to ensure it does not pass an unacceptable level of risk to the Trust.

The Trust's operational plan is dependent on closing the estimated capacity gap (estimated at up to 249 beds) which will require additional capital investment, including a new ward, new theatre, upgrades to our adult and paediatric critical care facilities and moving patients in our acute bed stock into the newly-refurbished St Francis wards at City Hospital.

These additional facilities would enable a number of service moves that will create better clinical adjacencies, improve pathway efficiency and significantly increase the number of acute medical beds at QMC, therefore supporting the step change we are planning in emergency care.

Initial assessment suggests this may require up to £16m of additional investment and the Trust is in discussion with NHSI as to how this investment could be funded, which could include accessing STP wave four funding, but also involves consideration of other mitigation plans. A key risk is that any capital funding will not be available in a timely enough manner to deliver the required capacity in time to impact our performance over the 19/20 winter period.

The capital plan for 19/20 planning process is £64.9m. The capital funds available to the Trust are from internally generated sources (depreciation) are £31.4m for 19/20 and will be supplemented by £3.6m of National Rehabilitation Centre business case development funding, capital investment loan funding for our ward renewal programme (phase one), £16m additional central capital funding and £3.3m of grants and donations (to fund dedicated iMRI equipment and other charity-funded schemes). Further funds to supplement our capital objectives can only come from business cases to national bodies (NHSI, DHSC etc). The 19/20 capital programme focuses on reducing significant Trust risks which are associated with capacity gaps, estates clinical safety and replacement of ageing medical equipment.

The Trust has undertaken capacity and demand modelling which outlines significant growth in activity is required to enable to the Trust to meet the constitutional standards. This has creates a pressing need to ensure the Trust has sufficient capacity across the entire estate in particular ward, theatre and critical care capacity, in order to deliver the planned activity for 19/20.

The Trust continues to develop our long-term estates plans, aligned to the STP Clinical Service Strategy for Nottingham and Nottinghamshire, which will enable us to secure a sustainable future for healthcare services across Nottinghamshire.

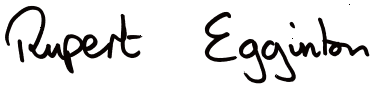
In conclusion

The Accounts have been prepared on a 'going concern' basis. It is reasonable for the Directors of NUH to conclude that the clinical services provided by NUH will continue in the future, as evidenced by inclusion of financial provision for these services in the Annual Report and Accounts, providing sufficient evidence of going concern.

This is supported by the 19/20 annual plan, which is aligned to delivery of the financial control total recognising that there remain risks in delivery of this plan. The Trust have will adequate resources to continue as a going concern for at least 12-months from the annual report and accounts submission deadline. The Trust will continue to operate within the NHS Finance regime from a cash perspective through a combination of its existing internal working capital and financial support offered by the DHSC, linked to its agreed I&E plan. NUH remains a going concern and has taken steps to ensure this remains the case. The Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 2019 and remains committed to making best use of resources, working with its partners across the health and care system.

We remain committed to sustainable financial recovery and returning to recurrent financial balance as soon as we can. This can only be achieved by working with our partners across the integrated health and care system to make the best use of the collective resources we have our disposal.

The Trust and the wider integrated care system remains committed to developing a fully integrated and effective care system within a financial system control total.



Rupert Egginton
Chief Financial Officer

23 May 2019

4 – 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 18/19 Group Accounting Manual issued by the Department of Health and Social Care. They represent a "true and fair view" of the Trust's activity in 18/19, are materially accurate and contain no misstatements or errors of such magnitude that they would mislead the reader with regard to the financial standing of the Trust.

The Trust is required to disclose related undertakings as required by the section 409 of the Companies Act 2006. Hospital Pharmacy Services Nottingham (HPSN) Limited is a wholly owned subsidiary of Nottingham University Hospital. The Accounts are presented for both the "Group" and "Trust", in accordance with the Group accounting standards (IFRS 10).

External auditors

The Trust 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, Quality Accounts and review of the Trust arrangements for securing economy, efficiency and effectiveness in our use of resources (value for money). KPMG charged a fee of £105,100 (excluding VAT) for the statutory audit and £19,400 (excluding VAT) for the Quality Accounts.

Non-audit services from KPMG in 18/19 were £3,750 (excluding VAT) to provide assurance over the Innovate Grant return.

Annual Governance Assurance Statement

The Annual Governance Assurance Statement is printed in full in the Trust's 18/19 Annual Accounts.

Fraud awareness

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

5 – Foreword to the accounts

The Accounts for the year ended 31 March 2019 have been prepared by Nottingham University Hospitals 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.

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

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

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

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

Signed

Tracy Taylor
Chief Executive

23 May 2019

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, recognised gains and losses 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

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

Tracy Taylor
Chief Executive

23 May 2019

Rupert Egginton
Chief Financial Officer

23 May 2019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Nottingham University Hospitals
NHS
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Annual Accounts 18/19

Statement of comprehensive income for year ended 31 March 2019

		Group	
		2018/19	2017/18
	Note	£000	£000
Operating income from patient care activities	3	891,002	840,299
Other operating income	4	130,950	147,200
Operating expenses	7	(1,045,766)	(968,584)
Operating surplus/(deficit) from continuing operations		**(23,814)**	**18,915**
Finance income	12	248	79
Finance expenses	13	(3,593)	(3,155)
PDC dividends payable		(11,337)	(11,314)
Net finance costs		**(14,682)**	**(14,390)**
Other gains / (losses)	14	95	(126)
Corporation tax expense		(30)	(122)
Surplus/(deficit) for the year from continuing operations		**(38,431)**	**4,277**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	16	-	-
Surplus/(deficit) for the year		**(38,431)**	**4,277**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(8,055)	(240)
Revaluations	24	33,095	19,506
Total comprehensive income/(expense) for the period		**(13,391)**	**23,543**
Surplus/(deficit) for the period attributable to:			
Nottingham University Hospitals NHS Trust		(38,431)	4,277
TOTAL		**(38,431)**	**4,277**
Total comprehensive income/(expense) for the period attributable to:			
Nottingham University Hospitals NHS Trust		(13,391)	23,543
TOTAL		**(13,391)**	**23,543**
Adjusted financial performance (control total basis):			
Surplus/(deficit) for the period		(38,431)	4,277
Remove net impairments not scoring to the Departmental expenditure	8	6,717	(7,296)
Remove I&E impact of capital grants and donations		(57)	759
Adjusted financial performance surplus / (deficit)		**(31,771)**	**(2,260)**
Provider sustainability/sustainability and transformation fund income (PSF/STF)	4	(11,767)	(28,505)
Adjusted financial performance excluding PSF (against Control Total)		**(43,538)**	**(30,765)**

Statement of Financial Position

	Note	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Non-current assets					
Intangible assets	17, 18	14,591	16,307	14,591	16,307
Property, plant and equipment	19, 20	531,571	498,313	531,571	498,313
Receivables	29	5,672	5,526	5,672	5,526
Total non-current assets		**551,834**	**520,146**	**551,834**	**520,146**
Current assets					
Inventories	28	22,066	21,690	20,175	19,736
Receivables	29	66,760	69,689	68,839	71,428
Cash and cash equivalents	32	25,127	13,360	23,952	13,238
Total current assets		**113,953**	**104,739**	**112,966**	**104,402**
Current liabilities					
Trade and other payables	33	(125,156)	(97,117)	(127,268)	(99,758)
Borrowings	35	(31,027)	(20,931)	(31,027)	(20,931)
Provisions	38	(1,881)	(1,913)	(1,881)	(1,913)
Other liabilities	34	(15,859)	(14,503)	(15,859)	(14,503)
Total current liabilities		**(173,923)**	**(134,464)**	**(176,035)**	**(137,105)**
Total assets less current liabilities		**491,864**	**490,421**	**488,765**	**487,443**
Non-current liabilities					
Borrowings	35	(89,234)	(81,369)	(89,234)	(81,369)
Provisions	38	(2,715)	(3,050)	(2,715)	(3,050)
Total non-current liabilities		**(91,949)**	**(84,419)**	**(91,949)**	**(84,419)**
Total assets employed		**399,915**	**406,002**	**396,816**	**403,024**
Financed by					
Public dividend capital		421,727	414,423	421,727	414,423
Revaluation reserve		97,053	75,471	97,053	75,471
Income and expenditure reserve		(118,865)	(83,892)	(121,964)	(86,870)
Total taxpayers' equity		**399,915**	**406,002**	**396,816**	**403,024**

The notes on pages 79 to 125 form part of these accounts.

Mrs Tracy Taylor
Chief Executive
23 May 2019

Statement of Changes in Equity for the year ended 31 March 2019

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**414,423**	**75,471**	**(83,892)**	**406,002**
Surplus/(deficit) for the year	-	-	(38,431)	**(38,431)**
Other transfers between reserves	-	(3,458)	3,458	**-**
Impairments	-	(8,055)	-	**(8,055)**
Revaluations	-	33,095	-	**33,095**
Public dividend capital received	7,304	-	-	**7,304**
Taxpayers' and others' equity at 31 March 2019	**421,727**	**97,053**	**(118,865)**	**399,915**

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**411,054**	**59,019**	**(90,983)**	**379,090**
Surplus/(deficit) for the year	-	-	4,277	**4,277**
Other transfers between reserves	-	(2,814)	2,814	**-**
Impairments	-	(240)	-	**(240)**
Revaluations	-	19,506	-	**19,506**
Public dividend capital received	3,369	-	-	**3,369**
Taxpayers' and others' equity at 31 March 2018	**414,423**	**75,471**	**(83,892)**	**406,002**

Statement of changes in equity for the year ended 31 March 2019

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**414,423**	**75,471**	**(86,870)**	**403,024**
Surplus / (deficit) for the year	-	-	(38,552)	**(38,552)**
Other transfers between reserves	-	(3,458)	3,458	**-**
Impairments	-	(8,055)	-	**(8,055)**
Revaluations	-	33,095	-	**33,095**
Public dividend capital received	7,304	-	-	**7,304**
Taxpayers' and others' equity at 31 March 2019	**421,727**	**97,053**	**(121,964)**	**396,816**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**411,054**	**59,019**	**(93,444)**	**376,629**
Surplus / (deficit) for the year	-	-	3,760	**3,760**
Other transfers between reserves	-	(2,814)	2,814	**-**
Impairments	-	(240)	-	**(240)**
Revaluations	-	19,506	-	**19,506**
Public dividend capital received	3,369	-	-	**3,369**
Taxpayers' and others' equity at 31 March 2018	**414,423**	**75,471**	**(86,870)**	**403,024**

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.

Statement of Cash Flows

	Note	Group 2018/19 £000	Group 2017/18 £000	Trust 2018/19 £000	Trust 2017/18 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(23,814)	18,915	(24,003)	18,408
Non-cash income and expense:					
Depreciation and amortisation	7	31,655	26,426	31,655	26,426
Net impairments	8	6,717	(7,204)	6,717	(7,204)
Income recognised in respect of capital donations	4	(1,235)	(383)	(1,235)	(383)
(Increase) / decrease in receivables and other assets		3,517	(17,002)	3,242	(17,022)
(Increase) / decrease in inventories		(376)	(890)	(439)	(273)
Increase / (decrease) in payables and other liabilities		26,735	14,660	26,086	15,108
Increase / (decrease) in provisions		(370)	(1,277)	(370)	(1,277)
Corporation tax paid		(123)	(94)	-	-
Net cash flows from operating activities		**42,706**	**33,151**	**41,653**	**33,783**
Cash flows from investing activities					
Interest received		248	79	248	79
Purchase of intangible assets		(4,893)	(6,177)	(4,893)	(6,177)
Purchase of PPE		(36,965)	(29,034)	(36,965)	(29,034)
Sales of PPE		157	169	157	169
Receipt of cash donations to purchase assets		1,102	276	1,102	276
Net cash flows used in investing activities		**(40,351)**	**(34,687)**	**(40,351)**	**(34,687)**
Cash flows from financing activities					
Public dividend capital received		7,304	3,369	7,304	3,369
Movement on loans from DHSC		20,033	12,829	20,033	12,829
Capital element of finance lease rental payments		(1,849)	(122)	(1,849)	(122)
Capital element of PFI and other service concession payments		(519)	(483)	(519)	(483)
Interest on DHSC loans		(1,386)	(1,297)	(1,386)	(1,297)
Other interest	13.1	(11)	(5)	(11)	(5)
Interest paid on finance lease liabilities		(254)	(12)	(254)	(12)
Interest paid on PFI and other service concession obligations		(1,835)	(1,804)	(1,835)	(1,804)
PDC dividend paid		(12,071)	(10,860)	(12,071)	(10,860)
Net cash flows from financing activities		**9,412**	**1,615**	**9,412**	**1,615**
Increase in cash and cash equivalents		**11,767**	**79**	**10,714**	**711**
Cash and cash equivalents at 1 April - brought forward		**13,360**	**13,281**	**13,238**	**12,527**
Cash and cash equivalents at 31 March	32	**25,127**	**13,360**	**23,952**	**13,238**

NOTES TO THE ACCOUNTS

Note 1: Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care (DHSC) has directed that the financial statements of the Trust shall meet the accounting requirements of the DHSC Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 18/19 issued by the DHSC. 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.

Note 1.1.1 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

The accounts for both the Trust and its subsidiary Hospital Pharmacy Services (Nottingham) Limited have been prepared on a going concern basis. International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The Government Financial Reporting Manual advises that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. An assessment of the Trust's position under the HM Treasury's Financial Reporting Guidelines (FReM), issued for the interpretation of paragraphs 25 to 26 of IAS1 for the public sector context, has been undertaken. It is the Trust's view under this guidance that these accounts can be prepared on a going concern basis. The Trust Board has carefully considered the principle of 'Going Concern' in the context of the Trust continuing to operate under the FReM.

For the year ending 31 March 2019, the Trust is reporting a post Provider Sustainability Funding (PSF) deficit of £31.8m (on an adjusted financial performance (*control total*) basis), which represented an adverse variance from plan of £39.7m. The deficit before PSF was £43.5m, which represented an adverse variance from plan of £18.7m. In order to address the cash shortfall arising from this deficit for the year, the DHSC provided the Trust with new revenue loans of £52.9m, whilst repaying £31.6m of revenue loans drawn down in prior years. For 19/20, NHS Improvement (NHSI) has set a break even control total, after planned receipt of £27m of PSF income. The Trust Board has agreed a financial plan aligned to delivery of this control total and included within this is a cost improvement plan of £37m. Although the Trust plans to deliver a break-even position, due to the phasing of this plan and the timing of receipt of PSF funding, in particular, it will require the support of new revenue loans from DHSC during the year of up to £43m (including £27.2m to cover a scheduled loan repayment). However, given the requirement to deliver an overall break-even position, the Trust is anticipating that it will repay most of these revenue loans drawn down in 19/20 up to £42.2m to DHSC by 31 March 2020, including loans drawn down in prior years that will reach maturity in 19/20. The net drawing of £0.8m reflects the expected timing of quarter 4 PSF (paid in 20/21) offset by the £8.3m 18/19 PSF that will be received in 19/20. The Trust also plans to draw down capital loans of up to £14.2m to finance its capital programme, although it is anticipated that £3.6m of this will ultimately be converted to PDC capital, in relation to funding for the National Rehabilitation Centre.

The Trust Board has concluded that whilst the financial position for 19/20 is very challenging and there remain inherent risks in delivering the plan, notably around capacity constraints and the financial efficiency programme, they have accepted the 19/20 control total issued by our regulator NHSI. The Trust will have adequate resources to continue as a going concern and providing services to patients for at least 12-months from the date of the 18/19 annual report and accounts submission. The Trust will continue to operate within the NHS Finance regime from a cash perspective through a combination of its existing internal working capital and financial support offered by the DHSC, linked to its agreed Income and Expenditure plan. The Trust remains a going concern and has taken steps to ensure this remains the case. The Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 2019 and remains

committed to making best use of resources, working with its partners across the health and social care system during the new financial year.

Note 1.3 Consolidation

Charitable Funds

The Trust's Charity (NUH Charity) is an independent Section 11 Charity with its own Trustees. The Trust does not exercise control or influence over the NUH Charity. The balances in the NUH Charity are also immaterial to the Trust. The Trust has therefore chosen not to consolidate the NUH Charity accounts with the Trust Accounts.

Subsidiaries

The Trust has only one subsidiary, Hospital Pharmacy Services (Nottingham) Limited, trading as Trust Pharmacy, which is wholly owned. There is therefore no minority interest. This is a private company limited by shares which was incorporated on 4 April 2012, to deliver outpatient pharmacy dispensing services from QMC and City Hospital.

