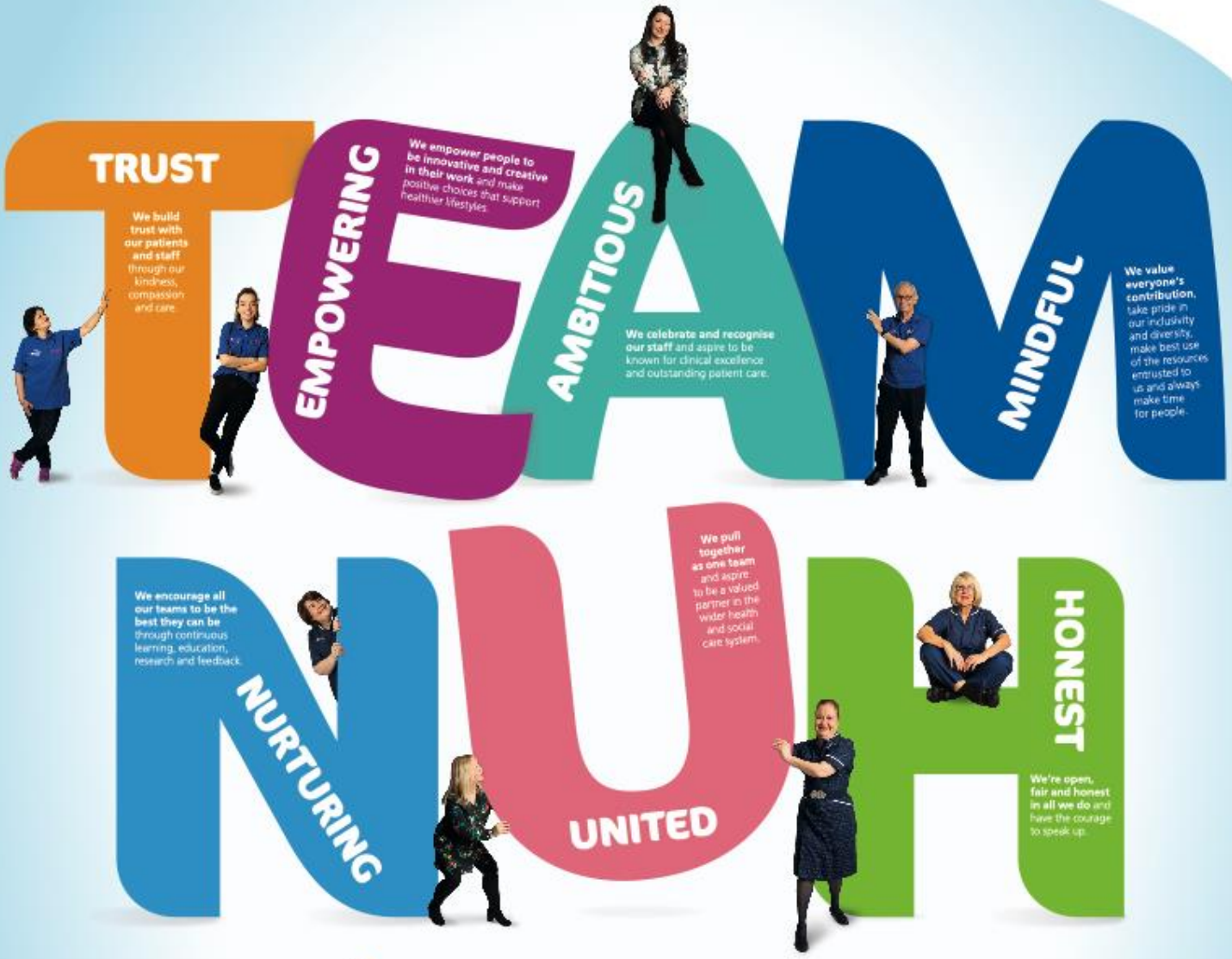
NHS
Nottingham
University Hospitals
NHS Trust

Annual Report

2019/2020

NHS
Nottingham
University Hospitals
NHS Trust



VALUES

Our values are the essence of our identity. They reflect our principles and beliefs and show people that we listen, and we care.

We are TEAM NUH

www.nuh.nhs.uk

We Listen
We Care

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Welcome from the Chairman and Chief Executive

We are delighted to present our annual report and accounts for 2019/20.

As we write this we are in the middle of dealing with the effects of a global pandemic along, so it is fair to say that it feels a little strange reflecting back over the financial year we completed just a week after the lockdown was put in place.

We achieved a lot during the year, as you will read throughout this report, and our introduction just highlights some specifics and our views on them.

You will see later in the document how we faired against the national performance standards, but we would like to highlight some areas. From May 2019 we were part of the national field testing programme for new clinical standards in urgent and emergency care, which meant that we stopped reporting against the four-hour standard to avoid contaminating the data that was being collected. We, and particularly our clinical teams, appreciated the opportunity to take part, testing and challenging assumptions around this very high profile area of care. The focus for our teams remained safe and timely care and the overall experience for our emergency patients, which became challenged during the winter with increased numbers of patients needing care.

We were given money to increase the number of beds, particularly in our admission areas, and further redesign our acute urgent and emergency care services. In mid-January we opened our brand new Acute Medical Unit on B floor at Queens, which is a mixture of new and old estate and provides us with 91 acute beds. The new unit is a very large assessment and treatment area for patients with medical problems that require a stay in hospital of less than 48 hours. It also cares for our older patients with dementia and we incorporated some dementia friendly designs into the new build. We received £5m of capital money for this build which took 16 weeks of very hard work for our team to pull together, and whilst this important work has delivered what it set out to, we have continued to struggle to admit patients in a timely way because we still do not have enough beds, particularly in our medical wards at Queen's.

These pressures were exacerbated during winter, when the flow of patients through our organisation slowed and the number of medically safe patients in our beds increased significantly. This regrettably has an impact on patients waiting in the Emergency Department, some of whom waited much longer than we would have liked for a hospital bed. That hit a critical point during the first week in November, when we, like many other acute hospitals saw a surge in patients which extended to long waits in ED and not enough in-patient beds to manage them, despite having already opened extra beds. Partnership working across the system at this point was crucial. It's fair to say that the recent response to the pandemic and emptying our beds quickly to be able to cope with potential COVID patients has taught us a lot; much of which we can turn into real change so that we don't see another situation arise like the incident in November as creating a more robust urgent and emergency care system remains one of our top priorities.

Taking control of the Treatment Centre in the summer made our cancer services amongst the largest in the UK, receiving between 2,300 and 2,800 two-week wait referrals every month. Despite this, our performance has remained strong against the cancer two-week wait, 14-day referral for breast symptoms to assessment, and the 31-day subsequent for drug and radiotherapy cancer standards. Whilst our 62-day referral to treatment performance has remained stable, our performance remains below the national standard, something we are working hard to improve. The 31-day diagnostic to treatment and 31-day second or subsequent surgery treatment have continued to under-perform during the year due to the waiting times for surgery; again, an area of focus for improvement. Eliminating surgical waits and reducing waits for diagnostic tests will help improve these measures, but capacity is a limiting factor. Our services are working hard to recruit staff but we struggle with national shortages for clinical staff in some specialties.

Again, COVID has presented many challenges over the last few months, not least for our cancer (and other urgent) patients for whom this continues to be an extremely worrying time. Our teams have worked tirelessly since the start of the incident to protect operating capacity for these patients and in May we operated on our 1,000th patient since the start of the lockdown. This would not have been possible without the amazing collaboration and flexibility of our surgical, anaesthetic, theatre and critical care

teams, to name but a few, to ensure that we maintained sufficient capacity throughout the COVID surge to offer operations to all cancer patients who were clinically safe to proceed with treatment. We already have established effective partnerships with our local independent sector providers, who have made their facilities available to the NHS and worked in partnership with us to ensure seamless pathways for patients, an arrangement we intend to continue as long as the national contract remains in place. A massive thank you to all staff who have contributed to this achievement, and those of you who have worked tirelessly in your own service to ensure we have maintained access for urgent patients throughout this difficult time.

Secretary of State for Health and Social Care Matt Hancock visited Queens during November following a request from Darren Henry (at the time) Conservative candidate for Broxtowe (now MP). During Mr Hancock's short visit he had a tour of our Emergency Department and Neonatal Intensive Care Unit to help him better understand the challenges we are facing. Shortly after his visit, we were told that we were one of the 21 organisations in the Department of Health & Social Care's Health Infrastructure Plan (HIP), a new hospital building programme to ensure the NHS' hospital estate can provide world-class healthcare services. This scheme will allow us to take forward our exciting Tomorrow's NUH reconfiguration programme. Over the coming months, working with our staff, partners, stakeholders and patients we will design a plan that will enable us to provide the right care in the right location, transform our services and meet the commitments made in our Strategy and Clinical Service Strategy, the NHS Long Term Plan and the vision for the Nottingham and Nottinghamshire Integrated Care System. It will also help address legacy issues that remain from merging two separate organisations, which impacts our ability to deliver modern care because of services split across sites or duplicated, spreading our staff and equipment too thinly. It will also support clinical best practice and fulfil our role as a regional centre and also fix the parts of our ageing estate that have received little or no investment and do not meet the needs of our services to deliver modern healthcare.