In separating outpatient from inpatient pharmacy services both the Trust and the company can focus their pharmacy teams on one core activity whilst benefiting from a sharing of skills and knowledge across the two organisations. The company will strive to secure optimum value for money and continued quality and safety for its services. The model seeks to provide cost improvements by taking the best from the NHS in high quality clinical skills and practices and a deep knowledge base, but also from the commercial sector in driving through efficiency savings, seeking new revenue opportunities, focussing on the customer and exploiting innovative ideas.

The subsidiaries' accounting policies are aligned with those of the Trust. The results from the subsidiary, which shares the same accounting periods, are consolidated in the results of the NUH Group. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

Note 1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

Note 1.4.1 Critical judgements in applying accounting policies

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

Note 1.4.2 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.

The estimate of the required level of provision is performed by the Trust on a case by case basis using the best information available at the time. The liability provided for at 31 March 2018 was £4,963,000. The liability provided for at 31 March 2019 is £4,596,000.

Due to the nature of the obligations to make provisions, amounts are uncertain and hence final settlement figures may vary from those provided for in the accounts.

Note 1.5 Transfers of functions to/from other NHS bodies

There have been no transfers between the Trust and other NHS bodies.

Note 1.6 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Trust.

Note 1.7 Income

Note 1.7.1 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). As directed by the GAM, the transition to IFRS 15 in 18/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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 obligation satisfied in that year. Where the Trust's entitlement to consideration for those goods or services in 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 is received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of IRFS 15 entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year-end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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.

NHS injury cost recovery (ICR) 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 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.

Revenue from Education and Training

As a large acute teaching hospital, the Trust generates significant research and education revenues from a range of funding sources and contracts, a number of which span more than one year. Trust contracts in this regard have been systematically reviewed to ensure that income is recognised in the appropriate financial year, in proportion to the benefits provided by the Trust and received by the customer (including National Institute for Health Research Comprehensive Research Network (NIHRCRN), drug companies and other research partners) as they are performed. These include the Learning and Development Agreement (LDA) with Health Education England (HEE), commercial and non-commercial clinical trials, DHSC collaborative research network and hosted contract arrangements, such as the Academic Health Sciences Network (AHSN).

Note 1.7.2 Revenue grants and other contributions to expenditure

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.

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, the corresponding notional expense is also recognised at the point of recognition of the benefit.

Note 1.7.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Non-patient care services to other bodies

The Trust provides non-patient care services to other non-NHS bodies such as Circle Health Limited at the Treatment Centre at QMC.

Note 1.8 Expenditure on employee benefits

1.8.1 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.

1.8.2 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. The schemes are an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies allowed under the direction of Secretary of State 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.

Employer's pension cost 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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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 Services received

The cost of services received in the year is recorded under the relevant expenditure headings within 'operating expenses.

Note 1.11 Property, plant and equipment

Note 1.11.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.11.2 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.

All 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.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided. City Hospital has been revalued using Gedling as a suitable alternative site.

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.

1.11.3 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.

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.

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 income.

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.

Note 1.11.4 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- The sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it

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. 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.

Note 1.11.5 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 purchased items of property, plant and equipment.

Note 1.11.6 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of

the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.11.7 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	Max life
	Years	Years
Buildings, excluding dwellings	2	95
Plant & machinery	1	15
Transport equipment	1	7
Information technology	1	5
Furniture & fittings	1	10

Finance-leased assets (including land) are depreciated over the shorter of the useful 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 in the table above.

Note 1.12 Intangible assets

Note 1.12.1 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; and where the cost is at least £5,000.

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 only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- The trust intends to complete the asset and sell or use it
- The trust has the ability to sell or use the asset
- How the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- Adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- The trust can measure reliably the expenses attributable to the asset during development.

Software

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

Note 1.12.2 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 under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.12.3 Useful economic life of intangible assets

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

	Min life	Max life
	Years	Years
Development expenditure	1	5
Software licences	1	5

Note 1.13 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 with the exception of both theatre and pharmacy stocks where a weighted average cost method is employed as permitted by IAS 2 - Inventories.

Note 1.14 Investment properties

The Trust does not have any investment properties.

Note 1.15 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 1.16 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory "cap" and trade scheme for non-transport CO2 emissions. The Trust has opted out of this scheme by participating in the European Union Emissions Trading Scheme (EUETS) which operates on similar principles.

Note 1.17 Financial assets and financial liabilities

Note 1.17.1 Recognition

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

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.

Note 1.17.2 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 finance leases are recognised and measured in accordance with the accounting policy for leases.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities measured at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the DHSC, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

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 one) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage two).

HM Treasury has ruled that central government bodies may not recognise stage one or stage two impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage one or stage two impairments against these bodies. Additionally, the DHSC provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage one or stage two impairments against these bodies.

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.

Note 1.17.3 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.18 Leases

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.

Note 1.18.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.18.2 The Trust as lessor

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

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

Note 1.19 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of positive 0.76% (17/18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date
- A nominal medium-term rate of positive 1.14% (17/18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date
- A nominal long-term rate of positive 1.99% (17/18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date
- A nominal very long-term rate of positive 1.99% (17/18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40-years from the Statement of Financial Position date

All 18/19 percentages are expressed in nominal terms with 17/18 being the last financial year that HM Treasury provided real general provision discount rates.

Note 1.20 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 contribution is charged to expenditure. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 38.3 but is not recognised in the Trust's accounts.

Note 1.21 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 1.22 Contingent liabilities and contingent assets

A contingent liability is:

- A possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or
- A present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Note 1.23 PFI assets, liabilities and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs'

within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

Note 1.23.1 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Note 1.23.2 Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Note 1.23.3 Other assets contributed by the Trust to the operator

Other assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, where these are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Note 1.23.4 Off Statement of Financial Position PFI schemes

Where the Trust has a PFI scheme that is judged to fall outside IFRIC 12 the scheme is accounted for as a lease under IFRIC 4 and IAS 17. Any assets of the Trust transferred to the operator continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Where the scheme is adjudged to take the nature of an operating lease the full charge from the operator is charged to the relevant expense category within the Statement of Comprehensive Income. Any assets constructed or purchased by the operator as part of the scheme remain the property of the operator.

Note 1.24 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.

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the DHSC as PDC 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, except for:
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the DHSC (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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.25 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 1.26 Corporation tax

The only Corporation Tax liability arises in the subsidiary company accounts for Hospital Pharmacy Services (Nottingham) Ltd. The company qualifies for the small company rate of Corporation Tax which is 19% (19% - 17/18) throughout the financial year to which these accounts relate.

The Trust has no income which is liable to Corporation Tax.

Note 1.27 Foreign exchange

The functional and presentational currency of the Trust is sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date then:

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

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenditure in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.28 Third party assets

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

Note 1.29 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, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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 1.30 Gifts

The Trust has made no gifts during the year.

Note 1.31 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 18/19.

Note 1.32 Standards, amendments and interpretations in issue but not yet effective or adopted

The following list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 18/19.

IFRS 14 Regulatory Deferral Accounts

Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 16 Leases

Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 23 Uncertainty over Income Tax Treatments

Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

The analysis by business segment is presented in accordance with IFRS 8 Operating segments, on the basis of those segments whose operating segments are regularly reviewed by the Board (the Chief Operating Decision Maker as defined by IFRS 8), as follows:

	Trust		HPSN Ltd		Consolidated	
	18/19	17/18	18/19	17/18	18/19	17/18
	£000	£000	£000	£000	£000	£000
Income	1,021,755	987,304	197	195	1,021,952	987,499
Surplus/(Deficit)	(38,552)	3,758	121	519	(38,431)	4,277
Net Assets:						
Segment net assets	396,816	403,024	3,099	2,978	399,915	406,002

Hospital Pharmacy Services Nottingham Limited (HPSN Ltd), trading as Trust Pharmacy, is wholly owned by the NUH and is a separate operating segment.

The income of HPSN Ltd in 18/19 is £29.379m, of which £29.181m is from NUH (99.3%).

The comparative figures for 17/18 are £29.562m of which £29.368m (99.3%) is from NUH.

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 1.7.1

Note 3.1 Income from patient care activities (by nature)

	18/19 £000	17/18 £000
Acute services		
Elective income	141,068	132,582
Non elective income	255,901	242,358
First outpatient income	39,092	28,148
Follow up outpatient income	72,276	80,617
A & E income	27,900	25,725
High cost drugs income from commissioners (excluding pass-through costs)	105,531	101,272
Other NHS clinical income	214,312	199,500
Community services		
Income from other sources (e.g. local authorities)	5,138	5,698
All services		
Private patient income	2,296	2,512
Agenda for Change pay award central funding	10,065	-
Other clinical income	17,423	21,887
Total income from activities	**891,002**	**840,299**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	18/19 £000	17/18 £000
NHS England	384,742	363,714
Clinical commissioning groups	479,839	458,976
Department of Health and Social Care	10,088	7
Other NHS providers	3,043	4,563
NHS other	578	197
Local authorities	5,243	5,698
Non-NHS: private patients	1,790	1,914
Non-NHS: overseas patients (chargeable to patient)	506	598
Injury cost recover scheme	4,335	4,170
Non NHS: other	838	462
Total income from activities	**891,002**	**840,299**
of which:		
Related to continuing operations	891,002	840,299
Related to discontinued operations	-	-

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

	18/19 £000	17/18 £000
Income recognised this year	506	598
Cash payments received in-year	-	116
Amounts added to provision for impairment of receivables	-	118
Amounts written off in-year	64	177

Note 4 Other operating income (group)

	18/19 £000	17/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	26,365	27,350
income)	42,484	42,332
Non-patient care services to other bodies	18,325	17,576
(PSF/STF)	11,768	28,505
Income in respect of employee benefits accounted on a gross basis	6,859	6,636
Other contract income	19,476	20,152
Other non-contract operating income:		
Education and training - notional income from apprenticeship fund	670	87
Receipt of capital grants and donations	1,235	383
Charitable and other contributions to expenditure	2,914	3,373
Rental revenue from operating leases (see note 11.1)	854	806
Total other operating income	**130,950**	**147,200**
of which:		
Related to continuing operations	130,950	147,200
Related to discontinued operations	-	-

Note 5

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	18/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	4,775
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	1,353
after one year, not later than five years	7,573
after five years	276
Total revenue allocated to remaining performance obligations	**9,202**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Profits and losses on disposal of property, plant and equipment

The Trust disposed of medical equipment. The sales proceeds of £157k (Statement of Cash Flows) were received and the Net Book Value of the equipment assets disposed was £62k (note 19.1 PPE) resulting in a profit on loss on disposal of £95k (note 14 Other gains/(losses)).

Note 6

Note 6.1 Feed 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.

	18/19	17/18
	£000	£000
Income	4,205	3,483
Full cost	(4,227)	(3,634)
Surplus/(deficit)	**(22)**	**(151)**

Note 7 Operating expenses (Group)

	18/19 £000	17/18 £000
Purchase of healthcare from NHS and DHSC bodies	6,708	4,203
Purchase of healthcare from non-NHS and non-DHSC bodies	2,128	1,478
Staff and executive directors costs	634,729	595,826
Remuneration of non-executive directors	73	71
Supplies and services - clinical (excluding drugs costs)	125,043	118,627
Supplies and services - general	7,257	9,145
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	107,163	103,180
Inventories written down (see note 45)	361	345
Consultancy costs	1,484	991
Establishment	8,434	8,446
Premises	29,217	27,263
Transport (including patient travel)	5,030	4,562
Depreciation on property, plant and equipment (see note 19 CY and note 20 PY)	25,046	20,761
Amortisation on intangible assets (see note 17 CY and 18 PY)	6,609	5,665
Net impairments (see note 8)	6,717	(7,204)
Movement in credit loss allowance: contract receivables / contract assets *	1,118	-
Movement in credit loss allowance: all other receivables and investments *	-	750
Change in provisions discount rate(s)	(56)	45
Audit fees payable to the external auditor		
audit services- statutory audit (including VAT)	128	126
other auditor remuneration (external auditor only)	28	37
Internal audit costs	211	185
Clinical negligence	30,652	32,739
Legal fees	621	274
Insurance	780	698
Research and development	27,178	24,665
Education and training	5,216	2,669
Rentals under operating leases (note 11.2)	1,479	1,500
Redundancy	174	226
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	4,924	4,798
Charges to operating expenditure for off-SoFP PFI schemes	4,701	4,995
Car parking & security	179	125
Hospitality	171	149
Losses, ex gratia & special payments (see note 45)	293	449
Other	1,970	795
Total	**1,045,766**	**968,584**
of which:		
Related to continuing operations	1,045,766	968,584
Related to discontinued operations	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 7.1 Other auditor remuneration (Group)

	18/19 £000	17/18 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	28	37
Total	**28**	**37**

Note 7.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £0.2m (17/18: £0.2m).

Note 8 Impairment of assets (Group)

	18/19 £000	17/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	92
Unforeseen obsolescence	2,754	-
Changes in market price	3,963	(7,296)
Total net impairments charged to operating surplus / deficit	**6,717**	**(7,204)**
Impairments charged to the revaluation reserve	8,055	240
Total net impairments	**14,772**	**(6,964)**

A Full Valuation of the Trust's Property estate was conducted by Gerald Eve LLP an independent firm of professional valuers . A number of properties inspected revealed advanced obsolescence - with some nearing 100%. For avoidance of doubt, these properties included:

- The Boiler House / Waste Incinerator (C190) £0.6m;
- St. Francis Admin (C123) £0.5m;
- Sherwood Function Hall (C155) £0.3m;
- Hospital Headquarters (C154) £0.3m;
- HR and Conference rooms (C121) £0.3m;
- Sherwood Kitchen/Offices (C156) £0.3m;
- Leen Gate Building (QV Q00098) £0.3m;
- Respiratory Medicine (C103) £0.2m

Total Unforeseen Obsolescence £2.754m

Note 9 Employee benefits (group)

	18/19 Total £000	17/18 Total £000
Salaries and wages	508,190	474,926
Social security costs	45,807	43,255
Apprenticeship levy	2,408	2,266
Employer's contributions to NHS pensions	59,477	55,981
Pension cost - other	158	100
Termination benefits	174	226
Temporary staff (including agency)	39,132	36,780
Total gross staff costs	**655,346**	**613,534**
Recoveries in respect of seconded staff	-	-
Total staff costs	**655,346**	**613,534**
of which		
Costs capitalised as part of assets	1,320	1,566

Note 9.1 Retirements due to ill-health (Group)

During 18/19, there were five early retirements from the Trust agreed on the grounds of ill-health (seven in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £389k (£410k in 17/18)

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

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 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 are published annually and can be viewed on the NHS Pensions website link below:

www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts

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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

With effect from 1 April 2013 an automatic enrolment contributory pension scheme is in operation for all eligible staff. This scheme is operated by NEST (the National Employment Savings Trust).

Note 11 Operating leases (Group)

Note 11.1 Nottingham University Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Nottingham University Hospitals NHS Trust is the lessor.

The Trust has a number of rental agreements with non-NHS organisations.

	18/19	17/18
Buildings	**£000**	**£000**
Operating lease revenue		
Minimum lease receipts	758	722
Contingent rent	96	84
Total	**854**	**806**

	31 March 2019	31 March 2018
Buildings	**£000**	**£000**
Future minimum lease receipts due:		
- not later than one year;	165	188
- later than one year and not later than five years;	470	545
- later than five years.	3,741	3,828
Total	**4,376**	**4,561**

Note 11.2 Nottingham University Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Nottingham University Hospitals NHS Trust is the lessee.

The majority of the Trust's leasing arrangements are for plant and equipment supplied under normal commercial terms by non-NHS suppliers.

In addition, the Trust leases two satellite dialysis facilities from neighbouring NHS bodies under typical intra-NHS arrangements.

Buildings	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	464	464
Total	**464**	**464**

Other	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,015	1,036
Total	**1,015**	**1,036**

Total	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,479	1,500
Total	**1,479**	**1,500**

Buildings	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	453	464
- later than one year and not later than five years;	1,108	1,432
- later than five years.	129	257
Total	**1,690**	**2,153**
Future minimum sublease payments to be received	-	-

Other	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	771	971
- later than one year and not later than five years;	2,376	2,681
- later than five years.	879	318
Total	**4,026**	**3,970**
Future minimum sublease payments to be received	-	-

Total	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	1,224	1,435
- later than one year and not later than five years;	3,484	4,113
- later than five years.	1,008	575
Total	**5,716**	**6,123**
Future minimum sublease payments to be received	-	-

Note 12 Finance income (Group)

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

	18/19 £000	17/18 £000
Interest on bank accounts	248	79
Total finance income	**248**	**79**

Note 13 Finance expenditure (Group)

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

	18/19 £000	17/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,490	1,327
Finance leases	254	12
Interest on late payment of commercial debt	11	5
Main finance costs on PFI schemes obligations	994	1,028
Contingent finance costs on PFI scheme obligations	841	776
Total interest expense	**3,590**	**3,148**
Unwinding of discount on provisions	3	7
Total finance costs	**3,593**	**3,155**

Note 13.1 The late payment of commercial debts (interest) Act 1998 / Public Contact Regulations 2015 (Group)

	18/19 £000	17/18 £000
Amounts included within interest payable arising from claims made under this legislation	11	5

Note 14 Other gains/(losses) (Group)

	18/19 £000	17/18 £000
Gains on disposal of assets	95	-
Losses on disposal of assets	-	(126)
Total gains/(losses) on disposal of assets	**95**	**(126)**

Note 15 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's surplus/(deficit) for the period was (£38.6m) (17/18: £2.8m). The Trust's total comprehensive income/(expense) for the period was (£13.5m) (17/18: £23.0m).

Note 16 Discontinued operations (Group)

The Group has no discontinued operations.

Note 17 Intangible assets - 18/19

Group and Trust	Software licences £000	Development expenditure £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**16,722**	**21,006**	**37,728**
Additions	753	4,140	**4,893**
Valuation/gross cost at 31 March 2019	**17,475**	**25,146**	**42,621**
Amortisation at 1 April 2018 - brought forward	**10,690**	**10,731**	**21,421**
Provided during the year	1,517	5,092	**6,609**
Amortisation at 31 March 2019	**12,207**	**15,823**	**28,030**
Net book value at 31 March 2019	**5,268**	**9,323**	**14,591**
Net book value at 1 April 2018	**6,032**	**10,275**	**16,307**

Note 18 Intangible assets - 17/18

Group and Trust	Software licences £000	Development expenditure £000	Total £000
Valuation/gross cost at 1 April 2017 - as previously stated	**15,672**	**4,425**	**20,097**
Additions	1,050	5,127	**6,177**
Reclassifications	-	11,454	**11,454**
Valuation/gross cost at 31 March 2018	**16,722**	**21,006**	**37,728**
Amortisation at 1 April 2017 - as previously stated	**9,332**	**2,870**	**12,202**
Provided during the year	1,358	4,307	**5,665**
Reclassifications	-	3,554	**3,554**
Amortisation at 31 March 2018	**10,690**	**10,731**	**21,421**
Net book value at 31 March 2018	**6,032**	**10,275**	**16,307**
Net book value at 1 April 2017	**6,340**	**1,555**	**7,895**

Note 19 Property, plant and equipment - 18/19

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**26,973**	**388,517**	**24,765**	**126,874**	**1,317**	**46,749**	**3,123**	**618,318**
Additions	-	10,837	21,036	5,214	-	2,865	91	**40,043**
Impairments	-	(22,973)	-	-	-	-	-	**(22,973)**
Reversals of impairments	87	8,114	-	-	-	-	-	**8,201**
Revaluations	(1)	19,858	-	-	-	-	-	**19,857**
Reclassifications	-	9,786	(15,186)	3,325	-	2,019	56	**-**
Disposals	-	-	-	(8,917)	(21)	(2,339)	-	**(11,277)**
Valuation/gross cost at 31 March 2019	**27,059**	**414,139**	**30,615**	**126,496**	**1,296**	**49,294**	**3,270**	**652,169**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**88,697**	**1,101**	**28,142**	**2,065**	**120,005**
Provided during the year	-	13,238	-	5,840	98	5,665	205	**25,046**
Revaluations	-	(13,238)	-	-	-	-	-	**(13,238)**
Disposals	-	-	-	(8,860)	(21)	(2,334)	-	**(11,215)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**85,677**	**1,178**	**31,473**	**2,270**	**120,598**
Net book value at 31 March 2019	**27,059**	**414,139**	**30,615**	**40,819**	**118**	**17,821**	**1,000**	**531,571**
Net book value at 1 April 2018	**26,973**	**388,517**	**24,765**	**38,177**	**216**	**18,607**	**1,058**	**498,313**
Land & Buildings NBV at 31 March 2019		**441,198**						
Land & Buildings NBV at 31 March 2018		**415,490**						

Note 20 Property, plant and equipment - 17/18

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - as previously stated	**26,966**	**361,666**	**20,934**	**123,010**	**1,304**	**47,103**	**3,084**	**584,067**
Additions	-	-	29,242	-	-	9,013	-	**38,255**
Impairments	-	(13,184)	-	-	-	-	-	**(13,184)**
Reversals of impairments	7	7,614	-	-	-	-	-	**7,621**
Revaluations	-	19,506	-	-	-	-	-	**19,506**
Reclassifications	-	12,915	(25,411)	9,292	44	(8,333)	39	**(11,454)**
Disposals	-	-	-	(5,428)	(31)	(1,034)	-	**(6,493)**
Valuation/gross cost at 31 March 2018	**26,973**	**388,517**	**24,765**	**126,874**	**1,317**	**46,749**	**3,123**	**618,318**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**-**	**-**	**89,004**	**1,030**	**29,717**	**1,865**	**121,616**
Provided during the year	-	12,527	-	4,957	91	2,986	200	**20,761**
Impairments	-	(12,527)	-	-	-	-	-	**(12,527)**
Reclassifications	-	-	-	-	-	(3,554)	-	**(3,554)**
Disposals	-	-	-	(5,264)	(20)	(1,007)	-	**(6,291)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**88,697**	**1,101**	**28,142**	**2,065**	**120,005**
Net book value at 31 March 2018	**26,973**	**388,517**	**24,765**	**38,177**	**216**	**18,607**	**1,058**	**498,313**
Net book value at 1 April 2017	**26,966**	**361,666**	**20,934**	**34,006**	**274**	**17,386**	**1,219**	**462,451**

Note 21 Property, plant and equipment financing - 18/19

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2019								
Owned - purchased	27,059	383,366	30,615	38,465	108	8,608	633	**488,854**
Finance leased	-	-	-	-	-	9,210	80	**9,290**
On-SoFP PFI contracts and other service concession arrangements	-	9,778	-	-	-	-	-	**9,778**
Owned - donated	-	20,995	-	2,354	10	3	287	**23,649**
NBV total at 31 March 2019	**27,059**	**414,139**	**30,615**	**40,819**	**118**	**17,821**	**1,000**	**531,571**

Note 22 Property, plant and equipment financing - 17/18

Group and Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2018								
Owned - purchased	26,973	356,666	24,765	35,531	201	9,588	676	**454,400**
Finance leased	-	-	-	-	-	9,013	188	**9,201**
On-SoFP PFI contracts and other service concession arrangements	-	10,129	-	-	-	-	-	**10,129**
Owned - government	-	-	-	-	-	-	-	**-**
Owned - donated	-	21,722	-	2,646	15	6	194	**24,583**
NBV total at 31 March 2018	**26,973**	**388,517**	**24,765**	**38,177**	**216**	**18,607**	**1,058**	**498,313**

Note 23 Donations of property, plant and equipment

The Trust received £1.235m of donations of property, plant and equipment during the year, all from the NUH Charity.

Note 24 Revaluations of property, plant and equipment

Summary Explanation of Revaluation 18/19

Assets are no longer routinely subject to annual indexation. Property is valued at fair value based on a modern equivalent basis (MEAV) as required by HM Treasury. As a minimum, a full revaluation is required to be undertaken every five years with an interim valuation every three years. An assessment of changes in property values is undertaken during the intervening years. The Trust engaged Gerald Eve LLP, an independent firm of professional valuers, to undertake its 18/19 full valuation and assess the continuing changes in property values of the NUH Estate. The 18/19 valuation resulted in an impairment on some Trust properties and upward revaluations on other buildings, with an overall net increase of £18.3m in the value of the Trust asset base (including in year 18/19 capital additions). This impairment reflects changes in value of the Trust's property arising both from economic use and market conditions during the course of the year.

The financial impact of the revaluation on each campus, including the impairment is summarised overleaf.

	£'000	£'000
Upward Valuation to Revaluation Reserve	33,095	
Upward Valuation Reversal of Previous Impairments	8,201	41,296
Downward Valuation/Impairment transferred to Revaluation Reserve	(8,055)	
Downward Valuation/Impairment transferred to SoCI	(14,918)	(22,973)
Total Impact of Valuation		**18,323**

Note 25 Investment Property

The Group and Trust have no investment properties.

Note 26 Investments in associates and joint ventures

The Group and Trust have no associate investments or joint ventures.

Note 27 Disclosure of interests in other entities

Hospital Pharmacy Services (Nottingham) Limited, trading as Trust Pharmacy which was incorporated on 4 April 2012, is a wholly owned subsidiary of NUH.

Note 28 Inventories

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Drugs	8,172	7,507	6,281	5,553
Consumables	13,782	13,937	13,782	13,937
Energy	112	246	112	246
Total inventories	**22,066**	**21,690**	**20,175**	**19,736**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £218,27 (17/18: £204,626). Write-down of inventories recognised as expenses for the year were £361k (17/18: £345k)

Note 29 Receivables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Contract receivables*	64,275	-	66,685	-
Trade receivables*	-	55,883	-	59,106
Capital receivables	71	71	71	71
Accrued income*	-	5,016	-	5,016
Allowance for impaired contract receivables/assets*	(4,704)	-	(4,704)	-
Allowance for other impaired receivables *	-	(3,591)	-	(3,591)
Prepayments (non-PFI)	4,849	4,128	4,849	4,128
PFI lifecycle prepayments	544	555	544	555
Finance lease receivables	643	356	643	356
PDC dividend receivable	751	17	751	17
VAT receivable	331	906	-	(578)
Other receivables	-	6,348	-	6,348
Total current receivables	**66,760**	**69,689**	**68,839**	**71,428**
Non-current				
Contract receivables*	4,859	-	4,859	-
Prepayments (non-PFI)	455	715	455	715
Finance lease receivables	358	358	358	358
Other receivables	-	4,453	-	4,453
Total non-current receivables	**5,672**	**5,526**	**5,672**	**5,526**
of which receivable from NHS and DHSC group bodies:				
Current	46,380	49,298	46,380	49,294
Non-current	455	715	455	715

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 29.1 Allowances for credit losses - 18/19

	Group		Trust	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - brought forward		-		-
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	3,591	(3,591)	3,591	(3,591)
New allowances arising	500	-	500	-
Changes in existing allowances	618	-	618	-
Reversals of allowances	-	-	-	-
Utilisation of allowances (write-offs)	(5)	-	(5)	-
Allowances as at 31 Mar 2019	**4,704**	**(3,591)**	**4,704**	**(3,591)**

Note 29.2 Allowances for credit losses - 17/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Group All receivables £000	Trust All receivables £000
previously stated		
Prior period adjustments		
Allowances as at 1 Apr 2017 - restated	**-**	**-**
Increase in provision		
Amounts utilised		
Unused amounts reversed		
Allowances as at 31 Mar 2018	**-**	**-**

Note 29.3 Exposure to credit risk

The Trust has not impaired NHS receivables and non-NHS Receivables have been reviewed on a case by case basis.

The Trust considers all other financial assets to be fully receivable.

Note 30 Other assets

The Group and Trust have no other financial assets.

Note 31 Non-current assets held for sale and assets in disposal groups

Neither the Group or the Trust have any assets held for sale or in disposal groups.

Note 31.1 Liabilities in disposal groups

Neither the Group or the Trust have any liabilities in disposal groups.

Note 32 Cash and cash equivalents movements

Cash comprises cash at bank and cash in hand. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	18/19	17/18	18/19	17/18
	£000	£000	£000	£000
At 1 April	**13,360**	**13,281**	**13,238**	**12,527**
Net change in year	11,767	79	10,714	711
At 31 March	**25,127**	**13,360**	**23,952**	**13,238**
Broken down into:				
Cash at commercial banks and in hand	1,201	148	26	26
Cash with the Government Banking Service	23,926	13,212	23,926	13,212
Deposits with the National Loan Fund	-	-	-	-
Total cash and cash equivalents as in SoFP	**25,127**	**13,360**	**23,952**	**13,238**
Total cash and cash equivalents as in SoCF	**25,127**	**13,360**	**23,952**	**13,238**

Note 32.1 Third party assets held by the Trust

NUH held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Bank balances	-	-
Monies on deposit	-	-
Total third party assets	**-**	**-**

Note 33 Trade and other payables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Trade payables	34,170	19,884	34,170	22,787
Capital payables	12,612	9,667	12,612	9,667
Accruals	64,132	54,984	66,299	54,869
Receipts in advance and payments on account	209	285	209	285
Social security costs	12,695	11,967	12,695	11,942
VAT payables	603	-	603	-
Other taxes payable (corporation tax)	29	122	(26)	-
Accrued interest on loans*	-	192	-	192
Other payables	706	16	706	16
Total current trade and other payables	**125,156**	**97,117**	**127,268**	**99,758**
Non-current				
Total non-current trade and other payables	**-**	**-**	**-**	**-**
of which payables from NHS and DHSC group bodies:				
Current	9,812	6,138	9,812	6,138
Non-current	-	-	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 35. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 33.1 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 2019 £000	31 March 2019 Number	31 March 2018 £000	31 March 2018 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 34 Other liabilities

	Group and Trust 31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	15,859	14,503
Total other current liabilities	**15,859**	**14,503**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 35 Borrowings

	Group and Trust 31 March 2019 £000	31 March 2018 £000
Current		
Loans from DHSC	28,725	18,995
Obligations under finance leases	1,748	1,420
Obligations under PFI or other service concession contracts (excl. lifecycle)	554	516
Total current borrowings	**31,027**	**20,931**
Non-current		
Loans from DHSC	72,256	61,657
Obligations under finance leases	5,568	7,745
Obligations under PFI or other service concession contracts (excl. lifecycle)	11,410	11,967
Total non-current borrowings	**89,234**	**81,369**

Note 35.1 Reconciliation of liabilities arising from financing activities

Group and Trust	Loans from DHSC	Finance leases	PFI schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**80,652**	**9,165**	**12,483**	**102,300**
Cash movements:				**-**
Financing cash flows - payments and receipts of principal	20,033	(1,849)	(519)	**17,665**
Financing cash flows - payments of interest	(1,386)	(254)	(994)	**(2,634)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	192	-	-	**192**
Application of effective interest rate	1,490	254	994	**2,738**
Carrying value at 31 March 2019	**100,981**	**7,316**	**11,964**	**120,261**

Note 36 Other financial liabilities

The Group and Trust have no other financial liabilities.

Note 37 Finance leases

Note 37.1 NUH as a lessor

Future lease receipts due under finance lease agreements where the Trust is the lessor.

The Trust operates a number of salary sacrifice schemes. The finance lease receivables relate to the Home Computer Initiative where staff are able to purchase equipment and repay the Trust over 36-months and the Cycle to Work scheme where staff are able to purchase a bicycle and repay the Trust over 12-months.

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Gross lease receivables	**1,001**	**714**
of which those receivable:		
- Not later than one year;	643	356
- Later than one year and not later than five years;	358	358
Unearned interest income	-	-
Allowance for uncollectable lease payments	-	-
Net lease receivables	**1,001**	**714**
of which those receivable:		
- Not later than one year;	643	356
- Later than one year and not later than five years;	358	358
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

Note 37.2 NUH as a lessee

Obligations under finance leases where the trust is the lessee.

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**7,791**	**9,902**
of which liabilities are due:		
- Not later than one year;	1,948	1,623
- Later than one year and not later than five years;	5,843	7,792
- Later than five years.	-	487
Finance charges allocated to future periods	(475)	(737)
Net lease liabilities	**7,316**	**9,165**
of which payable:		
- Not later than one year;	1,748	1,420
- Later than one year and not later than five years;	5,568	7,262
- Later than five years.	-	483
Total of future minimum lease payments to be received at the reporting date	**7,316**	**9,165**
Contingent rent recognised as expense in the period	-	-

The Trust is party to two significant finance leases in the years disclosed as follows:

- Existing lease for hospital beds, which entered its secondary lease term of seven years in 12/13 and terminates on 29/06/2019.

- The Trust entered into a five year agreement with Cisco on 23/03/2018 for the supply of communication equipment and support services over 60-months.