Another big venture that we have been working with partners on throughout the year, are the plans for the National Rehabilitation Centre (NRC) on the Stanford Hall Rehabilitation Estate in Leicestershire. The development of this new rehabilitation centre would be for NHS patients, providing a new and enhanced rehabilitation service and will allow us to develop new ways of delivering these services. It would be a standalone NHS facility, located close to the Defence Medical Rehabilitation Centre on the same site. Patients referred there would have access to some of the military rehabilitation facilities, but would be treated by NHS staff in a separate building. This is a unique opportunity to provide NHS services to NHS patients while benefitting from a co-located site with specialist military rehabilitation services. There is evidence that patients have an improved chance of returning to their lives more quickly if they have access to a specialist team and dedicated facilities all coordinated together under one roof during their time in hospital. The public consultation for this project will start in July of this year following a delay due to COVID. Money is available for this project so the consultation is on whether or not to take forward this opportunity, including the proposed transfer of existing services to the new facility. This is an exciting project and we hope that during the year we will see the business case process finish and the project start in earnest. We will continue to support this project which we feel will bring untold benefits to patients who need rehabilitation.

During 2019 we started the NHS Improvement/ Kings Fund culture and leadership programme. Pre COVID we had spent some time working through the first two phases of the programme; discovery and design. This entailed gathering intelligence from our staff across a number of areas and via a number of channels, such as focus groups, surveys and interviewing the Board and executive team. It was supported by our Culture Change Team, made up of 55 staff from a variety of services and staff groups. This data was then analysed and themed around the five cultural elements and shared back with the organisation at a co-design event. This intelligence contributed to a culture and leadership strategy which was due to be launched in April 2020 following the anticipated release of the NHS People Plan, but was paused and is in the process of being reviewed to ensure our learning from COVID-19 is reflected in the strategy. However, work across the five cultural elements continues and in some instances has been accelerated as a result of COVID-19. For example the development of two Well-being Centres and the wellbeing offer developed for staff to support them through this difficult time, as well as fantastic examples of learning and development

delivered differently, compassionate leadership, team working, numerous examples of innovation and staff living our TeamNUH values. We look forward to taking this work forward during this year.

This year has seen a number of changes to the Board and Executive Team. Professor John Atherton joined the Board on 1 April 2019, Anita Day joined on 15 April 2019 and Claire Urmston and Craig Wilcockson both joined us on 1 January 2020 all as Non-Executive Directors. Mark Chivers, previously an associate Non-Executive Director began his role as a substantive Non-Executive on 1 February 2020 and Sardip Sandhu joined us as an Associate Non-Executive Director on 1 January. In addition, Maggie Boyd joined the board as a Non-Executive Director from 1 April 2020

During the year we said thank you and farewell to Non-Executive Directors David Cartwright, Julie Pomeroy and to associate Non-Executive Director Dr Sheila Newport.

The Executive Team also saw some changes with Lisa Kelly joining us as Chief Operating Officer on 1 August, Tiffany Jones as Director of Communications and Engagement on 1 November and Dr Neil Pease became our Chief People Officer on 1 January 2020.

Finally, we could not end our introduction to this report without giving our sincere thanks to the many people and organisations that support our work. To our many volunteers who give their time freely, every day, to help our patients, visitors and staff; to our Patient Partnership Group, to our friends at Nottingham Hospitals Charity, to our colleagues at Notts Healthcare NHS Trust, CityCare and Sherwood Forest NHS Foundation Trust, partners at Healthwatch and the local Clinical Commissioning Groups, Local Authority partners, and GPs for their continued help and support. And of course, local people who have shown their support recently fundraising, donating gifts and clapping every Thursday for our staff; it's beyond heart-warming.

Most of all, our unreserved thanks, on behalf of the whole Trust Board, must go to our staff. This past year had already seen many challenges and pressures, before the COVID pandemic arrived. Yet despite this when we walk our wards, departments and corridors we are met with smiles and hear stories of people going above and beyond for our patients and their colleagues. They are the reason that the CQC recognised the care we deliver as outstanding.

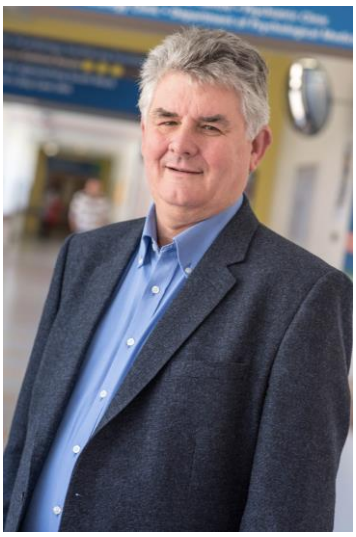
We really appreciate their dedication to our organisation and patients. We thank them for their on-going commitment to make things better, and we revere them for everything they do day in, day out to provide the best service that they can. We are immensely proud to lead Team NUH.

Eric Morton

Chair

Tracy Taylor

Chief Executive



About Nottingham University Hospitals

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

To help us achieve this we set out a ten year strategy in 2018 which included six promises: Patients, People, Places, Performance, Partners and Potential.

These promises are underpinned by a set of values and behaviours that are the essence of our identity. They reflect our principles and beliefs and show people that we listen, and we care. Quite simply they are Team NUH – Trust, Empower, Ambitious, Mindful, Nurturing, United and Honest.

Team NUH is made up of around 16,700 staff, making us one of the largest employers in the region. Our team work across Queen's Medical Centre, the City Hospital, Ropewalk House and a number of community facilities across the local region. We have an annual budget just under £1 billion, 90 wards and around 1,700 beds.

We are based in the heart of Nottingham and provide services to over 2.5 million residents of Nottingham and its surrounding communities. We also provide specialist services for a further 3-4 million people from across the region.

Queen's Medical Centre is where our Emergency Department (ED), Major Trauma Centre, Nottingham Treatment Centre and the Nottingham Children's Hospital are based. It is also home to the University of Nottingham's School of Nursing and Medical School.

Nottingham City Hospital is our planned care site, where our cancer centre, heart centre and stroke services are based.

Ropewalk House is where we provide a range of outpatient services, including hearing services.

We have a national and international reputation for many of our specialist services, including stroke, renal, neurosciences, cancer services and trauma.

We are at the forefront of many research programmes and new surgical procedures. In partnership with The University of Nottingham we host a Biomedical Research Centre carrying out vital research into hearing, digestive diseases, respiratory, musculoskeletal disease, mental health and imaging.

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.

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The Accountability Report

Our Trust Board

Declaration of interests

Voting Board members - Non-Executive Directors

	Mr Eric Morton Chair	Ice Hockey UK – Non Executive Board Member
	Mr Stephen Thomas Non Executive Director/Vice Chair	Experian PLC – Managing Director, Strategic Development | National Data Steering Group – Member | Digital Catapult – Non-Executive Director
	Prof. John Atherton term of office commenced on 1 April 2019 Non Executive Director	Pro Vice Chancellor for the Faculty of Medicine and Health Sciences in the University of Nottingham | Member of the Executive of Medical Schools Council | Member of Midlands Health Innovation which represents the interests of research-intensive Universities in the Midlands | Sit on the Steering Committee of the National Rehabilitation Centre at Stamford Hall | Medical Workforce Group of the Implementation Committee of the NHS Improvement Plan | Wife is Deputy Medical Director at NUH
	Mr David Cartwright [term of office ceased 31 March 2020] Non Executive Director	General Optical Council - Registered with regulator as a practicing Optometrist | General Optical Council – Member of Fitness to Practice Hearing Panel | College of Optometrists - Member of the professional body for Optometry | Chair of Eyecare Trust | Chair of Irvine Aitchison Fund – Fund that provides educational training within optical sector | DC Vision Ltd – Director | Company that provides Optometric services to Optical practices | Chair Derby/ Notts Eye Health Local Professional Network | A group that brings together those who have an interest in eye health to recommend patient pathways to improve eye health outcomes across Derby/ Notts | Member of Nottingham local Optical Committee | Employed with Boots Opticians as an Optometrist
	Mr Mark Chivers term of office as a substantive Non Executive Director commenced 1 February 2020 – was previously an Associate Non Executive Non Executive Director	Boots UK – Director of Estates, Engineering and Energy | Nottingham Enterprise Zone Development Company Ltd – Director | D200 Energy Limited - Director | Walgreens Boots Alliance – Shareholder | Director, Governor and Trustee of Nottingham High School
	Mrs Anita Day term of office commenced 15 April 2019 Non Executive Director	Non Executive Director – Worcestershire Acute Hospitals Trust | Principle – Anita Day Consulting | Associate – Steps Drama Learning Development
	Mrs Julie Pomeroy term of office ceased 31 January 2020 Non Executive Director	Dillistone Group PLC, plus subsidiaries – Director | Secantor – part time consultant | Nemaura Pharma Ltd – part time consultant | Nemaura Inc. – small shareholding
	Ms Clare Urmston term of office commenced on 1 January 2020 Non Executive Director	Chief Financial Officer - Anemoi Marine Technologies Limited | Board Advisory Member – DIAL Global Limited | Business Committee Member - ICAEW
	Mr Craig Wilcockson term of office commenced on 1 January 2020 Non Executive Director	Executive Director - Orbit Group Limited