Note 38 Provisions for liabilities and charges analysis (Group) and (Trust)

Group and Trust	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Other £000	Total £000
At 1 April 2018	**933**	**1,984**	**490**	**1,556**	**4,963**
Change in the discount rate	(12)	(44)	-	-	**(56)**
Arising during the year	98	-	-	580	**678**
Utilised during the year	(70)	(84)	(138)	(461)	**(753)**
Reversed unused	(1)	(48)	(1)	(189)	**(239)**
Unwinding of discount	1	2	-	-	**3**
At 31 March 2019	**949**	**1,810**	**351**	**1,486**	**4,596**
Expected timing of cash flows:					
- Not later than one year;	70	81	351	1,379	**1,881**
- Later than one year and not later than five years;	279	325	-	106	**710**
- Later than five years.	600	1,404	-	1	**2,005**
Total	**949**	**1,810**	**351**	**1,486**	**4,596**

Note 38.1 Clinical negligence liabilities

At 31 March 2019, £587,914 was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of NUH (31 March 2018: £536,313).

Note 39 Contingent assets and liabilities

The Group and Trust have no contingent assets or liabilities.

Note 40 Contractual capital commitments

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	2,880	1,461
Total	**2,880**	**1,461**

Note 41 Other financial commitments

The Group and Trust have no other financial commitments.

Note 41 Defined benefit and pensions schemes

The Group and Trust do not operate any defined pension benefit schemes.

Note 42 On-SoFP PFI or other service concession arrangements

The ENT/Ophthalmology Scheme provides ENT and ophthalmology facilities at QMC and had an estimated capital cost of £16,321,000. The scheme was contracted to start on 01/12/2000 and contracted to end on 31/01/2036. The Trust has granted the operator a 125-year head lease on the site with the operator responsible for design and construction of the facility. The operator leases back the facility to the Trust on a 35 year lease and is responsible for providing some non-clinical services, insuring and maintaining the facility. The unitary payment is adjusted for RPI.

The Trust has no obligations with regard to the assets at the end of the contract but does have the option to purchase the leasehold interest in the facility from the operator at open market value. Under IFRIC 12 the assets of the scheme are treated as assets of the Trust as the substance of the scheme is that the Trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges.

The Trust is party to a managed service arrangement whereby a third party designed and constructed a PET scanner on Trust property and now manages the facility to provide PET scans to Trust NHS patients. The scheme has been assessed as falling within IFRIC 12 - Service Concession Arrangements and thus is accounted for in the same manner as a PFI scheme.

The estimated capital cost of the scheme was £3,600,000 and commenced on 2 December 2004 for a term of 15-years.

The Trust has no LIFT arrangements.

Note 42.1 Imputed finance lease obligations

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Gross PFI or other service concession liabilities	**22,024**	**23,537**
of which liabilities are due		
- Not later than one year;	1,511	1,511
- Later than one year and not later than five years;	5,258	5,423
-Llater than five years.	15,255	16,603
Finance charges allocated to future periods	(10,060)	(11,054)
Net PFI or other service concession arrangement obligation	**11,964**	**12,483**
- Not later than one year;	554	516
- Later than one year and not later than five years;	1,749	1,785
- Later than five years.	9,661	10,182

Note 42.2 Total on-SoFP PFI and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI or other service concession arrangements	**77,582**	**83,604**
of which liabilities are due:		
- Not later than one year;	6,657	6,542
- Later than one year and not later than five years;	17,253	19,939
- Later than five years.	53,672	57,123
Total Future Liabilities	**77,582**	**83,604**

Note 42.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust	
	18/19	17/18
	£000	£000
Unitary payment payable to service concession operator	**6,712**	**6,761**
Consisting of:		
- Interest charge	994	1,028
- Repayment of finance lease liability	518	483
- Service element and other charges to operating expenditure	4,359	4,474
- Contingent rent	841	776
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	565	324
Total amount paid to service concession operator	**7,277**	**7,085**

Note 43 Off-SoFP PFI and other service concession arrangements

NUH incurred the following charges in respect of off-Statement of Financial Position PFI obligations:

The Combined Heat and Power (CHP) scheme provides CHP plant at the QuMC and has an estimated capital value of £7,300,000. The asset is not an asset of the Trust and the Trust has no residual interest in the scheme. The scheme commenced on 20/12/2013 for 15 years.

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Charge in respect of the off SoFP PFI or other service concession arrangement for the period	**4,701**	**4,995**
Commitments in respect of off-SoFP PFI or other service concession arrangements:		
- Not later than one year;	4,701	4,995
- Later than one year and not later than five years;	18,804	19,536
- Later than five years.	23,199	28,083
Total	**46,704**	**52,614**

Note 44 Financial instruments

Note 44.1 Financial risk management

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 Nottingham University Hospitals NHS 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 treasury 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. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

NUH is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

NUH borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations

Liquidity risk

NUH operating costs are incurred under contracts with primary care organisations, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore,

Note 44.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
- Trade and other receivables excluding non financial assets	62,633	-	-	**62,633**
- Other investments/financial assets	1,001	-	-	**1,001**
- Cash and cash equivalents	25,127	-	-	**25,127**
Total at 31 March 2019	**88,761**	**-**	**-**	**88,761**

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
- Trade and other receivables excluding non financial assets	67,765	-	-	-	**67,765**
- Other investments/financial assets	714	-	-	-	**714**
- Cash and cash equivalents	13,360	-	-	-	**13,360**
Total at 31 March 2018	**81,839**	**-**	**-**	**-**	**81,839**

Trust	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
- Trade and other receivables excluding non financial assets	62,633	-	-	**62,633**
- Other investments/financial assets	1,001	-	-	**1,001**
- Cash and cash equivalents	23,952	-	-	**23,952**
Total at 31 March 2019	**87,586**	**-**	**-**	**87,586**

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
- Trade and other receivables excluding non financial assets		70,287	-	-	**70,287**
- Other investments/financial assets		714	-	-	**714**
- Cash and cash equivalents		13,238	-	-	**13,238**
Total at 31 March 2018	**-**	**84,239**	**-**	**-**	**84,239**

Note 44.3 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	100,981	-	**100,981**
Obligations under finance leases	7,316	-	**7,316**
Obligations under PFI and other service concession contracts	11,964	-	**11,964**
Trade and other payables excluding non financial liabilities	110,252	-	**110,252**
Total at 31 March 2019	**230,513**	**-**	**230,513**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	80,652	-	**80,652**
Obligations under finance leases	9,165	-	**9,165**
Obligations under PFI and other service concession contracts	12,483	-	**12,483**
Trade and other payables excluding non financial liabilities	84,403	-	**84,403**
Total at 31 March 2018	**186,703**	**-**	**186,703**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	100,981	-	**100,981**
Obligations under finance leases	7,316	-	**7,316**
Obligations under PFI and other service concession contracts	11,964	-	**11,964**
Trade and other payables excluding non financial liabilities	114,262	-	**114,262**
Total at 31 March 2019	**234,523**	**-**	**234,523**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	67,823	-	**67,823**
Obligations under finance leases	295	-	**295**
Obligations under PFI and other service concession contracts	12,945	-	**12,945**
Trade and other payables excluding non financial liabilities	73,679	-	**73,679**
Total at 31 March 2018	**154,742**	**-**	**154,742**

Note 44.4 Fair values of financial assets and liabilities

The Group and Trust has no assets or liabilities valued at fair value.

Note 44.5 Maturity of financial liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
In one year or less	141,279	105,335	141,279	102,686
In more than one year but not more than two years	9,704	28,571	9,704	28,571
In more than two years but not more than five years	38,540	34,122	38,540	34,122
In more than five years	40,990	18,675	40,990	18,675
Total	**230,513**	**186,703**	**230,513**	**184,054**

Note 45 Losses and special payments

	18/19		17/18	
Group	**Total number of cases Number**	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Bad debts and claims abandoned	189	115	160	199
Stores losses and damage to property (inventories written down)	4,293	361	3,686	345
Total losses	**4,482**	**476**	**3,846**	**544**
Special payments				
Ex-gratia payments	102	178	87	243
Total special payments	**102**	**178**	**87**	**243**
Total losses and special payments	**4,584**	**654**	**3,933**	**787**
Compensation payments received	-	-	-	-
Total losses and special payments (excluding Stores losses and damage to property)	291	293	247	442

Note 46 Gifts

The Trust has made no gifts during the year.

Note 47.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £192k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a increase in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £9,941k.

The application of IFRS 9 has seen an increase of £368k in the provision for imparment of receivables.

Note 47.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The adoption of IFRS 15 has had no impact upon the Trust's accounts.

Note 48 Related parties

During the year, no Department of Health Ministers, Trust Board members or members of the senior Trust management team, or parties related to them, have undertaken any material transactions with Nottingham University Hospitals NHS Trust.

The Department of Health is regarded as a related party. During the year Nottingham University Hospital NHS Trust has had a significant number of material transactions with the DH and with entities for which the DH is regarded as Parent Department. These included:

Name of Counter Party				
NHS Commissioned Patient Care Activity				
Nottinghamshire Commissioning Consortia, comprised of:	**£000**	**£000**	**£000**	**£000**
	Income	**Expenditure**	**Debtors**	**Creditors**
NHS Commissioning Board (Specialised)	363,902	0	19,513	0
NHS Commissioning Board - N&D at (Dental / Public Health)	17,870	0	1,483	0
NHS England (Military)	28	0	23	0
Nottingham City CCG	186,149	(57)	3,156	1,910
Nottingham North & East CCG	84,941	33	8	623
Rushcliffe CCG	61,018	(2)	18	447
Nottingham West CCG	50,263	22	0	410
Erewash CCG	24,499	0	496	0
Newark & Sherwood CCG	15,166	14	232	0
Mansfield & Ashfield CCG	13,517	7	380	14
Southern Derbyshire CCG	9,529	0	321	0
South West Lincolnshire CCG	7,543	0	169	0
Lincolnshire West CCG	4,930	0	17	1
Lincolnshire East CCG	3,873	0	66	0
West Leicestershire CCG	4,639	15	173	0
East Leicestershire & Rutland CCG	4,671	0	53	0
Hardwick CCG	2,095	2	224	1
South Lincolnshire CCG	736	2	0	95
North Derbyshire CCG	660	0	14	0
Bassetlaw CCG	683	0	57	0
East Staffordshire CCG	626	0	54	0
Leicester City CCG	951	0	153	0
Nene CCG	527	0	48	0
Sheffield CCG	160	0	0	42
Doncaster CCG	106	0	1	0
South East Staffordshire & Seisdon CCG	400	0	45	0
Nottingham City Council	3,389	0	282	0
Nottinghamshire County Council	1,600	0	133	0

Note 48 Related parties (continued)

Non Patient Care activity	£000 Income	£000 Expenditure	£000 Debtors	£000 Creditors
NHS England	406,438	210	30,625	300
Health Education England	44,665	10	175	1
Department of Health - Incoming Resources	19,543	0	232	0
Department of Health - Outgoing Resources	0	0	0	0
Her Majesty's Revenue and Customs	0	48,245	331	13,327
NHS Pensions	0	59,477	0	8,332
Sherwood Forest Hospitals NHS Foundation Trust - Outgoing Expenditure	0	5,131	0	1,823
Sherwood Forest Hospitals NHS Foundation Trust - Incoming Resources	1,664	0	1,664	0
Nottinghamshire Healthcare NHS Foundation Trust - Outgoing Expenditure	0	2,881	0	796
Nottinghamshire Healthcare NHS Foundation Trust - Incoming Resources	695	0	695	0
Derby Teaching Hospitals NHS Foundation Trust - Outgoing Expenditure	0	1,537	0	982
Derby Teaching Hospitals NHS Foundation Trust - Incoming Resources	2,292	0	1,524	0
University Hospitals of Leicester NHS Trust - Outgoing	0	1,655	0	970
University Hospitals of Leicester NHS Trust - Incoming Resources	3,006	0	3,006	0
NHS Resolution (formerly NHS Litigation Authority)	0	31,140	0	34
NHS Blood and Transplant Authority	303	4,905	20	12
University of Nottingham - Incoming Resources	3,190		1,082	
University of Nottingham - Outgoing Resources		13,410		870
Nottingham City Council	343	5,317	0	0
Nottinghamshire County Council	197	0	0	0

NUH also received income (£1.2m) from the NUH Charity during 18/19 (£0.4m in 17/18).

During this time, Mrs Amanda Sunderland held posts as an Executive Director of NUH NHS Trust and a Trustee of the NUH Charity.

Hospital Pharmacy Services (Nottingham) Limited (Trust Pharmacy). Trust Pharmacy is a wholly owned private subsidiary of NUH NHS Trust.

In 18/19, the income and expenditure for NUH in relation to Trust Pharmacy activity was £27.1m (£27.9m in 17/18) and £29.2m (£29.4m in 17/18) respectively.

In 18/19, Mr Rupert Egginton and Ms Caroline Shaw served as Executive Directors of both NUH and Trust Pharmacy, but Caroline Shaw was reassigned to secondment on 14 January 2019. Dr Keith Girling was appointed as Executive Director of Trust Pharmacy on 1 February 2019 and is also a Trust Executive Director for all of 18/19.

Note 49 Transfers by absorption

There have not been any transfers by absorption within the Group or Trust.

Note 50 Prior period adjustments

There are no prior period adjustments.

Note 51 Events after the reporting date

The Trust has agreed a contract with CCGs to run the Treatment Centre for 5 years from 29 July 2019.

Note 52 Final period of operation as a trust providing NHS healthcare

The Group is continuing to operate as a provider of healthcare.

Note 53 Better Payment Practice code

	18/19 Number	18/19 £000	17/18 Number	17/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	184,131	528,950	177,997	498,321
Total non-NHS trade invoices paid within target	149,379	448,210	155,046	453,840
Percent of non-NHS trade invoiced paid within target	81.1%	84.7%	87.1%	91.1%
NHS Payables				
Total NHS trade invoices paid in the year	4,496	182,808	4,772	177,714
Total NHS trade invoices paid within target	2,500	164,585	3,029	167,318
Percent of NHS trade invoiced paid within target	55.6%	90.0%	63.5%	94.2%

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 a valid invoice, whichever is later.

Note 54 External financing

The Trust is given an external financing limit against which it is permitted to spend.

	18/19 £000	17/18 £000
Cash flow financing	13,202	15,514
Finance leases taken out in year	-	9,017
Other capital receipts	-	-
External financing requirement	**13,202**	**24,531**
External financing limit (EFL)	36,316	27,815
Under spend against EFL	**23,114**	**3,284**

Note 55 Capital resource limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	44,936	44,432
Less: Disposals	(62)	(202)
Less: Donated and granted capital additions	(1,235)	(383)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**43,639**	**43,847**
Capital Resource Limit	43,735	44,187
Under spend against CRL	**96**	**340**

Note 56 Break-even duty financial performance

	18/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(31,771)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 break-even adjustment	-
Break-even duty financial performance surplus/ (deficit)	**(31,771)**

57 Break-even duty rolling assessment

	97/98 to 08/09 £000	09/10 £000	10/11 £000	11/12 £000	12/13 £000	13/14 £000	14/15 £000	15/16 £000	16/17 £000	17/18 £000	18/19 £000
Break-even duty in-year financial performance		7,256	5,010	4,764	9,133	701	750	(47,154)	(20,108)	(2,168)	(31,771)
Break-even duty cumulative position	26,288	33,544	38,554	43,318	52,451	53,152	53,902	6,748	(13,360)	(15,528)	(47,299)
		722,169	742,215	784,605	812,969	847,938	874,090	870,621	934,771	987,499	1,021,952
Operating income break-even position as a percentage of operating income		4.6%	5.2%	5.5%	6.5%	6.3%	6.2%	0.8%	(1.4%)	(1.6%)	(4.6%)

6 – Independant Auditor's Report

Independent Auditor's report to the Board of Directors of Nottingham University Hospitals NHS Trust

Report on the audit of the financial statements

Opinion

We have audited the financial statements of Nottingham University Hospitals NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Group Statement of Comprehensive Income, Group and Trust Statement of Financial Position, Group and Trust Statement of Changes in Taxpayers Equity and Group and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2019 and of the Group'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 with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

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

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve 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 its 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").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of Brexit, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

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 absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. 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 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 18/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 18/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement of Directors' responsibilities in respect of the accounts, 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 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 dissolve the Trust without the transfer of its 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, 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
wwwirc.org.uk/auditorsresporisibilities

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 to you if the Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Nottingham University Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial sustainability, we identified that the Trust reported a pre-PSF financial deficit of £43.5m for the year-ended 31 March 2019. The Trust also received new revenue loans totalling £52.9m from the Department of Health and Social Care during 18/19 to support its working capital requirements. The Trust will need to deliver a £37m Cost Improvement Programme (CIP) to meet its forecast break-even target for 19/20. The Trust has a good track record in delivering its CIP.

These issues are evidence of weaknesses in the Trust's arrangements for planning its finances effectively to support the sustainable delivery of strategic priorities and maintaining its statutory functions.

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 of the Chief Executive's responsibilities as the Accountable Officer of the Trust, 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 (3)(c), as amended by schedule 13 paragraph 1 O(a), 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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017 as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. 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 issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- We issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- We make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

We are required 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.

On 28 May 2019 a referral was made to the Secretary of State under section 30(1)(a) of the Local Audit and Accountability Act 2014 in respect of the Trust's failure to achieve its statutory break-even duty.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Board of Directors of Nottingham University Hospitals 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 Nottingham University Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Bostock

for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
One Snowhill
Snow Hill
Queensway
Birmingham
B4 6GH

28 May 2019

7 – Appendices & Glossary

Sustainability Report 18/19

Overall Trust Performance

During 18/19, the Trust has continued to progress efficiencies and improvements in its operations to align with the Trust's sustainability commitments.

Commitment to sustainable development

In November 2018, the Trust Board approved the NUH Sustainable Development Strategy 2018-2023. This Strategy sets out a number of goals in the areas of Carbon Mitigation and Adaptation, Water, Waste and Sustainable Travel.

Carbon and energy

18/19 was a successful year for the Trust's climate action agenda which can be seen through a 1.38% reduction of its carbon footprint compared with 17/18. This achievement was attained in part by the continuation of the Trust switching from coal to gas as the main way to heat the City Hospital. Another significant contributor being 18/19 was a warmer year compared with 17/18 and the ongoing decarbonisation of the electrical grid in UK.

NUH has also continued its work on the business case to replace the heating infrastructure at City Hospital with a more sustainable solution; once delivered this will see a full cessation of coal usage and ultimately the production of on-site electricity. This project specifies that at least 5% of the energy which will be produced on the City site will be from renewable sources including photovoltaic panels, air source heat pumps and biogas.

During this reporting period the Trust also saw continued improvements across its Estates through retrofitting more sustainable systems as part of its capital projects. Some of these improvements during 18/19 are listed below:

- Provision of LED lighting with proximity detectors and smart lighting in new buildings and retrofits these include the New Workshops, Trent Cardiac Centre and the Clinical Haematology building at City Hospital
- Fitting of inverter drives in all pumps and fans installed in new buildings and refurbishments to reduce energy consumption
- Provision of four energy-efficient chiller units to replace old-technology units which provide cooling to Ropewalk House, the Endoscopy Unit and the Clinical Haematology building at City Hospital
- Provision of opening windows in refurbished wards and offices which provide natural ventilation and reduce the need for mechanical ventilation systems
- Provision of new energy-efficient boilers and pumps to replace old and inefficient units in Linden Lodge at City Hospital

Sustainable Food

The sustainable food programme continues delivering meals to patients, visitors and staff in the Trust from sustainable sources. The service has maintained its ethos of sourcing of most of its food ingredients from local sources. Therefore, contributing towards maintaining a low "carbon mileage" for the meals we serve, which helps increase the resilience and sustainability of NUH activities, and supports the local economy.

Sustainable commuting

NUH sustainable commute agenda was also very active during 18/19. In November 2018, the Trust Board approved the Trust's Travel Plan which aims to improve access to our sites and services more sustainably, and discourage single occupancy vehicle commutes.

In the area of public transport, NUH continues promoting its Travel to Work scheme, which aims to make access to NUH via public transport more attractive for NUH staff. In 18/19 membership to the scheme grew by 15%. Circa 1,300 staff now use the scheme to commute by bus to NUH. NUH also maintained its support for the Medilink Bus service which displaces circa 630 tCO2 from road emissions from patients, visitors and staff commuting between campuses. NUH also actively promotes the use of park and ride sites linked to the Medilink Bus service to reduce vehicles circulating within the City Hospital, and keeps supporting its car-sharing platform to help staff find a car-sharing partner.

The Trust's latest Staff Travel Survey suggests the number of staff commuting alone in private motor vehicles dropped by circa 2% compared with 2016 data.

In the area of active travel, NUH also continues promoting active travel via a number of initiatives including Dr Bike, Cycle to Work scheme, bike maintenance classes and roadshows aiming to promote health, wellbeing and active travel. The Cycle2Work scheme success continues. This scheme not only helps promote sustainable travel choices but also provides many health and wellbeing benefits. During 18/19, 170 members of staff applied for the scheme. Additional support to staff who cycle was also provided through the Dr Bike Sessions. These educational sessions provide staff with the skills in bike maintenance, therefore, increasing their safety awareness whilst travelling by bike. More than 330 staff subscribed to this initiative.

Infrastructure-wise, NUH partnered with Nottingham City Council and installed two cycle hubs in key areas at QMC and City Hospital.

Air quality

In 18/19, NUH continued using its gas boiler house as the leading heating infrastructure, and its coal-fired boiler house the backup heating infrastructure. This has reduced the emission of particulates and the Trust's carbon footprint by circa 8,000 tCO2. This has had a positive impact on the local air quality. The Trust also continues engaging with its contractors to ensure its energy facility at QMC operates as efficiently as possible.

The Trust during this period has also replaced standby generators in two substations at QMC which are run by latest highly-efficient technology. These are fitted with state-of-the-art environmental controls including catalytic converters and particulate filters to prevent pollutants being emitted in the exhaust, therefore, contributing to improvements of the air quality in the area.

Social agenda

The Trust continues working in partnership with Nottingham City Council in a common vision of health via the County Council's Health and Wellbeing Board. The ethos of this vision is the "Happier Healthier Lives: Nottingham City Joint Health and Wellbeing Strategic Framework 2016–2020". This strategy aims to increase Healthy Life Expectancy and close the gap between the most affluent and poorest areas of the city.

Waste and finite resources consumption

The Trust continues pushing to improve its waste and water agendas. In line with Department of Health guidance, during 18/19 NUH increased the segregation of "offensive waste", by reducing the amount of waste classed as clinical. NUH continues working to reduce the impact of its waste to the environment. NUH contributes to minimising the impact on the environment through its continued increases in waste recycling

In addition to its recycling initiatives, NUH is striding towards waste minimisation via a number of initiatives including paperless hospital and during 18/19 it achieved some key milestones.

The Trust now requires its construction services contractors under the Framework Contract to demonstrate their credentials in responsible sourcing of materials, waste management and local procurement which is scored as part of the selection criteria during the tender process.

In 18/19, NUH reduced its consumption of water by 3.7%.

The achievements of NUH for the 18/19 Sustainability Report can be seen in summary opposite.

AREA	16/17	17/18	18/19
GREEN HOUSE GASES REPORT			
Total Energy Consumption (GJ)	**1,001,082**	**968,114**	**986,122**
Coal	246,010	73,686	105,677
Natural Gas	551,658	701,568	670,763
Electricity (Imported)	116,746	103,083	105,656
Electricity (Produced)	77,659	85,646	100,096
Gasoil	9,009	4,131	3,930
Energy expenditure (£)	**9,879,519**	**11,102,048**	**12,419,169**
Total Business Travel (miles)	**1,361,808**	**1,137,392**	**1,237,951**
Car	1,009,172	784,932	863,143
Train	280,590	314,322	346,504
Airplane (domestic)	72,046	38,138	28,304
Carbon Emissions (TCO2eq)	**65,457**	**53,621**	**53,124**
Scope 1			
Coal	22,604	6,827	9,850
Natural Gas	28,195	35,890	34,276
Gasoil (GJ)	728	332	318
Scope 2			
Electricity Imported	13,363	10,067	8,308
Scope 3			
Business Travel Miles	567	506	132
WASTE MINIMISATION & MANAGEMENT			
Total Waste Produced (tonnes)	**5,472**	**5,112**	**5,166**
Waste recycled/reused	2,018	1,125	1,212
Waste to energy	468	1,055	1,148
Waste to recovery treatment*	1,901	2,276	2,121
Waste for alternative treatment	385	307	251
Waste to Landfill	700	348	434
Total Waste disposal expenditure (£)	**£902,255**	**£1,353,906**	**£1,397,569**
FINITE RESOURCE CONSUMPTION			
Total Water consumed (m3)	**662,837**	**686,462**	**653,072**
Water Imported	173,344	171,849	148,899
Waster Abstracted	489,493	514,613	504,173
Total Water Expenditure (£)	**£900,795**	**£947,039**	**£1,059,556**

Annual Governance Statement 18/19

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Nottingham University Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Nottingham University Hospitals NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Chief Executive has overall accountability for ensuring that robust and effective risk management systems are in place to deliver safe and effective services and to ensure the Trust operates its activities in compliance with all relevant statutory requirements and Department of Health guidance. The Director of Corporate Governance has responsibility for the implementation of the Risk Management Strategy and for ensuring the Trust has effective processes in place for the management of risk.

Risk management training is provided to staff in order to ensure that they are able to undertake their specific roles and responsibilities.

- The training provided includes:
- an introduction to risk management as part of the Trust's compulsory induction for new staff
- Structured training sessions with the Trust Board, Management Board and with Divisional teams where requested
- Role related risk management training for specific disciplines such as Health and Safety, Patient Safety and Complaints as evidenced by the relevant annual reports
- Training has been delivered to key individuals who will undertake risk management training for the Trust

The objectives of the training are to ensure:

- Improved awareness and identification of potential hazards
- Improved assessment of risk and the reduction of potential adverse outcomes
- Improved service quality and safer delivery of care
- Elimination or reduction of preventable incidents, accidents and near misses by risk assessment, treatment and control
- Continuous improvement and deployment of safer working practices
- The provision of safe environments for patients, staff and visitors
- The integration of risk management into all business activities:
  - ✓ Delivery of safer healthcare
  - ✓ Business planning
  - ✓ Objective setting
  - ✓ Business continuity and crisis management
  - ✓ Financial planning and management
  - ✓ Performance management with associated more effective and efficient use of resources

In addition, a range of risk management resources are accessible via the Trust's intranet along with the contact details for the specialist advisors within the Trust who can support managers and staff with specific risk management issues.

4. The risk and control framework

Nottingham University Hospitals NHS Trust is committed to the provision of the highest possible standards of care and recognises that the management of risk is a key pre-requisite for achieving this objective. The Trust's risk management policy is fundamental to ensuring the continual improvement of the quality of our services for patients, the community we serve and meeting our corporate social responsibility. The recording and evaluation of existing controls forms a key part of the Trust's risk assessment process. Where it is identified that the controls in place are inadequate or a significant residual risk exists; then additional controls / remedial actions are identified, recorded and implemented to further mitigate the risk to an acceptable level. Where risks cannot be mitigated, or where the upside benefits are felt to outweigh the potential for harm, the risk is escalated to the appropriate level of management for action or acceptance as appropriate.

As part of the Trust's risk management process, arrangements have been prescribed that require risks to be kept under review in order to ensure that the controls and any mitigating actions remain effective.

For all significant risks the risk assessment (including any controls) are recorded in the Trust's risk register and reported to the Board Committee with responsibility for risk oversight. At the Committee; assurances are sought to confirm that the risks are being adequately mitigated and that ongoing monitoring is taking place to ensure that controls remain effective.

Similarly, for high and moderate risks, the responsibility for the action required to eliminate or reduce the risks is delegated to divisions and specialties. Risks at this level will be monitored via the relevant risk committee (high risks) or through divisional governance forums (moderate, low and very low risks).

Robust policies and procedures are in place across a comprehensive range of risk management topics to ensure that risks are proactively identified and managed. Specific arrangements are in place to proactively deter and minimise personal harm, disruption and damage to Trust staff, services and premises. All Trust policies require an equality impact assessment and these are integral to the policy documents.

An internal audit review of the Trust's risk management framework during the year has provided a significant assurance opinion. The review confirmed that the Trust has put significant effort into improving and developing its risk management framework over the last year.

The Trust acknowledges that in order to achieve its objectives some risk is acceptable whereas in other scenario's it must be rigorously avoided. For example a risk to achieving statutory compliance would not be acceptable whereas the potential patient benefits of developing new procedures may be acceptable / beneficial. By defining its risk appetite, the Trust can arrive at an appropriate balance between uncontrolled innovation and excessive caution. It can guide decision makers on the level of risk permitted and encourage consistency of approach across an organisation.

The Trust uses the risk appetite classification below in considering its decision making and assurance process for classification of risk.

Risk Appetite	Description
Avoid	Avoidance of risk and uncertainty or ultra safe options required (linked to key organisational objectives)
Minimal	As little as reasonably possible
Cautious	Preference for safe options that have a low degree of residual risk
Open	Willing to consider all potential options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering potentially higher rewards, despite greater inherent and residual risk
Mature	Confident on setting High levels of Risk Appetite

4.1 Quality governance arrangements

The executive leads for quality, safety, patient experience and clinical governance are the Medical Director and Chief Nurse.

The Trust has a 2018-2023 quality strategy which was informed by a dialogue with patients to establish what was most important to them in their experience of the Trust's services. 'Our Patient' promise is the delivery of consistently high quality, safe care with outstanding outcomes and experience.

We will achieve our promise through collaboration with all professions supported by expert non-clinical staff within strong governance mechanisms.

The Trust's overarching quality objectives are to:

- Maintain patient safety at all times
- Be clinically effective and lead to best possible health outcomes for patients
- Provide a positive patient experience

Each year the Trust describes its quality priorities in its quality account. Achievement of the quality priorities is monitored through the Trust's performance management arrangements, annual plan reports to the Board, and the Board assurance framework.

All Board members participate in a range of quality and safety visits to clinical areas, these include:

- Board patient safety conversations
- Chair and Chief Nurse walkabouts
- Executive Director quality visits to clinical areas
- Board Directors' visits to wards and departments on Board meeting days to learn about staff and patient experience.

The Board and its Quality Assurance Committee have programmes of work which detail the range and frequency of quality reporting including:

- Matrons' reports
- Patient experience reports (including patient stories)
- Safeguarding reports
- Safety reports (both patient safety and health and safety)
- Serious incident reporting, including never events
- Clinical effectiveness reports

The presentation of key clinical quality reports by the responsible clinician is encouraged.

4.2 Clinical governance

The Trust's Management Board reports to the Trust Board through the Chief Executive on the operational delivery and effectiveness of the Trust's arrangements for clinical governance and risk management, thus ensuring there is an integrated approach to the management of clinical and organisational risk. The Quality, Risk and Safety Committee, reports to Management Board. The Risk Management Committee and Health and Safety Committee have both reported into the Quality, Risk and Safety Committee during the year, but it has been agreed that the status of the Risk Management Committee will be elevated from April 2019 to a committee of Management Board, such is the importance of the management and mitigation of risk to the organisation. Divisions provide more detailed reviews to the Quality, Risk and Safety Committee on a quarterly basis of:

- Clinical effectiveness
- Patient experience
- Patient safety
- Health and safety
- Organisational quality

in order to give assurance that each of these quality domains are being given sufficient attention.

In addition to the work of these committees, the Trust has monthly divisional performance management meetings with each of the five clinical divisional leadership teams and the estates and facilities directorate. The first item on the agenda for each of these monthly meetings is quality, risk and safety with confirm and challenge taking place in relation to key quality indicators and risks.

4.3 CQC registration

The Trust is fully compliant with the registration requirements of the Care Quality Commission, with no conditions on its registration.

The Trust has a peer review system in which compliance with the CQC's standards of quality and safety is assessed within all specialties across the Trust on a regular basis so that over the period of a year, compliance with all standards have been formally assessed and sometimes reassessed, dependent upon the risk. Reports from these peer reviews are reported to the Board Quality Assurance Committee.

The Trust's overall self-assessment of compliance with the five key domains in 2018/19 was:

SAFE	GOOD
EFFECTIVE	GOOD
CARING	GOOD
RESPONSIVE	GOOD
WELL LED	GOOD

4.4 CQC inspection status

The Trust underwent a Care Quality Commission (CQC) inspection between November 2018 and January 2019. This involved both a quality of care inspection and a use of resources assessment, the latter being carried out by NHS Improvement. The results of the inspection were published in March 2019 as follows:

OVERALL	GOOD
SAFE	REQUIRES IMPROVEMENT
EFFECTIVE	GOOD
CARING	OUTSTANDING
RESPONSIVE	GOOD
WELL LED	GOOD
ARE RESOURCES USED PRODUCTIVELY?	REQUIRES IMPROVEMENT

There was one regulatory action following the quality of care inspection relating to do not attempt cardiopulmonary resuscitation decision making and recording. The Trust has submitted its action plan to the CQC and implementation of the plan will be closely monitored by the Quality and Safety Committee and Trust Board. More information on the outcome of this inspection can be found in the 18/19 Quality Account.