Voting Board members - Executive Directors

Mrs Tracy Taylor

Chief Executive

NHS Providers Board – Member

Mr Rupert Egginton

Chief Financial Officer/ Deputy Chief Executive

J.T. Egginton Ltd – Director | Hospital Pharmacy Services (Nottingham) Ltd – Director

Dr Keith Girling

Medical Director

Appointed to the role of Pharmacy Director for Hospital Pharmacy Services (Nottingham) Ltd, with effect from 1 February 2019

Ms Mandie Sunderland

Chief Nurse

NUH Hospitals Charity - Trustee

Ms Lisa Kelly
commenced in this role on 1 August 2019

Chief Operating Officer

None

Ms Rachel Eddie
acting up arrangements ceased on 31 July 2019

Acting Chief Operating Officer

None

Non-voting Board members - Associate Non-Executive Directors

	Dr Sheila Newport term of office ceased on 30 August 2019 Associate Non Executive Director (non Voting)	None
	Ms Sardip Sandhu term of office commenced on 1 January 2020 Associate Non Executive Director (non Voting)	Non Executive Director – West Nottinghamshire College | Vidiya Consulting Services Ltd - Director
	Ms Natalie Sigona Associate Non Executive Director (non Voting)	Head of Diversity and Inclusion at BAE systems

Non-voting Board members - Executives

	Mrs Michelle Rogan Director of Corporate Governance	None
	Ms Alison Wynne Director of Strategy and Transformation	Partner is Executive Medical Director at University Hospitals of Derby and Burton NHS Foundation Trust

In attendance at Board

	Ms Tiffany Jones commenced in this role on 1 November 2019 Director of Communications and Engagement	None
	Dr Neal Pease commenced in this role on 2 January 2020 Director of Workforce and Organisational Development	None
	Ms Laura Skaife-Knight left this role on 3 October 2019 Director of Communications and Engagement	None
	Ms Nicky Hill left this role 9 September 2019 Director of HR	None

What is a Non-Executive Director?

The role of Non-Executive Directors is different to that of an Executive Director. They do not have responsibility for the day to day management of the Trust but share the Board's corporate responsibility for ensuring that the Trust is run efficiently, economically and effectively. They will scrutinise the executive management's performance in meeting agreed goals and objectives and monitor the reporting of performance. They must satisfy themselves on the integrity of financial information and that financial controls and a sound system for the management of risk are in place. They will seek to establish and maintain public confidence in the Trust, and must be independent in judgement and constructively challenge and help develop decisions and strategy for which they bear equal responsibility.

To be effective a Non-Executive Director needs to be well-informed about the Trust and have a good grasp of the relevant issues.

Our Non-Executive Directors bring independence, external perspectives, skills and challenge to strategy development and hold our Executive Team to account for the delivery of the strategy. They actively support and promote a healthy culture for the organisation and this reflects in their own behaviour. It is imperative that they provide visible leadership in developing a healthy culture so that staff believe Non-Executive Directors provide a safe point of access to the Board for raising their concerns.

Some of the Non-Executive Directors chair key committees that support accountability. Individual Non-Executive Directors are members of specific Board Committees, although papers of all those meetings are available to all Non-Executive Directors if they wish to see them. The Chairman and all Non-Executive Directors are members of the Trust's Remuneration Committee.

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

Committee	Board Member Chair
Audit Committee	Mr Mark Chivers, Non-Executive Director
Remuneration & Terms of Service Committee	Mr Eric Morton, Trust Chair
Finance and Investment Committee	Mr Stephen Thomas, Non-Executive Director/ Vice Chair
Quality Assurance Committee	Professor John Atherton, Non-Executive Director
People Committee	Mrs Anita Day, Non-Executive Director
Appointment of CEO	Mr Eric Morton, Trust Chair
Appointment of Other Executive Directors	Mr Eric Morton, Trust Chair
Advisory Appointments (medical consultant appointments)	Any Non-Executive Director of the Board

Trust 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 our website: www.nuh.nhs.uk and are also available from: Michelle Rogan, Director of Corporate Governance, Trust Headquarters, Nottingham City Hospital, Nottingham, NG5 1PB. Tel: 0115 969 1169 extension 76001 or e-mail: michelle.rogan@nhs.nhs.uk

Annual Public Meeting

Our annual public meeting for the year ending 31 March 2019 was held on 23 September 2019 in the Postgraduate Education Centre at City Hospital.

We shared our responsibilities and good stewardship of public funds in the previous financial year with patients, public members and partners.

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

There were presentations from the BAME Shared Governance Council and patient representatives about patient and local community engagement. We also heard how our partnership with the Redthread Charity was preventing young patients becoming victims of violent crime and we learned about the crucial role our volunteers play in improving patient experience.

Openness and Accountability

We have adopted the NHS Executive's code of conduct and accountability, and incorporated them into our corporate governance policies (our Standing Orders, Standing Financial Instructions and Scheme of Delegation).

Anti-fraud and corruption statement

The Bribery Act 2010 came into effect on 1 July 2011. Bribery is generally defined as giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so. The maximum penalty for bribery is 10 years imprisonment, with an unlimited fine.

In addition, the Act introduces a corporate offence of failing to prevent bribery by an organisation not having adequate preventative procedures in place. The organisation may avoid conviction if it can show that it had procedures and protocols in place to prevent bribery. The corporate offence is not a stand-alone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

As a result, we confirm that the Nottingham University Hospitals NHS Trust will commit sufficient time and resources to the development and embedding of an appropriate anti-bribery programme to include:

- A commitment to carry out business fairly, honestly and openly
- A commitment to zero tolerance towards bribery
- The consequences of breaching the policies for employees and managers
- The avoidance of doing business with others who do not commit to doing business without bribery as a 'best practice' objective
- The protection and procedures for confidential reporting of bribery (Whistleblowing)
- To support key individuals and departments involved in the development and implementation of the Trust's bribery prevention procedures

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

The Board and its Committees

The Board discharges its responsibilities through 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 from page 13.

Fit and Proper Person Test

In 2019/20, the directors individually updated their declarations to confirm continuing compliance with the Fit and Proper Person Test.

Modern Slavery Act (2015) Transparency in Supply Chains

We are committed to ensuring the absence of slavery in our organisation and supply chain.

In line with the requirements of the Modern Slavery Act (MSA) which came into force in 2015; we continue to take the following actions:

- On-going assessment of our contracts which have the highest risk of modern slavery;
- Use of national MSA compliant supplier Pre-Qualification Questionnaire (PQQ); to support assurance that our suppliers comply with the MSA;
- Inclusion of MSA clause in our standard terms and conditions.

Corporate Governance Report, inc Annual Governance Statement

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 2020 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 is in place
- Structured training sessions with the Trust Board, Management Board and with Divisional teams is ongoing as part of the agreed roll out of risk management training for key groups and individuals
- 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 deliver cascade risk management training across 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 approved 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.

The Trust acknowledges that in order to achieve its objectives some risk is acceptable whereas in other scenarios 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.

Appetite	Descriptor	Risk Level	Strategic objective
OPEN	Eager to be innovative and to choose options based on those that offer the highest probability of productive outcomes. Prepared to accept high and even extreme rated risks in pursuit of our objectives in these areas to realise the rewards	**15-25**	
MODERATE	Willingness to consider all potential delivery options and choose based on delivery of an acceptable level of reward and value for money. Prepared to accept that risks are likely to occur in the pursuit of our objectives in this area and that we will need to tolerate risks up to a rating of 'high' to realise potential rewards	**8-12**	Potential Partners
CAUTIOUS	Potential for safe delivery options that have a low degree of inherent risk and may have more limited potential for reward. Willing to expend some time and resource to mitigate risks, but accepting that some risks in this area will not, or cannot, be mitigated below a moderate level	**4-6**	Patients People Places Performance
AVERSE	Preference for ultra-safe delivery options that have a low degree of inherent risk and only limited reward potential. Prepared to expend significant time and resource to mitigate risks in this area to a minimal level	**1-3**	
AVOID	No appetite. Not prepared to tolerate risk above a negligible level	**0**	

Nottingham University Hospitals NHS Trust took over the running of the Nottingham NHS Treatment Centre (TC) from Circle Nottingham Limited on 29 July 2019. A smooth transfer of services was achieved in just

eight weeks, against the original expected timescale of seven months, with minimal disruption to patients and staff during the transition. Since then we are proud to report that the Treatment Centre has successfully treated over 116,000 outpatients, elective and day case patients.

The stringent timescale was determined by multiple legal challenges made during the procurement process and gave rise to a number of risks around the estate's leases and licences, ad-hoc arrangements for medical staff, the provision of essential medical equipment and the transfer of appointments and waiting lists. However, these were effectively managed and mitigated by the Mobilisation Board, an executive led group which met weekly throughout the mobilisation period to oversee the transfer phase. The governance structure provided a clear route to all relevant NUH committees, including the Trust Board and the Finance and Investment Committee who received regular reporting and updates.