The use of resources assessment concluded that whilst the Trust's productivity compared well for some areas, there were several areas where productivity improvements could still be achieved, and the Trust's financial position had worsened in-year.

5. Significant risks

5.1 Trust Risk Profile

The profile below reflects the Trust risk register as at 31 March 2019. It is important to note that NUH's approach is to capture all risks, from a range of systems, in one single risk register, which includes, for example, all health a safety risk assessments and cleaning audit risks, as well as the traditional clinical, financial and operational risks. This makes all risks transparent and accounts for the large number of risks which are visible on the DATIX risk management system.

Risk scoring bands	1-9	10-12	15/16	20/25	Total Live	Total archived
No of Risks	2,518	458	221	25	3,222	160

Out of the 2,518 risks scoring between one and nine, 761 score between one and three and as such are deemed to be managed to an acceptable level.

5.2 Current significant risk register

There are currently 25 risks scoring 20 or more on the Trust's significant risk register.

These are:

1 Poor standards of cleanliness in clinical areas – being mitigated by increased numbers of cleaning staff; purchase and training in new cleaning equipment; joint environmental oversight by estates and facilities and infection, prevention and control and assessed through programme of cleaning audits

2 Delay in patient care caused by overcapacity in the ED resuscitation room – being mitigated by advanced clinical practitioners gaining critical care skills to enhance skill mix when working in resus room, assessed by increased timeliness of patient care

3 Risk of increased length of stay and overcrowding in ED when bed occupancy is above 92% - being mitigated through a combination of clinical system changes, investment and closer partnership working.

4 Risk of harm as a result of an inability to provide CCOT response or intervention out of hours – being mitigated through a business case for 24/7 CCOT provision.

5 Risk of harm caused by a failure to recognise or respond to deterioration – being mitigated through the implementation of new clinical processes, early screening and management of sepsis and education programmes.

6 Risk of harm due to failure of the lift systems to South Corridor Wards at City Hospital – being mitigated through the replacement of the affected lifts, with

detailed business continuity plans in place to manage the intervening period until replacement.

7 Failure to provide a canopy to the Food Production Kitchen – being mitigated through the installation of a new canopy.

8 Risk of harm due to the lack of theatre capacity for Skin Cancer patients – being mitigated through the provision of additional theatre capacity, use of waiting list initiatives and job planning.

9 Risk of infection outbreaks due to poor work surfaces in the Maternity Building – being mitigated through the replacement of the affected work surfaces.

10 Risk of delay to delivery of timely care due to a lack of Haematology Consultants – being mitigated through effective use of locums, training and ongoing recruitment.

11 Inability to provide appropriate numbers of skilled staff within fragile Trust services – being mitigated through robust people investment and planning.

12 Inability to provide sufficient staff resilience to meet service demands – being mitigated through people investment, new roles and flexible ways of working.

13 Risk of failure to provide safe/high quality care due to inadequate nurse/midwifery staffing numbers – being mitigated through increased clinical time, flexible working and service efficiencies.

14 Risk of poor experience and contractual breach due to the lack of suitable mortuary storage – being mitigated through ongoing monitoring of storage capacity, communication with the HM Coroner and business continuity plans.

15 7 Day Services – being mitigated through impact assessment, job planning and potential increases in staffing.

16 Failure of critical non-clinical or clinical systems due to failure of IT infrastructure (network) – being mitigated by procurement of new systems for which contracts have been exchanged and signed following tender process. The Trust's "Paperless Hospital Board" are overseeing system changes and monitoring performance.

17 Enforcement action and reputational damage from a failure to meet statutory EFM compliance.

18 Significant Business Continuity impact due to failure of EFM infrastructure/systems.

19 Risk of harm due to failure to provide safe healthcare premises. Risks 17, 18 and 19 are being mitigated by capital investment in key infrastructure projects; appointment of approved persons, including training and familiarisation with Trust maintenance systems and processes and will be assessed through audit and completion of projects.

20 Lack of manufacturer support for voice and data infrastructure.

21 Cybersecurity risk.

22 Risks 20 & 21 are being mitigated by procurement of new systems for which contracts have been exchanged and signed following tender process. Trust's paperless Hospital Board overseeing system changes and monitoring performance.

23 Risk to theatre service due to infrastructure failure – being mitigated through increased and ongoing theatre maintenance schedules, additional checks and implementation of the modular ventilation upgrade plan.

24 Risk of unplanned cancellation of surgery due to failure of ventilation systems – being mitigated through increased maintenance, testing and forward investment.

25 Risk of not meeting national neonatal standards due to low staffing numbers – being mitigated through workload management, clinical guidelines and forward people investment.

26 Risk of harm due to limited Critical Care Capacity – being mitigated through workload management, flexible working and forward business case.

5.3 Newly-identified Significant Risks in 18/19

1 Risk of harm due to failure of the lift systems to South Corridor Wards at the City Hospital – mitigations described in 6) above

2 Risk of poor experience and contractual breach due to the lack of suitable mortuary storage – mitigations described in 14) above

3 Seven-Day Services Risk – mitigations described in 15) above

The significant risks on the risk register are used as a prioritising factor for the Trust's capital programme. The Trust has an ageing estate with a large information technology (IT) and equipment infrastructure. The Trust is looking to develop a business case for a fundamental refresh of its estate given the above and the scale of backlog maintenance which will be driven through the integrated care system and external funding.

6. Well-led assessment

The Trust was assessed for the quality of its leadership by the Care Quality Commission in January 2019 and rated as 'Good' in the well-led domain because:

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. There was clear leadership of the trust to drive and improve the delivery of high quality person centred care
- The Trust Executives presented as an exceptionally cohesive and collaborative team who were well supported, and appropriately challenged, by a range of Non-Executive Directors. There was clear leadership from the Chair and Chief Executive

- Leaders understood the challenges to quality and sustainability; they could identify actions needed to address these
- Executive Board members were capable, they had been both open and responsive to challenges and had strived for improvement throughout the organisation
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community
- The trust had become key partners in the Integrated Care System (ICS) and worked with partners to better co-ordinate the Nottinghamshire health and care system through strong system leadership. The trust was fully involved in all elements of governance and leadership of the ICS. The trust played a lead role within the Integrated Care Partnerships (ICP) in greater Nottingham, demonstrating collaborative system leadership and actively developing a programme plan for ICP in Greater Nottingham
- Managers across the Trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values
- Staff were in general motivated and wanted to provide the best possible care for patients and were proud to work for the trust. Staff articulated the contributions made by themselves and their teams
- Without exception the Executive Directors, Directors and Non-Executive Directors described a workforce focused on doing their best and striving to deliver.
- The Trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish
- The Trust had made some changes to strengthen the committee structure since our last inspection. Structures, processes and systems of accountability, including governance and management of partnership arrangements were clearly set out, understood and effective
- The Trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected
- The Trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards
- The Trust had invested in innovative and best practice systems and processes to support the delivery of care
- The Trust had a 'Best-of-Breed' Strategy to become a 'Paperless Hospital' by 2020 and had a mission to be a global digital exemplar
- There was holistic understanding of performance. Integrated reporting supported effective decision making
- The Trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation
- There was a strong culture of continuous improvement, driven through transformation work
- There was a strong focus on research and innovation which supported local, national and international best practice

The Trust will commission an external review of its leadership capacity and capability in 19/20 as part of the NHS Improvement well led framework requirements.

7. The Board and its committees

The Trust Board is responsible for determining the strategic direction of the Trust, agreeing its policy framework, and monitoring its performance. Its statutory duties are set out in the codes of conduct and accountability, published by the Department of Health.

The Trust Board has discharged its responsibilities through regular Board meetings, an annual public meeting, and a number of formal committees. The following are currently formal committees of the Trust Board.

- Audit
- Remuneration & Terms of Service
- Finance and Investment
- Quality Assurance
- People
- Appointment of Chief Executive
- Appointment of Other Executive Directors
- Advisory Appointments (medical consultant appointments)

All Board committees are chaired by non-executive directors. Scrutiny of the reports and information takes place in executive led operational committees prior to submission to the Board committees and the Board.

7.1 Board membership

The Board comprises a Chair, five Non-Executive Directors, three Associate Non-Executive Directors (non-voting), five Executive Directors and two (non-voting) Directors.

The following changes were made in 18/19:

- Mrs Michelle Rogan took up appointment as Director of Corporate Governance on 2 April 2018
- Ms Christine Reed stepped down as Associate Non-Executive Director on 31 July 2018
- Ms Natalie Sigona took up appointment as Associate Non-Executive Director (non-voting) on 27 September 2018

- Ms Alison Wynne took up appointment as Director of Strategy and Transformation on 1 October 2018
- Ms Edwina Grant stepped down as Non-Executive Director on 30 November 2018
- Ms Rachel Eddie has been formally acting up into the role of Chief Operating Officer since 14 January 2019 when Ms Caroline Shaw, the existing post-holder, went on secondment

7.2 Board meetings

The Board held eleven formal Board meetings and three Board development sessions during 18/19. The formal meetings were open to the public (except for those matters which the Board resolved to consider in confidential session). Information about Board meetings, including agendas and papers, is posted on the Trust's website - **www.nuh.nhs.uk**.

7.3 Principal Board committee responsibilities

7.3.1 Audit Committee

The committee meets about six times a year. It reviews systems of integrated governance, risk management and internal control, ensures that there is an effective internal audit function, reviews the findings of the external auditor, reviews the findings of other significant assurance functions and considers the draft annual report and financial statements before their submission to the Board.

The Audit Committee meets in private session with the internal auditors, external auditors and the Director of Finance and Procurement to review the effectiveness of the committee and its working relationships. The committee also conducts a detailed annual self-assessment in line with the national model, which is also informed by feedback from other stakeholders.

7.3.3 Finance & Investment Committee

The Finance and Investment Committee meets monthly. It defines the financial planning principles and performance indicators for the planning period, including assessment of the impact on quality; monitors on a regular basis the Trust's financial position; defines the Trust's philosophy and objectives in respect of treasury management; defines the Trust's investment philosophy and objectives in respect of capital expenditure and commitments, service developments and other significant revenue commitments in the context of the Trust's agreed strategy; and considers and provides advice to the Board on the implications of the Integrated Care System.

7.3.4 People Committee

The People Committee meets monthly. Its purpose is to provide assurance to the Board on the effectiveness of the Trust's arrangements for the leadership, engagement, training, development and education of staff at NUH.

7.3.5 Quality Assurance Committee

The Quality Assurance Committee meets monthly. Its purpose is to provide leadership and assurance to the Board on the effectiveness of the Trust's arrangements for quality, ensuring there is a consistent approach throughout the Trust, specifically in the domains of:

- Safe services
- Caring services
- Responsive services
- Effective services
- Well-led services

7.3.6 Remuneration and Terms of Service Committee

The committee meets as and when required. In relation to the Chief Executive, other Executive Directors and other senior employees, it advises the Board about appropriate remuneration and terms of service, all aspects of salary, provisions of other benefits and arrangements for termination of employment and other contractual terms. It receives an annual report from the Trust Chair on the performance of the Chief Executive and an annual report on each of the Executive Directors from the Chief Executive.

7.4 Register of interests

The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

7.5 Performance management

The Trust has in place a performance management framework that prescribes its approach to performance management and ensures that it is effective and standardised across the organisation and that operational priorities are being accurately monitored and reported. It is recognised good data quality is required to enable the Trust to accurately monitor performance. A Data Quality & Reporting Assurance Committee, reporting to the Information Governance and Records Committee, is responsible for monitoring information reports, developing policies and procedures, identifying issues associated with the collection and recording of information, and ensuring adherence to and progression of the Information Governance Standards associated with Data Quality. The Trust uses a data quality assurance indicator that is incorporated within our Balanced Scorecards to assess and report on the data quality of each KPI. It is a visual indicator that acknowledges the variability of data and makes an explicit assessment of the quality of evidence upon which the performance measurement is based. Each indicator measure is assessed as 'Sufficient' (green), ' Insufficient' (red) or 'Not yet Assessed' (blank) on seven distinct elements of data quality. The seven areas of the indicator are:

1. Timeliness: the data is the most up to date available
2. Audit: the system and processes involved in the collection, extraction and analysis of the data have been audited to give sufficient assurance
3. Source: relevant users understand how to extract data and what data is available on the system. All have up to date training on system usage
4. Validation: the data is validated against a secondary source in line with the data validation policy
5. Completeness: the data demonstrates no significant change in volume month on month, or where it does there is an explanation. All mandatory fields are complete
6. Granularity: the data can be broken down to sub Trust-level or the indicator is only collected at a Trust-level and being broken down to a lower level would offer no additional assurance
7. Judgement of Executive Director: the Executive Director (or deputy) can give significant assurance about the quality of the data

All indicator owners are contacted by the corporate Information and Insight team bi-annually with a request to provide an assessment of assurance by completing and returning a self-assessment pro-forma. For each area of the indicator, assurance will be marked as sufficient/insufficient with justification. Monitoring of compliance is held within the Data Quality and Reporting Assurance Committee. As well as the self-assessment of the indicators by their owners the Trust has a rolling internal audit programme with 360 Assurance to audit the data quality and processes of data capture of any digital systems as identified within annual programme planning. Reports and actions coming out of these audits are seen at the Trust Audit Committee to ensure compliance with audit recommendations. The data quality assurance indicator is currently under review to explore if it can be improved and potentially aligned with other regional Trusts to improve consistency of data quality assurance across the region.

8. Workforce strategies and staffing systems

There are a number of key groups and committees within and outside of the Trust focusing on people planning.

The Director of HR chairs the Nottinghamshire Strategic Workforce Group (SWG) tasked with identifying and planning for the key workforce implications emerging from the Nottingham Integrated Care System (ICS). The Deputy Director of HR is a member of the HR/OD Collaborative, a key delivery workstream of the SWG.

The Trust has in place a People Planning and Investment Group (PIPG) whose membership includes professional heads and Divisional leads. The Group is responsible for identifying key issues relating to people planning within NUH and to support Divisions in the development of their plans.

During November 2018, the PIPG STAT co-ordinated the identification of Divisions 'Top five' people issues and challenges to inform the ongoing people planning and investment agenda and scheme of work. Running parallel to the conversations were consultations around the proposed 19/20 workforce plan (which is used to inform the NHSI return as part of the Annual Planning Cycle). The workforce plan for 19/20 has been co-ordinated through the Trust's People Investment and Planning Group (PIPG) and has been through a series of confirm and challenge discussions before being presented to the Management Board and Trust Board for sign off in its public session.

The PIPG has a number of work streams focused on identifying solution to the people issues raised including:

- Development of apprenticeships
- Developing innovative approaches to hard to fill vacancies
- Development of a number of alternative roles, including Medical Team Assistants, Advanced Clinical Practitioners and Physicians Associates

Progress of the workstreams is monitored by the PIPG who also provide a quarterly update to the People Assurance Committee (a sub-committee of the Trust Board).

Progress against our workforce plan is measured through the People Management Committee with Board oversight.

The Trust's Board Assurance Framework includes three strategic risks in relation to people. Each risk is mitigated by a detailed action plan. Progress against plans are discussed regularly at the People Assurance Committee and Trust Board.

The Trust Risk Management Committee oversees the management of the Trust's significant risk register and also focuses on risks scoring over 15 in our risk matrix. The people based risks are included within this review. There are 4 people risks within the significant risk register. Each risk is mitigated by a detailed action plan. The significant risk register is discussed on a regular basis at the Board. The risks scoring over 15 in our risk matrix are usually based on the lack of availability of staff. Divisions regularly report to the Risk Management Committee is terms of action planned to mitigate the risks.

Safe staffing levels for nursing and midwifery staff are reported on a quarterly basis to the People Management Committee and People Assurance Committee.

Monthly performance meetings consider key HR key performance indicators (KPIs) including turnover, absence and bank and agency spend in all staff groups. The KPIs are also discussed within Divisional People Committees, People Management Committee and People Assurance Committee. A comprehensive report is provided every quarter.

In terms of compliance with Developing Workforce Safeguards the following can be highlighted:

For nursing and midwifery staff, there is a well-established process of reviewing establishments every six months using the evidence based methodology for safe staffing. The Chief Nurse signs off each review. In addition, safe staffing levels are reported regularly as described above and the Trust has also developed a safe staffing App with professional judgement required to declare levels of staffing safe or unsafe on daily basis. The Trust also has E-roster tools in place to support efficient and effective staff deployment.