The mobilisation programme, which concluded in October 2019, successfully delivered the transfer of 536 staff, along with 90 medical and clinical practitioners who provided services under various contract arrangements. In addition, it oversaw implementation of new Information Technology (IT) systems and the data transfer of approximately 50,000 bookings for outpatient and surgery appointments into the Trust's patient administration system (PAS). The development of a single point of access for PALS (patient advice and liaison service) enquiries and complaints provided a first line response and resolution service to patients, relatives and carers concerned about the impact on their care. The initial 49 complaints in the first three months were subsequently reduced to the current average of three per month.

In November 2019, the TC Transformation Board began bringing together clinical and operational teams from relevant specialties to drive forward the transformation programme aimed at improving and integrating patient pathways. This work has currently been paused in light of the COVID-19 pandemic, but is due to restart as part of the Trust's restoration and recovery programme.

The Trust's business impact analysis and each individual business continuity plan were all activated during the Trust's response to the COVID-19 pandemic. A command and control structure was put in place in line with the Trust's pandemic flu plan and risks managed through this structure. Service curtailment was necessary across the Trust as well as expansion/surge planning in some areas such as critical care and laboratory services.

As part of the incident response, staff were redeployed across the organisation in order to support critical services; and changes were made to premises use as well as usual working patterns.

During the recovery phase of the incident, each business continuity plan will be reviewed in light of the actions taken during the pandemic in order to capture the organisational learning and to influence future service improvement and response.

The Trust has put together a COVID-19 restoration and recovery plan which has been supported by Management Board, based on establishing a 'new norm'. The NUH goals for restoration and recovery throughout 2020/21 are to safely provide sufficient capacity/services to manage COVID and non-COVID patients throughout the year in line with demand; and to embed new ways of working to support the delivery of our services whilst reducing / stopping waste. The principles behind the restoration and recovery framework are to:

- Let go of the systems and processes that were stopped and which were /are now unfit for purpose
- Restore services and process where they are needed
- Build on and improve new ways of working that NUH and partners started doing during the COVID - 19 pandemic
- Stop doing activities that are very specific to COVID-19 at the right time

In terms of planning timeframes, NUH will plan in short cycles of three months as we manage the uncertainty of COVID and non- COVID demand

The immediate focus will be on the restoration of urgent services in phase one whilst planning for the delivery of services and recovery in phases two and three.

Phases two and three will continue with the restoration of services within the constraints we are working in, recognising that phase three will place a different demand on our services with the anticipated winter pressures. This position will constantly be reviewed as we get a better understanding of likely demands and the ability to manage the constraints.

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:

- 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, including clinical audit reporting

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 and Safety and Risk Management Committees both report to Management Board, such is the importance of the management and mitigation of risk to the organisation. Divisions provide more detailed reviews to the Quality and Safety Committee on a quarterly basis of:

- Clinical effectiveness
- Patient experience
- Patient safety (including incident reporting and duty of candour)
- 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 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.

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.

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 (DNACPR) decision making and recording. The Trust has seen a slowly improving picture in this domain and during the year invested in a specific DNACPR quality improvement project in order to facilitate a step change in performance. Further detail on progress is described in the Trust's 2019/20 quality account.

Progress with the implementation of the action plan put in place following the inspection has been closely monitored by the Quality and Safety Committee, Management Board and the Trust Board via its Quality Assurance Committee.

The robustness of the action plan scrutiny was tested during the year by internal audit who issued a significant assurance opinion in November 2019. There is evidence that 60% of the 'should do' recommendations have been completed. Management Board specifically agreed the plans to address those recommendations which required significant investment in medical and nurse staffing; along with infrastructure changes via business case development, along with the timelines for these, some of which extend to 2024. These include emergency department medical staffing, paediatric radiology medical staffing, midwifery staffing and the redesign of maternity and neonatal services. The expansion of critical care has commenced as has the expansion to MRI (magnetic resonance imaging) capacity.

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. During 2019/20 The Trust put in place a range of financial recovery interventions, including a strengthened cost improvement programme (CIP) delivery structure and a more robust expenditure control environment. Paragraph 16 of this statement describes more fully the outcome of these measures in terms of the year-end financial position.

The CQC's children's services directorate undertook a standalone inspection of NUH's children's sexual assault referral centre (SARC) in November 2019 and issued its inspection report in February 2020. The inspection findings do not impact on the Trust's ratings. The outcome of the inspection was that NUH was meeting the relevant regulations in the Safe, Effective, Caring and Responsive domains but that governance arrangements and board assurance on the safe and effective operation of the SARC were underdeveloped. The CQC explicitly stated that the impact of their concerns, in terms of the safety of clinical care, were regarded as minor and that once the shortcomings had been put right the likelihood of them occurring in the future was low. I can confirm that the leadership and governance arrangements for the SARC have been significantly strengthened and that the action plan had been fully implemented by the year end

4.5 Quality of performance information

The accuracy of data to support Board, executive and divisional decision making continues to improve where required. Externally the validity of data remains high and in most cases above the level of peer Trusts and national averages where relevant. NUH regularly scores greater than 98% in NHS Digital's overall score for data quality maturity index (DQMI).

The Trust undertakes six monthly reviews of data quality against a number of data sets relating to both corporate data and patient data. Actions taken or proposed to address any data quality issues are reported to both the Information Governance & Records Committee and the Audit Committee.

5. Significant risks

5.1 Trust Risk Profile

The profile below reflects the Trust risk register as at 31 March 2020.

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 and 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	2421	426	198	56	3101	623

Out of the 2421 risks scoring between one and nine; 667 score between one and three and as such are deemed to be managed to an acceptable level.

Out of the 56 x 20/25 scoring risks:

- 22 are new risks that are under development (being scoped and assessed)
- 16 are new / existing risks undergoing approval (undergoing confirm and challenge)
- 18 are approved live risks (undergoing mitigation)

5.2 Current significant risk register

There are currently 18 approved risks scoring 20 or more on the Trust's significant risk register.

These are:

1. *7881- Risk if 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.*
2. *5549 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; assessed through programme of cleaning audits.*
3. *680- 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.*
4. *7119- 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, independent sector service provision and job planning.*
5. *1107- Inability to meet the British Association of Perinatal Medicine [BAPM] standards – being mitigated through workload management, monitoring, increased staffing against the safe service model assessment.*
6. *6355- Risk of failure to provide safe / high quality care due to inadequate nurse / midwifery staffing numbers – being mitigated through increased clinical time, flexible working, temporary staffing, volunteers and service efficiencies.*
7. *8045- 7 Day Services – being mitigated through impact assessment, job planning and a business case to increase staffing.*
8. *8425 – Potential loss of activity due to pension taxation – being mitigated through a detailed understanding of clinical activity loss by division, communication of national guidance, workshops, policy changes and succession planning.*
9. *8033- Inability to provide appropriate numbers of skilled staff within fragile Trust services – being mitigated through robust people investment and planning, periodic nursing establishment reviews and ongoing monitoring.*

10. *8387- EFM Staffing Risk – being mitigated through recruitment, training, development of apprenticeship roles and investment cases.*
11. *8025- Inability to provide sufficient staff resilience to meet service demands – being mitigated through people investment, new roles and flexible ways of working.*
12. *3385- Risk of harm due to limited Critical Care Capacity – being mitigated through planned C6 expansion, workload management and flexible working.*
13. *8398 - Operation, maintenance, repair and replacement of heating, ventilation and air conditioning [HVAC} systems, equipment and infrastructure – being mitigated through ongoing maintenance programmes and investment cases.*
14. *8396 – Management and maintenance of buildings, grounds and gardens - being mitigated through ongoing maintenance programmes and investment cases.*
15. *8405- Fire Safety Infrastructure – being mitigated through ongoing investment based on fire risk assessment outcomes, planned preventative maintenance, policies, training and monitoring.*
16. *8402 – Operation, maintenance, repair and replacement of domestic hot and cold water pipeline systems, equipment and infrastructure – being mitigated through ongoing maintenance programmes, investment cases and ongoing asset verification.*
17. *8401 – Operation maintenance and repair of Specialist Ventilation – being mitigated through ongoing maintenance programmes, investment cases and ongoing asset verification.*
18. *8397 – Operation, maintenance, repair and replacement of Electrical Systems, equipment and infrastructure – being mitigated through ongoing maintenance programmes, investment cases and ongoing asset verification.*

5.3 Newly identified Significant Risks in 2019/20

- Potential loss of activity due to pension taxation (Risk 8425) - this risk has now been down scored to 12 so is no longer classed as a significant risk
- Review of estates and facilities (EFM risks) [Risks 8397,8398,8396,8405, 8402, 8401, 8397] - During 2019 / 20 a full review of the current estates and facilities risks was undertaken resulting in a focussed set of risks relating to ageing infrastructure, maintenance backlog and investment gaps – these are being subject to detailed scrutiny by the Risk Management Committee in July 2020 to agree the current level of risk they present to the organisation

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 NEDs. 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 NEDs 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 is in the process of commissioning an external review of its leadership capacity and capability as part of the NHS Improvement well led framework requirements which will take place in 2020/21.