For other staff groups, there is far less national guidance on recommended staff levels to undertake the regular review described above. Discussions are currently being held with medical, healthcare scientist and allied health professional (AHP) leads within the Trust to scope possibility of an 'establishment' based on evidence-based tools (where they exist), professional judgement and outcomes and also the potential to roll out the safe staffing App to other staff groups. In the meantime, the mechanisms described above give services regular opportunity to raise concerns regarding staffing levels and develop action plans accordingly.

The Trust has an established system of exception reporting for doctors in training to report occasions where they have had to work beyond their rostered hours or without a break or have bene unable to leave their clinical area for training/education. In addition, the Guardians of Safe Working are also available for trainees to escalate general concerns about workload/safety and report this formally to the People Committee on a quarterly basis and the Board on an annual basis.

The Trust is starting to use Model Hospital workforce data to compare services with peer trusts in terms of staffing and costs. Whilst there are issues with data quality in some areas, current data does not suggest that our headcount/staffing costs for nursing and midwifery, medical and AHP are significantly lower than our peers.

The Trust uses a matrix system to capture financial efficiency projects. Those which have staffing implications are required to be supported by a quality impact assessment (QIA) which is signed off by the Deputy Chief Nurse (for all staff groups).

9. NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

10. Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

11. Sustainable development

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust will ensure that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

12. Information Governance

Eleven information governance (IG) incidents were reported to the Information Commissioner's Office (ICO) and/or Department of Health and Social Care (DHSC) in 18/19

Category	18/19	ICO Action Taken
Corruption or inability to recover electronic data – network failure	1	DHSC issued an enforcement notice requiring NUH to report all future Network and Information System (NIS) incidents within the statutory 72 hour deadline
Disclosed in error	3	No ICO action taken for two incidents Awaiting ICO outcome for one incident
Lost/stolen paperwork	1	No ICO action taken
Data availability breach	1	No ICO/DHSC action taken
Unauthorised access/disclosure	5	No ICO action taken for three incidents Awaiting ICO outcome for one incident For one incident the ICO is waiting for NUH's internal investigation to conclude
Total	**11**	

All IG incidents are assessed for severity according to NHS Digital guidance. The Trust's Caldicott Guardian and Data Protection Officer confirms severity in each case and authorises reporting to the ICO or DHSC, via the Data Security and Protection Toolkit.

The Trust investigated all incidents and responded to the questions posed by the ICO/DHSC.

All new and revised information processing systems are subject to a Data Protection Impact Assessment (DPIA) process to identify potential privacy risks and concerns around data security. Where such risks are identified, robust control measures are put in place before information processing commences or continues. Eleven DPIAs were signed off in 18/19.

The Trust's ICT network is routinely subject to penetration testing and vulnerability assessments. In 18/19 three penetration tests were conducted:

- iCareCentric Community Portal Penetration Test - Significant Assurance
- Secure Email (Microsoft Exchange) Penetration Test - Significant Assurance
- iDionach NHS IT Health Check test - two Critical Findings (both immediately resolved), six High Findings (one immediately resolved, five have target dates agreed) and eight Medium Findings (six have target dates agreed, two under further investigation).

The Trust continues to invest in modern security solutions to protect our information assets and infrastructure.

IG incidents are analysed to identify trends and vulnerabilities in processes. This information is used to identify changes to processes and/or training to help reduce the recurrence of incidents.

Most breaches of data security are related to user's actions. Annual IG training is mandated for all Trust employees to ensure they are aware of how to safely handle information and so minimise occurrence of information governance breaches.

13. Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust's 18/19 Quality Account will be published on 30 June 2019. The Trust has taken a number of steps to assure itself of the accuracy of the account, including quality checks of the robustness of the data through the Trust's information governance processes; scrutiny of the report by the Trust Board, Joint Health Scrutiny Committee, Lead Commissioner (Nottingham North and East Clinical Commissioning Group), all of whom have been invited to comment on the account. At the time of submission of this statement, the Trust's external auditors, KPMG, are finalising their audit of the quality account.

13.1 Quality and accuracy of waiting time data

The Trust uses a weekly Patient Tracking List (PTL) and daily backlog manager to proactively manage waiting lists. The backlog manager presents information on total incomplete pathways as well as admitted and non-admitted stops. The PTL is refreshed every morning and covers around 30,000 waiting patients. The corporate operations elective performance team ensures all long waits are validated on a weekly basis. In addition, different specialties are selected for review, a process which includes checking waiting list data from Medway (the Trust's patient administration system) against electronically scanned letters from the patients' pathway. A suite of reports designed to capture any breaches in data quality are utilised across specialties and all waits and stops of 18 weeks and above are checked and validated. The corporate operations elective performance team also reviews patient pathways by exception. There is a governance structure and process in place to escalate any waiting list issues as part of the management of elective care. The Trust uses 31-day and 62-day cancer pathway PTLs which are validated by cancer pathway coordinators to ensure the integrity of the data.

Diagnostic patients are tracked and reported on the weekly DM01 return. Diagnostics waiting list validation is undertaken weekly by all relevant departments to ensure the accuracy of the waiting list and any reported breaches. Performance and accuracy is challenged at the weekly PTL meetings.

14. Integrated Care System (ICS)

NUH is represented on the Integrated Care System (ICS) Leadership Board by myself and the Trust Chair. The ICS Board has a significant role in overseeing the integration agenda in Nottinghamshire. An approach has been agreed by the ICS Board that will support the implementation of the NHS long-term plan locally. The ICS Board has asked that further work be done to focus on three priority areas: mental health, urgent and emergency care and financial performance. The Board also asked that consideration particularly be given to ensuring that best use be made of the limited resources across the ICS through streamlining and de-duplication and that partners from across the system are able to contribute at all levels.

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

15.1

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

The Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 2019.

Governance relating to financial stewardship is exercised through the Trust Board where a monthly financial report is incorporated and discussed as part of the public agenda. Accountability for economy, efficiency and effectiveness to the Board is delivered through its committee structure, most notably through the Finance and Investment and Audit Committees. The role of the Finance and Investment Committee, which meets monthly, is to provide overall value for money assurance, including approving and performance monitoring of the Trust's finance, efficiency and recovery plans and reviewing divisional financial and business performance. Financial governance and accountability arrangements have also been strengthened by the establishment of Divisional Finance Committees. The Audit Committee

receives regular reports on all aspects of the Trust's systems of internal control, including reports from internal audit, and reviews the Trust's accounting policies and statutory accounts. This is supported by the work of 360 Assurance (internal audit) to ensure that delivery of services takes place within a sound system of internal control, designed to meet the Trust's objectives and that controls are generally being applied consistently. The Head of Internal Audit issued a significant assurance opinion to that effect.

The Trust delivered a £43.5m deficit before provider and sustainability funding (PSF), representing an adverse variance against the Trust's financial control total of £18.6m. Our plan for 19/20 incorporates an expected improvement in 19/20, aiming to deliver a pre PSF deficit of £27m as part of the longer term plan to return to financial balance. Until 18/19, the Trust had consistently delivered its financial control total agreed with NHSI. NUH reported an overall deficit (after PSF) at 31 March 2019 of £31.8m and delivered efficiencies of £40.3m in 18/19 (3.9% of income).

A combination of factors contributed to the 18/19 deficit. These included: under delivery and loss of elective income and unplanned costs associated with keeping emergency escalation beds open throughout the year to ease bed pressures, associated with higher than planned non elective admissions.

A range of financial recovery interventions were put in place which included strengthening of CIP delivery structures, a more robust expenditure control environment and income improvement schemes. The Trust has also commissioned reports on the Trust's financial control environment, performance management regime and has engaged additional support from Ernst and Young to supplement the Trust's cost improvement drive.

The Trust continues to operate within the NHS Finance regime from a cash perspective through a combination of its existing internal working capital and financial support offered by the DHSC, linked to its agreed I&E plan.

NHS Improvement (NHSI) measures use of resources through the Single Oversight Framework (SOF). The Trust achieved a score of three, which represents the best possible score that it could have achieved, given scoring a four on any component of the metric triggers an override to the calculation, as a result of the financial deficit achieved. The Trust delivered a score of one for spending less on agency staffing than its cap.

The Trust achieved a reference cost of 99 in 18/19, demonstrating that its resources have been deployed effectively for the benefit of patient care. The Trust uses the reference cost benchmarking tool alongside other operational information to highlight areas where there may be financial efficiency opportunities. NUH uses costing data and service line reporting across its service lines. This is used to generate financial reports that are actively used to manage speciality and divisional financial performance. Costing data is also used to drive more efficient practices across services. NUH levers its costing expertise to identify costs of cross organisational clinical pathways.

The Trust also maintained its overall rating of 'good' by the CQC (February 2019) following the inspection, although concluded that use of resources at NUH does require improvement as we spend more than our peers on staff resources to deliver activity and there are several areas of improvement required in clinical support services. Readmissions also remain high and further work is required to understand and address all the relevant drivers.

The Trust is committed to using its resources productively to maximise patient benefit. CQC reported that the Trust has made productivity improvements within its workforce and clinical services, in particular improved utilisation of bed capacity by reducing the time patients spend in hospital waiting for procedures and out of hospital care (delayed transfers of care). Transformation work undertaken to improve utilisation of outpatient capacity has also delivered a significant reduction in the level of missed clinic appointments. These findings together with the use of Carter Model Hospital and Getting it Right First Time (GIRFT) approach, combined with strengthening the financial control environment (in particular in relation to appointing staff), are being used to drive the efficiency programme and to target performance improvement to support the level of transformation required to secure a financially sustainable position. The Trust has an established performance management process to maintain divisional financial accountability.

Despite missing its control total in 18/19 NUH remains committed to achieving sustained financial recovery. The Trust has been set a control total (before PSF funding) of a £27m deficit. The Trust has developed a detailed plan in 19/20 that has been built with the full engagement of our clinical leadership and is aligned to the key strategic objectives of improving our performance in the key domains of emergency care pathway and financial performance. Significant progress had been made in developing the detail of the annual plan, particularly around understanding the capacity constraints facing the Trust and also in negotiating contracts with key commissioners. There are still inherent risks to delivery of the plan, in particular creating additional capacity and delivering an efficiency programme of £37m. However, having reviewed the detail of the plan and following discussions with partners in the healthcare system, the Board agreed to sign off the plan and accept the pre PSF control deficit total of £27m, which if achieved would allow the Trust to access to £27m of PSF funds to secure an overall break even position in 19/20.

In providing an audit opinion for the financial year, the Head of Internal Audit reflected upon the environment in which the Trust has been required to function and the need to meet quality challenges whilst reducing costs.

The Head of Internal Audit noted that whilst this would undoubtedly impact on the operation of control, the system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure.

From his review of the design and operation of the board assurance framework (BAF) and strategic risk management arrangements; the outcome of individual assignments reported within the 18/19 internal audit plan; and the extent to which NUH has responded to audit recommendations a significant assurance opinion has been provided that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide the Board with assurance. The assurance framework itself provides evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed regularly.

Other important sources of assurance are:

- The External Auditor's Annual Audit Letters
- The External Auditor's review of specific services
- The Care Quality Commission's system of registration, compliance, special and periodic reviews
- Internal Audit risk-based audit assignments
- The views of the Local Authority Overview and Scrutiny Committee (Joint Health Scrutiny Committee)
- The views of the Local Healthwatch and Health and Wellbeing Boards
- The views of the Local Safeguarding Boards

I am advised on the implications of the result of the reviews of the effectiveness of the system of internal control by the following Board and Management Board committees:

- The Audit Committee
- The Finance and Investment Committee
- The Quality Assurance Committee
- The Management Board
- The Quality, Risk and Safety Committee
- The Information Governance and Records Committee
- The Trust Health and Safety Committee

Four out of the 22 internal audit assignments completed during the year have been given a limited assurance opinion. Two pieces of 'core' audit work were provided with a limited assurance opinion – the first in relation to the data security and protection toolkit and the second in relation to the Trust's quality governance arrangements. Actions have been agreed in response to these reviews, the implementation of which will be overseen by the Director of Digital Services and Medical Director respectively.

15.2 Modern Slavery Act 2015 - Transparency in Supply Chains

NUH has taken all of the necessary steps during this financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

More information can be found on our website at:
www.nuh.nhs.uk/modern-slavery-act

16. Discharge of statutory functions

The Trust has reporting arrangements in place to check that it is discharging its statutory functions. From these reports, and the audit programme to support them, the Trust is not aware of any irregularities and considers that it is legally compliant.

17. Significant control issues

When determining whether an internal control issue is significant Trusts are advised to consider whether:

- The issue prejudices achievement of priorities
- The issue undermines the integrity or reputation of the NHS
- The view the Audit Committee takes on the point
- Any advice internal or external audit has given
- Whether delivery of the standards expected of the Accountable Officer could be at risk
- Whether the issue has made it harder to resist fraud or other misuse of resources
- Whether the issue has diverted resources from another significant aspect of the business
- Whether the issue had a material impact on the accounts
- Whether national or data security or integrity be put at risk

Achievement of the four-hour emergency standard continued to be a challenge throughout 2018/19 with staffing being insufficient to meet experienced demand in terms of both increased attendances and outflow from the emergency department into our hospitals' bed base.

I chair the A&E Delivery Board which brings together commissioners, providers and local authority senior officials. Through this governance arrangement collaborative operational recovery and emergency pathway transformation plans are in place to improve performance against the four hour emergency standard and provide a better patient experience.

The Trust's 62-day cancer performance remained below the national standard. The underperformance was largely due to insufficient surgical capacity to meet demand, diagnostic waiting times, case complexity, patient choice and oncology waiting times. Closely monitored recovery plans remain in place across all tumour sites and diagnostic areas.

The Board dedicated considerable time and resource to ensure clarity about the drivers for both these patient pathway challenges and the required actions both within NUH, its partner organisations and the wider health and social care community.

The Trust remains committed to delivering financially sustainable services within the NHS Financial framework working with our partners across the integrated health and care. It has accepted the pre PSF control deficit total of £27m, which if achieved would allow the Trust to access to £27m of provider sustainability funds and financial recovery funds to secure an overall break even position.

The Trust has undertaken capacity and demand modelling which outlines growth in activity is required to enable to the Trust to meet the constitutional standards. This creates a pressing need to invest capital in the Trust's estate; in particular ward, theatre and critical care capacity. A plan to achieve these ambitions is being discussed with NHSI and incorporates the application of STP capital funds aimed at improving emergency care. Further capital investment of £31m is also planned to address backlog maintenance, and equipment replacement in order to both manage the risks in these areas and deliver the planned activity for 19/20.

** From October 2016, NHS Improvement (NHSI) has monitored NHS Trusts' financial performance using a composite indicator called the Single Oversight Framework (SOF) - a finance and use of resources metric, which measures a combination of the Trust's liquidity, its ability to service debt, its I&E margin, its distance from its financial plan and the Trust's compliance with the ceiling on agency spend. The Trust achieved a rating in segment three of the SOF - *Mandated support.*

18. Conclusion

Four significant control issues have been identified above, all of which have improvement plans to address them. Notwithstanding these, the Head of Internal Audit opinion provides significant assurance on the Trust's systems of internal control.

Tracy Taylor
Chief Executive

Date: 29 May 2019

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hello my name is...
Kayti

Glossary

A

Accountability – the requirement for organisations to report and explain their performance. Acute – describes a disease of rapid onset, severe symptoms and brief duration. The majority of hospital services provided by QMC and Nottingham City Hospital are for acute illnesses.

Admission – the point at which a person enters hospital as a patient.

Advanced Nurse Practitioners – a registered nurse who has acquired the knowledge, decision-making skills, and clinical competencies for expanded practice beyond that of a registered nurse.

Agency staff – staff working at NUH but employed by a private recruitment agency.

Associate Non-Executive Director – see Non-Executive Director – Associate Non-Executive Directors is that they don't have voting rights at Board.

B

Bank staff – staff who are available for short-term or flexible work to help manage vacancies more effectively.

Best practice – a way of working that is officially accepted as being the best to use.

Biomedical Research Centre (BRC) – there are 20 centres of excellence for clinical research around the country, established by the National Institute of Health Research (NIHR). Nottingham was designated as a new BRC in April 2017 and focuses on six research areas – gastro-intestinal and liver disorders; Magnetic Resonance Imaging (MRI); respiratory disease; mental health and technology; musculoskeletal disease; and hearing.

C

Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian.

Capital expenditure – the money allocated for buildings, equipment or land, also known as fixed assets.

Care Quality Commission (CQC) – the independent regulator of health and social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations.

Clinical Commissioning Groups (CCGs) – the NHS organisations responsible for planning and funding the majority of healthcare.