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 CEO
- 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, seven Non-Executive Directors, two Associate Non-Executive Directors (non-voting), five Executive Directors and two (non-voting) Directors. A revision to the Trust's Establishment Order in June 2019 amended the non-executive component of the Board from five to seven. The following changes were made in 2019/20:

Non-Executive/Associate Non-Executive Directors:

- Professor John Atherton took up appointment as Non-Executive Director on 1 April 2019
- Mrs Anita Day took up appointment as Non-Executive Director on 15 April 2019
- Dr Sheila Newport's term of office as Associate Non-Executive Director ended on 30 August 2019.
- Mr Craig Wilcockson took up appointment as Non-Executive Director on 1 January 2020
- Mrs Clare Urmston took up appointment as Non-Executive Director on 1 January 2020
- Ms Sardip Sandhu took up appointment as Associate Non-Executive Director on 1 January 2020.
- Mr Mark Chivers' term of office as Associate Non-Executive Director ended on 31 January 2020 and he took up appointment as Non-Executive Director on 1 February 2020.
- Mrs Julie Pomeroy's term of office as Non-Executive Director ended on 31 January 2020
- Mr David Cartwright's term of office as Non-Executive Director ended on 31 March 2020.

Executive Directors:

- Ms Rachel Eddie formally acted up into the role of Chief Operating Officer until 31 July 2019.
- Ms Lisa Kelly took up appointment as Chief Operating Officer on 1 August 2019.

7.2 Board meetings

The Board held eight formal Board meetings and three Board development sessions during 2019/20. The formal meetings were open to the public (except for those matters which the Board resolved to consider in confidential session) and in March 2020 the public were requested not to attend due guidance received in relation to the Coronavirus outbreak. Information about Board meetings, including agendas and papers, is posted on the Trust's website - www.nuh.nhs.uk.

Throughout the last quarter of 2019-20 and the beginning of 2020/21, the Board has been kept fully briefed on the impact of the Trust's response to COVID-19 and, where necessary, been directly involved in decision making, for example in relation to approving a derogation from national personal, protective equipment guidance.

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 Chief Financial Officer to review the effectiveness of the committee and its working relationships.

7.3.2 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.

7.3.3 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.

7.3.4 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

7.3.5 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.

7.4 Register of interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) 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 Key Performance Indicator (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.

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 focussing on people planning.

The Chief People Officer attends the Nottinghamshire People and Culture Board on behalf of NUH, to oversee achievement of the ICS' People and Culture Strategy and its underpinning Delivery Plan. The Deputy Director of People is a member of the HR/OD Collaborative and the People Information and Planning Manager a member of the Workforce Intelligence Group, both people and culture sub-groups and delivery groups.

The Trust has in place a People Investment and Planning Group (PIPG) whose membership includes Human Resources, Professional Leads, Finance, Strategy, Transformation 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.

An extended Management Board session in 2019 around 'People' enabled identification of a number of 'big ticket' actions for PIPG to progress and support:

- Creation of a task and finish group to consider how a transformation fund to support development of new/alternative roles will be created, vital where funding for 'double running' costs is required
- PIPG will take responsibility for the development of the Trust People Investment Plan (as part of the Integrated Annual Planning process) for approval at Management Board
- Ensuring Annual Planning process includes sufficient opportunity for 'brave' decisions around the future delivery of services
- Creation of a Strategic Apprentice Steering Group, with commitment to senior representation and Director level SRO
- Support the principle of an opt-out approach for vacancies to be considered as Apprenticeships (to be further developed by Steering Group)

The 2020/21 Annual Planning round focused on developing 3-year integrated speciality plans, ensuring alignment with the NUH Planning Principles at a speciality level, across activity plans, operational delivery (workforce, beds, theatres, diagnostics, capital, performance standards) and financial constraints.

Specifically for the workforce element, during November and December PIPG supported specialties to complete a numerical and narrative template by considering what plans, activity and initiatives were expected to take place over the next 3-years that would change the whole time equivalent figures (staff in post) for each staff (occupational) group. A People Investment and Planning Resource (Toolkit) was created to support teams and specialities to have meaningful and informed conversations to determine their future workforce needs. The completed templates then inform and support the PIPG work streams for 2020 and the NHSI return at both Trust and Integrated Care System (ICS) level.

Progress of the work streams is monitored by the PIPG who also provide a quarterly update to the People 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 these plans are discussed regularly at the People 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 five 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 Quality 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 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. Initial discussions have taken place with medical, healthcare scientist and allied health professional (AHP) leads within the Trust to scope the 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 been 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 uses 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.

In response to risk 8425 described above, the Trust introduced a Pension Re-structuring Payment Policy following approval by the Remuneration Committee in July 2019. The policy outlines arrangements and options for employees who are current active members of the NHS Scheme but affected by the annual or lifetime allowances in respect of their pension savings and for those members who have opted out of said schemes as a consequence of the charges to allowances.

The policy was introduced to address significant operational risks identified as a result of the changes introduced to the pension tax regime which have meant that staff, in particular medical consultants, were reducing the type and amount of work they did. It is also intended to address recruitment and retention issues as a result of pension's tax changes causing individuals to opt for different career options.

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.

Monitoring of actions are tabled at a revised (since January 2020) Equality and Diversity Action Group, (EDAG), which is a reference group of the People Experience Group with the Chair (executive lead) reporting to the Board People Committee to strengthen governance and accountability.

Equality Diversity and Inclusion initiatives continue to be measured by the regulatory metrics including Workforce Race Equality Scheme, Workforce Disability Equality Scheme, Equality Delivery System version 3 (to be launched by NHSE&I in 2020), the National Staff Survey, NHS Nottingham/ Nottinghamshire CCG partnership Goals & Requirements, 360 Assurance, and be guided by the NHS People Plan and local Strategy 2019-2021. These reports will enable the Trust to identify where we are achieving and what needs to be improved upon for staff experience to improve.

The Trust regularly engages with staff for feedback on their experience at the Trust through tools such as the Staff Friends and Family Test (FFT), National Staff Survey and Starters and Leavers surveys. Progress and achievements are published in the Trusts annual report.

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 ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

12. Information governance and data security

12.1 Information Governance

Information Governance (IG) provides a framework for effective handling of information, particularly the personal and special category information of patients and employees, to ensure that information is processed legally, securely and confidentially. The ultimate aim is to ensure we are protecting data and handling information securely

12.2 Data Security and Protection Toolkit (DSPT)

DSPT requires NHS organisations to self-assess their compliance with current legislation and national guidance.

In 2019/20 the Trust has continued to work on achieving the assertions that were agreed as part of an action plan last year. Due to COVID-19 the final submission date for 19/20 has been postponed until September 2020.

	2014/15	2015/16	2016/17	2017/18	2018/19*	2019/20
Overall assessment	Satisfactory	Satisfactory	Satisfactory	Satisfactory	Standards not fully met (improvement plan agreed)	Submission delayed nationally due to COVID-19

Specifics:

- The Trust has seen a significant increase in the volume of Subject Access Requests (SARs) since the introduction of GDPR/ DPA 18. This has led to a backlog in some cases; however a recovery plan has been produced and approved to resolve this.
- The number of DPIAs undertaken in 19/20 has increased since the previous year, which is a positive indicator.

12.3 ICO Reported Incidents

Seven IG incidents were reported to the Information Commissioner's Office (ICO) and/or Department of Health and Social Care (DHSC) in 2019/20.

Category	2019/20	Action Taken
Corruption or Inability to Recover Electronic Data – Network Failure	1	No ICO action.
Disclosed in Error	4	No ICO action.
Lost/Stolen Paperwork	0	No ICO action taken.
Data Availability Breach	0	No ICO/DHSC action taken.
Unauthorised Access/Disclosure	2	1- No ICO action taken. 2- ICO case remains open.
Total	**7**	

All reported IG incidents are assessed for severity according to national guidance. Where it is considered the incident needs to be reported to the ICO, they are escalated to the Trust's Caldicott Guardian and Data Protection Officer who confirm the scoring, ensure appropriate action has been taken and authorise reporting to the ICO or DHSC, via the Data Security and Protection Toolkit.

The DPO is responsible for ensuring a thorough investigation of incidents are undertaken and acts as the single point of contact with the ICO.

The Trust has recently made changes to its incident management process to ensure that all reported incidents receive a level of follow up relevant to the nature of the incident, regardless of severity. The Trust believes this is important to ensure there is a strong culture of IG awareness in the organisation.

The Trust works to Privacy by Design process to identify potential privacy risks and concerns around data security when changes/ new elements to data processing are considered. The Trust has a comprehensive Data Protection Impact Assessment (DPIA) process and these must be signed off by both the DPO and Caldicott Guardian before work is approved.

12.4 Data Security

The Trust's data infrastructure is routinely subjected to penetration testing and vulnerability assessments.

Two pen tests came back with significant assurance. There are 3 outstanding actions from the external pen testing conducted by Dionach /NHSD and we have plans to complete two of them once our new storage array goes into operation. These are:

- Migration from legacy OS severs to new servers
- Open shares on storage Windows storage array

The Trust continues to invest in modern security solutions to protect our information assets and infrastructure. This year we hit our target to have 60% of all desktops using Windows 10 and all our end points now have ATP (advanced threat protection) centrally monitored. We have a new backup solution (Cohesity) which is 'ransom ware proof' and can react to cloud provisioning as part of our DR plan. We have also installed new Cisco Firepower Firewalls which are currently running in detection mode soon to me moved to prevention mode. We have also recently procured IT Health which is currently receiving data from all our IT elements across the entire NUH organisation.

13. Data quality and governance

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 45,000 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. 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 2019/20 Quality Account will be published by 31 July 2020. 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, greater Nottingham Clinical Commissioning Partnership, all of whom have been invited to comment on the account.

15. Integrated care system (ICS)

Nottingham University Hospitals is represented on the Integrated Care System (ICS) Leadership Board by me and the Trust Chair. The ICS Board has a significant role in overseeing the integration agenda in Nottinghamshire. The ICS Board and individual partner organisations have agreed a five year strategy that responds to the requirements of the NHS long-term plan and the locally agreed ICS outcomes framework. The strategy sets out a focus on five service priorities that are underpinned by five enabling priorities. There is a population health focus in areas including prevention, the wider determinants of health and proactive care as well as emphasis on the significant system pressures in: mental health, urgent and emergency care, cancer and financial performance.

Across the ICS there has been continued implementation of the underpinning governance needed. During the year appropriate Trust officers have been engaged in the development of the three Integrated Care Partnerships and supporting the establishment of Primary Care Networks. 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.

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

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.

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 take place through the 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.

Since being established, NUH has established a strong financial performance, delivering annual surpluses up to 2014/15 and delivering its financial control totals in all years, with the exception of 2018/19. Like most

acute providers, nationally, the Trust has been exposed to unprecedented operational and financial pressures over the last 5 years, culminating in the COVID-19 response in March 2020. In 2019/20, the Trust delivered its financial control total with a small surplus of £0.9m, which represented a £48k underspend against its financial control total. This was achieved through putting in place a range of financial recovery interventions, including a strengthened CIP delivery structure and a more robust expenditure control environment. Planned care reduced to enable the Trust to free up capacity to treat patients presenting with COVID 19. However, co-operation across the integrated care system ensured that, in line with national guidance, the Trust's financial position was not adversely impacted by reductions in activity as a result of COVID-19 as the Trust and Commissioners agreed appropriate funding arrangements to support the Trust in delivering financial balance.

Trust delivered a £28.8m deficit before Financial Recovery Funding (FRF), £1.9m adverse to the original control total of £26.9m agreed with NHSI, as a consequence of the unfunded COVID-19 related increase in our annual leave accrual (£2.4m). However, NHSI confirmed this item was an allowable miss against our pre-FRF control total. The Trust therefore met its financial control target for 2019/20 and was therefore able to recognise, in full, the FRF available for the year of £27.9m. In addition and as a consequence of hitting its control total, the Trust was also allocated additional year-end FRF /COVID-19 funding of £1.8m, allowing the Trust to report the overall surplus of £0.9m. In achieving this position, the Trust delivered efficiencies of £33 million in 2019/20 (2.9% of income).

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 3, which represented the best possible score that it could have been achieved, given scoring a four on any component of the metric triggers an override to the calculation. Despite scoring at least 2 in 3 of the 5 indicators, the Trust only scored 4 for liquidity and the override in the calculation prevented the Trust from scoring more than 3, as a consequence. The deterioration in the agency performance compared with last year was explained by the Treatment Centre contract mobilisation, the COVID-19 response and the additional areas that were opened to cover the increased non elective demand on top of the planned increased capacity, which required agency and bank staffing.

The Trust maintained its reference cost of 99 in 2019/20, demonstrating that its resources have been deployed effectively for the benefit of patient care. The Trust uses the reference cost benchmarking tool alongside the model hospital and 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 has an overall rating of 'good' by the CQC (February 2019) following the inspection in 2018/19, although concluded that use of resources at NUH required improvement.

The Trust is committed to using its resources productively to maximise patient benefit. Carter Efficiencies and the Model Hospital were the key driver of FEP plans for 2019/20. This can be seen in both schemes developed independently by Divisions, as well as the savings achieved through the Rapid Improvement (Wave) and Getting It Right First Time' (GIRFT) programmes. The Model Hospital remains a key source of information to identify and secure opportunities for further productivity improvement. It is clear identifying opportunities to save, especially recurrently, has become increasingly challenging and has led to a revised strategy for 2020/21 and the following years. The Trust has committed to following an approach focused on Quality Improvement and Waste reduction. This has been aligned to the agreed culture and leadership development programme. The Trust has an established performance management process to maintain divisional financial accountability, although a temporary pause has been put on the divisional performance meetings and financial efficiency measures are only progressed where they support the Trust's COVID-19 measurers and recovery and restoration planning.

The planning round for 2020/21 was suspended in March nationally due to the COVID-19 outbreak and for the first four months of 2020/21, the Trust, alongside all other providers, is being funded through a block funding arrangement. Although NHSI are not yet able to definitively announce the contracting

arrangements that will be in place for the rest of 2020/21 and beyond, it remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded and government funding is in place for this.In providing an opinion for the financial year, the Head of Internal Audit reflected on the environment in which the Trust had been required to function throughout the year. For the majority of 2019/20 it had been business as usual, with an ongoing need to meet quality challenges whilst reducing costs. For the final weeks of the year, the Trust had the significant impact of COVID-19 to deal with, which may have impacted on the operation of control.

In consideration of the above, the Head of Internal Audit has provided a **significant assurance** opinion that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Significant assurance is provided in relation to three elements of the opinion – BAF (board assurance framework) and strategic management; internal audit plan outturn; and first follow-up implementation rate.

Executive directors 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
- National Clinical Audit reviews, including Getting it right first time (GIRFT) 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 People Committee
- The Quality Assurance Committee
- The Quality and Safety Committee
- The Risk Management Committee
- The Information Governance and Records Committee
- The Trust Health and Safety Committee

Four out of 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 – these related to the data security and protection toolkit and compliance with documentary requirements of the Mental Health Act. A further 'core' report was issued with a split limited / significant assurance opinion, the limited element in respect of data analysis of the risk register. Actions have been agreed in response to these reviews, the implementation of which will be overseen by the Director of Digital Services, Medical Director

and the Director of Corporate Governance respectively, with progress will be regularly reported to the Audit Committee.

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

Throughout 2019/20 there have been ongoing pressures across the emergency, elective and cancer pathways, exacerbated by the COVID-19 pandemic at the close of the year.

NUH has continued to struggle to admit patients in a timely way from its emergency department resulting in excessively long waiting times in the department. Performance and improvement plans for urgent and emergency care are in place and improving timely emergency access remains a top priority for the Trust and its partners in 2020/21.

Waiting lists for elective care have grown for the first time since June 2012 and the COVID-19 pandemic will significantly impact on the Trust's elective care performance in 2020/21, with plans for restoration of elective capacity a priority when safe to do so.

The Trust remains below the national standard for 62 day referral to treatment cancer care due to capacity issues. The Trust remains focused on progressing actions to mitigate the risks on a month by month basis, whilst addressing the underlying challenges. During the COVID-19 pandemic, NUH worked hard to protect its cancer services, in partnership with the private sector.

18. Conclusion

Three 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: 22 June 2020

Trust Board and Committee attendance 2019/20

Cumulative Record of Trust Board Attendance (2019/20)

Name	Possible	Actual	Name	Possible	Actual
Mr E Morton	8	8	Mr R Egginton	8	8
Prof J Atherton	8	3	Ms R Eddie	4	4
Mr D Cartwright	8	6	Dr K Girling	8	8
Mr M Chivers	8	7	Prof M Sunderland	8	7
Ms A Day	8	5	Ms T Taylor	8	8
Ms S Newport	4	2	Ms L Kelly	4	3
Ms J Pomeroy	7	7	Ms M Rogan	8	8
Ms N Sigona	8	7	Ms A Wynne	8	6
Mr S Thomas	8	4	Ms S Sandhu	2	2
Mr C Wilcockson	2	2	Ms C Urmston	2	2

Cumulative Record of Audit Committee Members' Attendance (2019/20)

Name	Possible	Actual	Dial in
Mrs J Pomeroy	5	5	0
Mr D Cartwright	6	3	1
Mrs A Day	6	3	2
Mr M Chivers	6	6	0
Ms N Sigona	6	1	3
Mrs C Urmston	2	1	1

Cumulative Record of Finance and Investment Committee Attendance (2019/20)

Name	Possible	Actual
Mr R Egginton	12	12
Dr K Girling	12	10
Mrs J Pomeroy	10	9
Mrs T Taylor	12	8
Mr S Thomas	12	10
Mr M Chivers	10	8
Ms R Eddie	4	2
Ms L Kelly	8	5
Mrs A Wynne	12	6
Mrs C Urmston	3	3
Ms S Sandhu	3	2
Mr C Wilcockson	3	2

Cumulative Record of People Committee Members' Attendance (2019/20)

Name	Possible	Actual
Mr D Cartwright	10	7
Ms A Day	10	8
Ms R Eddie	3	0
Ms N Hill	4	3
Ms L Kelly	6	4
Ms S Newport	4	2
Ms N Sigona	10	7
Ms L Skaife-Knight	5	5
Prof M Sunderland	10	6
Ms T Taylor	10	6
Ms B Asher	4	4
Mr C Wilcockson	2	0
Dr N Pease	2	2
Ms T Jones	4	4

Cumulative Record of Remuneration and Terms of Service Committee Attendance in 2019/20

Name	Possible	Actual
Professor J Atherton	5	3
Mr D Cartwright	5	2
Ms A Day	5	2
Mr E Morton	5	5
Mrs J Pomeroy	5	5
Mr S Thomas	5	4
Mr C Wilcockson	1	1
Ms C Urmston	1	1

Cumulative Record of Quality Assurance Committee Members' Attendance (2019/20)

Name	Possible	Actual	Dial in
Professor J Atherton	12	9	
Mr D. Cartwright	12	7	1
Mr M Chivers	2	2	
Dr S Newport	5	4	
Ms S Sandhu	3	2	
Mrs T Taylor	12	3	
Dr K Girling	12	9	
Deputy for Dr Girling	2	2	
Professor M Sunderland	12	8	
Deputy to Professor Sunderland	4	4	
Ms R Eddie/Ms L Kelly	12	9	
Mrs M Rogan	12	9	

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 Nottingham University Hospitals 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 Nottingham University Hospitals this is defined as the Trust's Executive and Non-Executive directors.