Clinical outcomes – the end result of a medical intervention, such as survival or improved health.

Clinical Research Network East Midlands – provides the infrastructure that allows high-quality clinical research to take place in the NHS, so that patients can benefit from new and better treatments. It is hosted by University Hospitals of Leicester NHS Trust.

Clostridium difficile (C. diff) – a healthcare associated intestinal infection that mostly affects elderly patients with other underlying diseases.

Commissioning – the process of identifying the needs of local people and funding services to meet those needs; commissioning is done at a number of different levels in the NHS, but the majority of services patients receive are commissioned by the Clinical Commissioning Group for their local area.

Community care – long-term care for people who are mentally ill, elderly, or disabled which is provided in the patient's own home, in a residential or care home rather than in hospitals.

Commissioning for Quality and Innovation (CQUIN) – a system of reward payments made by commissioners to hospitals to encourage better experience, involvement and outcomes for patients.

Cognitive Behavioural Therapy (CBT) – a talking therapy that can help manage your problems by changing the way you think and behave.

Cystic fibrosis (CF) – a genetic disease that causes blockages in the lungs and other organs, such as the liver and the pancreas.

D

Defence and National Rehabilitation Centre (DNRC) – The new Defence Medical Rehabilitation Centre, known as 'DMRC Stanford Hall', started treating patients in October 2018, with the transition of staff from the previous Defence rehab facility, Headley Court in Surrey, having occurred in the previous two months. More information: **www.thednrc.org.uk**.

Dementia – describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. Dementia is caused when the brain is damaged by diseases, such as Alzheimer's Disease or a series of strokes.

Discharge to assess – enabling patients to be assessed for their longer term health and social care needs at home or in the community, rather than waiting for this to happen in hospital.

E

Early Warning Score (EWS) – a categorisation that uses data taken from routine patient observation to calculate a score indicating potential severity of illness and to act as a prompt to nursing staff to request a medical review at specific trigger points. (PEWS is a specific type of early warning score designed to assess children.)

East Midlands Radiology Consortium (EMRAD) – a consortium of seven Trusts across the East Midlands who are collaborating on radiology services. Together they have procured and deployed a new, common digital radiology system.

Elective care – care that is planned. This is usually where the patient is referred by their GP or other healthcare professional. Appointments, treatments and admissions to hospital will be confirmed in advance.

Elective surgery – an operation that is planned ahead and for which the patient will be given a date to be admitted to hospital.

Emergency Department (ED) (also known as Accident and Emergency) – the department specialising in the care of patients with life-threatening or life-changing needs, which require immediate, specialist care.

Emergency tariff – the payment rate for treating an emergency patient. A provider receives payment at 30% of the tariff price for all emergency activity above the baseline in 08/09. Equality and diversity – equality is about creating a fairer society where everyone can fully take part. It means giving people an equal opportunity to have their individual needs considered and met, in recognition that society comprises different people with different needs at different times. Diversity is the positive recognition of difference.

End of life care – ensuring that the care people receive at the end of life is compassionate, appropriate, and gives people choices regarding where they die and how they are cared for. Care is co-ordinated across health and social care services.

E-observations – a digital system for recording vital signs of a patient (such as blood pressure, temperature and heart rate). NUH clinical staff use a mobile device to collect and store patient observations, creating a set of information that can assist in making clinical judgments. This can help indicate signs of deterioration, for example sepsis and acute kidney injury.

Evidence Based Practice (EBP) – the integration of clinical expertise and the best research evidence into the decision making process for patient care.

F

4Cs – patient experience as measured by complaints, concerns, comments and compliments submitted by patients and their friends/family.

Financial control total – the maximum amount of deficit or surplus that an NHS organisation is required to achieve. This amount is set by NHS Improvement and agreed with each organisation, or as part of the wider health and care community.

First attendance – the first or only time a patient attends hospital after being referred by their GP or health professional.

Follow-up attendances – the second and subsequent times patients attend hospital for assessment, diagnosis or treatment as an outpatient.

Foundation Trust – see 'NHS Foundation Trust'.

Francis Inquiry – an independent inquiry conducted by Sir Robert Francis in February 2013, examining the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009.Friends and Family Test (FFT) – the national patient satisfaction programme which gives every patient the opportunity to feedback on the quality of their care. There is also a version of this survey for NUH staff.

Full-time equivalent (FTE) – the measurement and calculation of total staff numbers, using a standard working day. Also known as whole time equivalent (WTE).

G

Getting It Right First Time (GIRFT) – the Getting It Right First Time (GIRFT) programme aims to bring about higher-quality care in hospitals, at lower cost, by reducing unwanted variations in services and practices

H

Health and Wellbeing Board – health and wellbeing boards were established to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

Health Scrutiny Committee/Overview and Scrutiny Committee – a function of local councils in England. The committee has the responsibility to review policies, decisions and services in their own council and in other organisations, including the NHS, which may impact on local residents.

Healthcare Assistant (HCA) – staff who work under the guidance of a qualified healthcare professional, usually a nurse. Sometimes staff working in HCA roles are known as nursing assistants, nursing auxiliaries or auxiliary nurses.

Healthcare for older people (HCOP) – a general term for the range of services designed around the needs of older people.

Healthcare Resource Groups (HRGs) – standard groupings of clinically similar treatments which use common levels of healthcare resource. Health Service Ombudsman – investigates complaints that individuals have been treated unfairly or have received poor service from the NHS in England. HfMA – professional body for the healthcare finance staff.

Healthwatch Nottingham/Nottinghamshire – the local service affiliated to Healthwatch England, the national consumer champion in health and care. They have statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

Hospital Standardised Mortality Rates (HSMR) – an indicator of healthcare quality that measures if the death rate at a hospital is higher or lower than you would expect. The HSMR compares the expected rate of death in a hospital with the actual rate of death. Factors such as age and severity of illness are taken into account.

I

Information Governance – the set of multi-disciplinary structures, policies, procedures, processes and controls implemented to manage information to ensure an organisation's regulatory, legal, risk, environmental and operational requirements.

Inpatient – a patient who is admitted to hospital for a period of treatment or to undergo an operation. Inpatients are those that stay in hospital for 24 hours or more.

Integrated Care System (ICS) – new developments in NHS care which bring together commissioners and healthcare providers to plan and deliver care without organisational and financial boundaries.

Integrated discharge – planning and managing a patient's discharge from hospital across all services and all part of the hospital.

Intervention – any measure to improve health or alter the course of disease.

In-session utilisation – the proportion of time used effectively within timetabled operating sessions in operating theatres. (also see Session utilisation).

L

Lesbian, Gay, Bisexual and Transgender (LGTB) staff association – a group to promote equality in sexual orientation that is open to all staff who are lesbian, gay, bisexual, heterosexual or transgender. It provides a safe environment to share and discuss work related experiences in order to gain support and advice.

Linear accelerator (LINAC) – is the device most commonly used for radiation treatments for patients with cancer. The linear accelerator is used to treat all parts/organs of the body. It delivers high-energy x-rays (or electrons) directly to the patient's tumour.

Local Health Resilience Partnership – a multi-agency strategic forum that plans the local response to emergencies in the health sector.

Local Safeguarding Boards – the statutory committee operating in each local authority area to coordinate work to safeguard and promote the welfare of children and to ensure the effectiveness of the work organisations do individually and together.

Locum staff – nurses and doctors employed by the NHS on a temporary, fixed-term basis.

M

Magnet® – the only international recognition programme for excellence in nursing care. It sets the standard for the quality of care patients receive and is an indication of the world-class standards of care that the whole hospital team provides.

Major Trauma Centre – QMC is home to the major trauma centre for the East Midlands. It treats people with very serious, multiple injuries like those you would associate with car accidents, serious gun and knife wounds or falling off a horse.

Magnetic resonance imaging (MRI) – is a test that uses a magnetic field and pulses of radio wave energy to make pictures of organs and structures inside the body. The technology was developed in Nottingham and gives different information about structures in the body than can be seen with an X-ray, ultrasound, or computed tomography (CT) scan.

Memory Menu – the Trust's award-winning menu, uniquely design for patients, by patients following extensive consultation and engagement with our local community.

Methicillin Resistant Staphylococcus Aureus (MRSA) – is a type of bacteria that is resistant to a number of commonly used antibiotics. It lives on the skin and is mostly harmless unless it gets deeper into the body, for example, if it gets into a wound or where the skin is broken.

Model Hospital – a digital information service designed to help NHS providers improve their productivity and efficiency by comparing and benchmarking performance against peers/ other centres.

N

National emergency access standard – a national standard for all Emergency Departments/Accident and Emergency Departments. The standard measures the number of patients seen, admitted or discharged within four hours; hospitals are expected to achieve 95%. It is often known as the 'four hour' standard.

National Institute for Health Research (NIHR) – is the research arm of the NHS which manages and funds research programmes across healthcare and academic organisations.

National Patient Survey – ensures patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services. All NHS trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. There are inpatient, maternity and outpatient surveys.

National Rehabilitation Centre (NRC) – the DNRC (see page 154), envisaged both a Defence element and a civilian (National) facility nearby on the same site. The 'National' opportunity is receiving detailed consideration in 2019 and this work is ongoing. The work is being undertaken on the basis of a National Rehabilitation Centre (NRC) Programme where the NHS sponsor is NUH, with clinical experts from our hospitals leading this important work. More information: **www.thednrc.org.uk**.

Never events – serious, but largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

NHS Improvement – is responsible for overseeing NHS trusts, as well as independent providers that provide NHS-funded care.

NHS Trust – a statutory, self-governing NHS organisation providing healthcare services. NHS trusts – and NHS Foundation trusts - provide the majority of hospital, mental health and ambulance services. Their income is derived from service agreements and contracts with clinical commissioning groups or, for some highly specialist services, NHS England. They have freedom to decide staff numbers and rates of pay and some powers to invest and borrow money.

Non-elective care – is provided when the patient is assessed as needing treatment or hospital admission urgently or in an emergency.

Non-Executive Director – a member of the Trust's Board of Directors who is not part of the Executive Team. A Non-Executive Director typically does not engage in the day-to-day management, but is involved in policy making and planning exercises. In the NHS Non-Executive Director appointments are managed by NHS Improvement. Non-Executive Directors have voting rights on the Board.

Nottingham Treatment Centre – a healthcare facility based at QMC, which provides a range of outpatient and inpatient services to our local population. NUH took on the running of this facility on 29 July 2019, as part of a new five-year contract which was awarded earlier this year..

NUHonours Awards – an annual awards ceremony that recognises and pays tribute to those staff and volunteers from NUH who have gone the extra mile for patients, visitors and colleagues.

Nurse Associate – a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients.

O

On-the-day cancellation – refers to a planned operation that is cancelled on the day the patient was due to arrive (at hospital), after the patient has arrived in hospital or on the day of the operation if the patient is already in hospital.

Overview and Scrutiny Committee – see Health Scrutiny Committee.

Palliative care – services for people living with a terminal illness where a cure is no longer possible. Palliative care aims to treat or manage pain and other physical symptoms. It will also help with any psychological, social or spiritual needs.

P

Parliamentary Health Service Ombudsman (PHSO) – the Ombudsman makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations.

Pathway of care – the planned and most efficient way to provide care from referral to diagnosis, treatment and follow-up care. Pathways are in place for most common diseases and conditions, using evidence based practice to determine the best way for patients to be seen and treated.

Patient Administration System (PAS) – computerised system to record non-medical patient details such as name and address as well as appointments/visits to the hospital.

Patient Advice and Liaison Service (PALS) – provides information, advice and support to help patients, families and their carers. Patient experience – the experience a patient has in our hospitals, whether as an inpatient or an outpatient. This includes not only the care received

Patient experience – how it feels to be an inpatient or an outpatient. This includes not only the care received, but also aspects such as the hospital facilities and the patient's comfort throughout their visit.

Patient flow – the different elements that make up a patient's progress through the hospital system from referral through to diagnosis, treatment and discharge. This includes all of the staff, departments and organisations who are involved in providing the end-to-end care.

Patient level costing (PLICS) – computerised information systems in hospitals to track and enable analysis of the costs of care incurred by individual patients.

Provider Sustainability Fund (PSF) – national bonus monies allocated to Trusts by quarter based on performance versus plan, including financial plan and emergency access performance. Previously called Sustainability and Transformation Fund.

Public Sector Equality Duty – the public sector's legal duty to eliminate discrimination, advance equal opportunities, and foster good relations, and publish data on progress.

Q

Quality Account – every NHS Trust is required to publish a Quality Account, setting out how we continue to improve the quality of services we provide covering three key areas: patient safety, clinical effectiveness and patient experience.

Quality assurance – the maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production.

Quality Innovation, Productivity and Prevention (QIPP) – a large-scale programme to drive forward quality improvements in NHS care, at the same time as making healthcare more efficient.

Quality governance framework – a set of standards for trusts to continuously monitor themselves against.

R

Radiology – is the science that uses images to diagnose and in some cases treat diseases. It is a general term which covers X-ray, CT and MRI scans.

Readmissions – the number of patients re-admitted as an emergency within either 7 or 28 days of being discharged following previous treatment.

Recurrent income – ongoing income, expenditure or savings.

Reference Cost Index – unit costs to the NHS of providing defined services in a given financial year to NHS patients in England, published by the government.

Resilience – the ability of an organisation to adapt and respond to disruptions, whether internal or external, to deliver organisationally agreed critical activities.

Respiratory – the specialty which deals with illnesses and conditions affecting breathing.

Ropewalk House – the city centre site of NUH that provides breast screening and audiology services.

Resilience Team – the team is responsible for writing, updating and exercising all the emergency plans for NUH. In the event of a major incident the Emergency Planning Team helps to co-ordinate the Trust's response.

Referral to Treatment (RTT) – national maximum waiting times set out in the NHS Constitution from the point a patient is referred to hospital by their GP.

S

Safety culture – the attitude, beliefs, perceptions and values that employees share in relation to safety in the workplace. Safety culture is part of organisational culture; a positive safety culture is a key part of improving the quality of care.

Shared governance – a management structure for nurses which empowers frontline staff to work together and make decisions that affect nursing practice and patient care. It involves teamwork, Evidence Based Practice (EBP), and accountability with the aim of improving productivity and patient outcomes.

Staff engagement – encouraging staff to be committed to their organisation's goals and values, motivated to contribute to organisational success, and enhance their own sense of job satisfaction.

Single Oversight Framework (SOF) – sets out how our regulator NHS Improvement oversee NHS Trusts and NHS foundation trusts, helping to determine the level of support they need based on a range of performance measures.

Sustainability and Transformation Partnership (STPs) – joint health and social care partnerships for improving the health of local people through joined-up working and the development of new models for providing services. There are 44 partnerships across England including the one for Nottingham and Nottinghamshire, which includes NUH. Now called Intergrated Care System. See ICS.

Sustainability and Transformation Fund (STF) – a national budget to support the development of NHS services, set up in 2015. It is allocated to hospitals based on their achievement of a number of specific targets. Now called Provider and Sustainability fund. See Provider Sustainability Fund.

T

Teaching trust – a hospital that provides clinical education and training to future and current health professionals in partnership with university medical schools. NUH is the third largest teaching hospitals in the country.

Tertiary care – there are three levels of healthcare in the NHS: primary care (the first point of contact for patients including GPs, dentists, pharmacists and opticians); secondary care (specialist services, often provided by a hospital, that patients are referred to from primary care); and tertiary care which is further specialised treatment and care provided by professionals with specific expertise in a given field, for example neurosurgery, cardiac surgery and cancer management.

Tertiary referrals – referrals for specialist care from consultant to consultant. These can be within the same hospital/service or between different hospitals and services.

Tumour sites – the place in the body affected by cancer. Most cancers start in one part of the body – the primary tumour site. For example, if you have cancer that starts in the breast, you have primary breast cancer.

Two-ticks – a recognition scheme given by Jobcentre Plus to employers based in Great Britain who have agreed to take action to meet five commitments regarding the employment, retention, training and career development of disabled employees.

U

Urgent Care Centre – based in the centre of Nottingham, the Urgent Care Centre is open every day of the year between 7am and 9pm. It is designed to provide care for people who have an urgent, but not life-threatening injury or illness.

Urgent Treatment Centre – a service staffed by GPs within NUH's Emergency Department at QMC that is available seven days a week to manage patients with urgent, but not life-threatening conditions.

W

Waiting times – the period that a patient may wait before being seen at a routine appointment or for admission to hospital. The standards and maximum waiting periods are set nationally under the NHS Constitution.

We Listen
We Care

Designed by NUH Communications Team