The 2019/20 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.

We use permanent appointments with three 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.

Salary and Pension Entitlements of Senior Managers Remuneration

Name and Title	2019/20				2018/19				Notes
	Salary (bands of £5,000) £000	Performance pay and bonuses (bands of £5,000) £000	All pension-related benefits * (bands of £2,500) £000	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) £000	TOTAL (bands of £5,000) £000	
Executives									
Mrs T Taylor, Chief Executive	235-240	0	12.5-15	250-255	225-230	0	202.5-205	430-435	1
Ms M Sunderland, Chief Nurse	155-160	0	0	155-160	160-165	0	0	160-165	
Dr K Girling, Medical Director	195-200	0	25-27.5	220-225	195-200	0	575-577.5	770-775	
Mr R Egginton, Chief Financial Officer	190-195	0	0	190-195	180-185	0	0	180-185	2
Ms L Kelly, Chief Operating Officer	95-100	0	75-77.5	175-180	0	0	0	0	3
Ms R Eddie, Acting Chief Operating Officer	40-45	0	0	40-45	25-30	0	7.5-10	35-40	4
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	5
Ms A Day	5-10	0	0	5-10	0	0	0	0	6
Ms C Urmston	0-5	0	0	0-5	0	0	0	0	7
Mr C Wilcockson	0-5	0	0	0-5	0	0	0	0	8
Mr M Chivers	0-5	0	0	0-5	0	0	0	0	9
Mr S Thomas	5-10	0	0	5-10	5-10	0	0	5-10	
Mr D Cartw right	5-10	0	0	5-10	5-10	0	0	5-10	10
Professor J Atherton	5-10	0	0	5-10	0	0	0	0	11

Notes:

1. The Trust introduced the Pension Restructuring Payment Policy in 19/20 which was approved by the Remuneration Committee in July 2019. The policy addresses the operational risks that have been identified as a result of the changes introduced to annual and lifetime allowances in respect of members pension savings. The Pension Restructuring payments are equal to the employer's contribution to the NHS Pension Scheme, paid net of employer's National Insurance contribution and other income tax treatments. This is a financially cost neutral model to the Trust and results in no overall increase in the remuneration package for this individual. This figure includes an element of Pension Restructuring payment.
2. Rupert Egginton was appointed Deputy Chief Executive Officer on 14 January 2019
3. Lisa Kelly was appointed Chief Operating Officer on 1 August 2019
4. Rachel Eddie was appointed Acting Chief Operating Officer on 14 January 2019 until 31 July 2019
5. Julie Pomeroy's term of office ended on 31 January 2020
6. Anita Day joined the Trust Board on 15 April 2019
7. Clare Urmston joined the Trust Board on 1 January 2020
8. Craig Wilcockson joined the Trust Board on 1 January 2020
9. Mark Chivers was appointed as a substantive Non-Executive on 1 February 2020
10. David Cartwright's term of office ended on 31 March 2020
11. Professor John Atherton joined the Trust Board on 1 April 2019

There are no performance pay, long term performance pay or bonuses for the directors in 2019/20

* All pension related benefit 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 in 2013/14.

Salary and pension entitlements of senior managers pension benefits 2019/20

Name and title	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 accrued pension at pension age at 31 March 2020 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2019 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real Increase in Cash Equivalent Transfer Value £000
Mrs T Taylor, Chief Executive	0 – 2.5	2.5 – 5	95 – 100	290 – 295	1,905	2,027	57
Ms M Sunderland, Chief Nurse	0 – 2.5	0 – 2.5	65 – 70	195 – 200	1,446	1,525	22
Dr K Girling, Medical Director	2.5 – 5	0	80 – 85	215 – 220	1,678	1,791	45
Mr R Eggington, Chief Financial Officer	N/A	N/A	N/A	N/A	1,448	N/A	N/A
Ms L Kelly, Chief Operating Officer	2.5 - 5	0	15 - 20	0	106	172	32

Notes:

The Trust has no employer contributions for Partnership pension accounts

N/A - NHS Pensions has failed to supply any pension information for Mr R Egginton

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 2019/20 was £235,000-£240,000 (2018/19, £225,000-£230,000). This was 7.9 times (2018/19, 7.8 times) the median remuneration of the workforce, which was £29,817 (2018/19, £29,059). In 2019/20, 2 (2018/19) five employees received remuneration in excess of the highest paid director. Remuneration ranged from £6,003 to £340,272 (2018/19 £6,157 to £281,662). 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 2019/20.

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

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

Our tax policy ensures compliance with the Department of Health and HMRC guidelines. During 2018/19 all existing off-payroll engagements were subject to a risk-based assessment as to whether assurance needed to be sought that the individual was paying the right amount of tax. Where necessary, that assurance has been sought.

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

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

- For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months.
- For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months.
- For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

Summary of Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months	
For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:	**TOTAL**
Number of existing engagements as of 31 March 2020	78
of which, the number that have existed:	
for less than one year at the time of reporting	53
for between one and two years at the time of reporting	6
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	5
for 4 or more years at the time of reporting	13

Table 2: New Off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months	TOTAL
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	56
of which...	
No. assessed as caught by IR35	41
No. assessed as not caught by IR35	15
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll board member / senior offcial

For any off-payroll engagements of board members, and / or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.	TOTAL
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	14

Severance and Exit Packages

Actual redundancy and other departure payments in the year were £45,000.

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	Number of compulsory redundancies Accounts 31-Mar-20 2019/20 No.	Cost of compulsory redundancies Accounts 31-Mar-20 2019/20 £000	Number of other departures agreed Accounts 31-Mar-20 2019/20 No.	Cost of other departures agreed Accounts 31-Mar-20 2019/20 £000	Total number of exit packages Accounts 31-Mar-20 2019/20 No.	Total cost of exit packages Accounts 31-Mar-20 2019/20 £000	Number of departures where special payments have been made Accounts 31-Mar-20 2019/20 No.	Cost of special payment element included in exit packages Accounts 31-Mar-20 2019/20 £000
Exit package cost band (including any special payment element)								
<£10,000			1	4	**1**	**4**		
£10,000 - £25,000			1	11	**1**	**11**		
£25,001 - £50,000			1	30	**1**	**30**		
£50,001 - £100,000					**0**	**0**		
£100,001 - £150,000					**0**	**0**		
£150,001 - £200,000					**0**	**0**		
>£200,000					**0**	**0**		
Total	**0**	**0**	**3**	**45**	**3**	**45**	**0**	**0**

Reporting of other compensation schemes - exit packages	Number of compulsory redundancies Accounts 31-Mar-19 2018/19 No.	Cost of compulsory redundancies Accounts 31-Mar-19 2018/19 £000	Number of other departures agreed Accounts 31-Mar-19 2018/19 No.	Cost of other departures agreed Accounts 31-Mar-19 2018/19 £000	Total number of exit packages Accounts 31-Mar-19 2018/19 No.	Total cost of exit packages Accounts 31-Mar-19 2018/19 £000	Number of departures where special payments have been made Accounts 31-Mar-19 2018/19 No.	Cost of special payment element included in exit packages Accounts 31-Mar-19 2018/19 £000
Exit package cost band (including any special payment element)								
<£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**

Exit packages: other (non-compulsory) departure payment	Payments agreed Accounts 31-Mar-20 2019/20 No.	Total value of agreements Accounts 31-Mar-20 2019/20 £000	Payments agreed Accounts 31-Mar-19 2018/19 No.	Total value of agreements Accounts 31-Mar-19 2018/19 £000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	3	45	11	175
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval (special severance payments)*	0	0	0	0
Total**	**3**	**45**	**11**	**175**
of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Staff report

The CQC's use of resources assessment (February 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 its services to increase capacity and provide resilience within clinical teams, for example reporting radiographers and advanced clinical practitioners (ACPs). These roles have provided career development opportunities for existing staff, which has supported staff retention. We have 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.

The charts below show the number of staff employed by our organisation as at the end of March 2020, show as full time equivalent (fte), headcount and %, plus the split by gender:

	2019/20		2018/19		2017/18		2016/17	
Main Staff Group	**FTE**	**Headcount**	FTE	Headcount	FTE	Headcount	FTE	Headcount
Add Prof Scientific and Technical	670.08	750	649.34	728	621.52	694	608.71	679
Additional Clinical Services	2,407.75	2,775	2,293.80	2,628	2,118.47	2,436	1,995.87	2,294
Administrative and Clerical	2,836.77	3,224	2,606.21	2,959	2,601.26	2,946	2,560.99	2,922
Allied Health Professionals	717.73	824	702.86	802	670.38	769	647.50	748
Estates and Ancillary	1,243.89	1,487	1,184.30	1,420	1,055.37	1,263	102.52	110
Healthcare Scientists	525.78	572	521.10	564	494.50	536	486.87	534
Medical and Dental	1,871.61	1,977	1,735.58	1,827	1,644.11	1,730	1,643.37	1,728
Nursing and Midwifery Registered	4,280.06	4,878	4,138.46	4,698	4,027.96	4,568	3,924.52	4,442
Other	0.43	1	0.50	0			3.00	3
Grand Total	**14,554.09**	**16,488**	**13,832.15**	**15,626.00**	**13,233.56**	**14,942.00**	**11,973.35**	**13,460.00**

	2019/20				2018/19				2017/18				2016/17			
Gender	**FTE**	**Headcount**	**FTE %**	**Headcount %**	FTE	Headcount	FTE %	Headcount %	FTE	Headcount	FTE %	Headcount %	FTE	Headcount	FTE %	Headcount %
Female	10,820.95	12,576	74.35%	76.27%	10,322.93	11,965.00	74.63%	76.57%	9,917.14	11,479.00	74.94%	76.82%	9,216.79	10,608.00	76.98%	78.81%
Male	3,733.14	3,912	25.65%	23.73%	3,509.22	3,661	25.37%	23.43%	3,316.42	3,463	25.06%	23.43%	2,756.56	2,852	23.02%	21.19%
Grand Total	**14,554.09**	**16,488**	**100.00%**	**100.00%**	**13,832.15**	**15,626**	**100.00%**	**100.00%**	**13,233.56**	**14,942**	**100.00%**	**100.00%**	**11,973.35**	**13,460**	**100.00%**	**100.00%**

Numbers of staff (average WTE in 2019/20)

Average Staff Numbers	Total 19/20 Number	Permanently Employed Number	Other Number	Total 18/19 Number	Permanently Employed Number	Other Number
Medical and dental	**2,273**	1,927	346	**1,937**	1,734	203
Administration and estates	**2,392**	2,217	175	**2,298**	2,206	92
Healthcare assistants and other support staf	**4,136**	4,071	65	**3,823**	3,742	81
Nursing, midwifery and health visiting staff	**4,839**	4,232	607	**4,611**	4,101	510
Scientific, therapeutic and technical staff	**1,467**	1,435	32	**1,429**	1,392	37
Healthcare Science Staff	**571**	558	13	**519**	504	15
Other	**0**			**0**		
TOTAL	**15,678**	**14,440**	**1,238**	**14,617**	**13,679**	**938**

Numbers of staff (% of workforce)

Main Staff Group	2019/2020	2018/19	2017/18	2016/17
Add Prof Scientific and Technical	**4.09%**	3.71%	3.27%	3.16%
Additional Clinical Services	**6.60%**	5.99%	5.70%	5.91%
Administrative and Clerical	**4.13%**	3.78%	3.67%	3.50%
Allied Health Professionals	**2.93%**	2.49%	2.50%	2.22%
Estates and Ancillary	**6.50%**	5.49%	5.67%	4.93%
Healthcare Scientists	**2.74%**	2.27%	2.24%	2.53%
Medical and Dental	**1.20%**	1.15%	1.37%	1.30%
Nursing and Midwifery Registered	**4.50%**	4.34%	4.01%	4.01%
Grand Total	**4.36%**	3.99%	3.82%	3.65%

Policy in relation to disabled employees

We value the unique contributions that our people bring to the organisation in terms of background, lived experience, knowledge and skills.

We are committed to enabling all staff, irrespective of grade or position, to achieve their full potential in an environment characterised by dignity and mutual respect. We have a proactive employment of individuals with disabilities and are committed to ensuring that all individuals with disabilities, whether applicant or employee are not subject to discrimination, harassment or less favourable treatment due to their disability. We have signed up to the Disability Confident scheme; part of this is to interview all applicants with disabilities who meet the minimum criteria for a job vacancy and to consider them on their abilities. We have developed several resources with our Staffability Network to support employees with disabilities such as a Ways of Working Diary and an Access to Work Standing Operating Procedure.

Reducing staff absence

Overall sickness absence rates have been maintained above/ below the national median, with our sickness rate at 4.36% in 2019/20 compared to a national median of 3.95%, placing us in in the lowest (best) quartile nationally. Our staff rotation programmes continue to have had a positive impact on sickness absence and staff retention rates. We have a staff well-being programme in place, including increased support for mental health and personal financial management issues. The sickness absence rate has worsened year on year, comparing with 3.99% in 2018/19.

Sickness Absence				
Staff group	**% sickness 2019/20**	**% sickness 2018/19**	**% sickness 2017/18**	**% sickness 2016/17**
Add Prof Scientific and Technical	4.09%	3.71%	3.27%	3.16%
Additional Clinical Services	6.60%	5.99%	5.70%	5.91%
Administrative and Clerical	4.13%	3.78%	3.67%	3.50%
Allied Health Professionals	2.93%	2.49%	2.50%	2.22%
Estates and Ancillary	6.50%	5.49%	5.67%	4.93%
Healthcare Scientists	2.74%	2.27%	2.24%	2.53%
Medical and Dental	1.20%	1.15%	1.37%	1.30%
Nursing and Midwifery Registered	4.50%	4.34%	4.01%	4.01%
Total	**4.36%**	**3.99%**	**3.82%**	**3.65%**

Our sickness performance is summarised in the table below:

Sickness Data 2019/2020		
Absence FTE (01/04/2019 - 31/03/2020)	**FTE (as at 31/03/2020)**	**Avg working days lost per FTE**
224,623.89	14,554.09	15.43

Sickness data 2018/19		
Absence FTE (01/04/2018 - 31/03/2019)	**FTE (as at 31/03/2019**	**Avg working days lost per FTE**
194,926.36	13,832.15	14.09

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 (DHSC) considers these as a reasonable proxy for the financial year.

We have a wide range of measures and support mechanisms in place to reduce sickness absence. These include staff physiotherapy, an employee assistance programme (including 24/7 advice line and access to counselling) and Occupational Health services. To support these, our Staff Wellbeing service provides numerous schemes and programmes including healthy eating, mindfulness, cycle to work, smoking cessation, resilience and managing stress.

We pro-actively training managers on performance management and managing health, attendance and wellbeing and all managers have access to local HR teams to support with this.

Our wellbeing and attendance management policies detail best practice in managing long and short term sickness absence, together with details and triggers for informal and formal actions, and advice on managing case specific matters such as disability and domestic violence.

The HR team monitor sickness absence levels on a monthly basis, sharing details of 'hot spots' and concerns with their Divisional leadership teams, and also directly with local managers where they see long term absence cases, or individuals with numerous sporadic episodes. Interventions always aim to be supportive and help staff either return to work, or stay at work, making reasonable adjustments where necessary.

Workforce Management

We use e-rostering to support effective deployment of our nursing, midwifery and junior medical workforce, and an acuity model is used to ensure the nursing staffing levels meet patient need. We demonstrate that rotas are agreed six weeks in advance to ensure that gaps are identified and addressed promptly, avoiding the use of premium agency staffing, wherever possible, and 90 per cent 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 has also been some progress in developing partnership with other NHS trusts within some of the hard to recruit services. We are working with other neighbouring NHS trusts to streamline and provide more sustainable clinical services in areas such as Urology, Stroke, Vascular and Oncology.

Staff Retention

Our overall retention rate reduced slightly over the last twelve months from 86.8% to 84%. We continue to focus on improving staff retention through various initiatives including; engagement with the NHS Improvement retention schemes for nursing staff, our own Magnet (retention) programme and introduction of targeted training and career development opportunities for the non-qualified nursing workforce. We also directly employ junior doctors to our local NHS trust grade programme which has helped reduce gaps in its junior doctor workforce.

Tracy Taylor
Chief Executive (on behalf of the Trust Board)
Date: 22/06/2020

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The Performance Report

Performance Report

This section of the report is intended to give an overview of how we did against the priorities we set ourselves for 2019/20 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.

Overview

Urgent and emergency patient care: In 2019/20 there was 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.

In May 2019 we started reporting against new clinical standards for Urgent and Emergency Care as part of the national field testing programme. Reporting against the four-hour standard paused for 2019/20 for those Trust's involved in the pilot to avoid contaminating the study design.

During the field testing period a memorandum of understanding was in place that precluded us from publically reporting performance against the new metrics that were being tested.

Despite the reporting changes, our focus has remained to improve the timeliness of care, and therefore the overall experience for our emergency patients. Significant investment has been made to increase hospital capacity, expand our admission areas and further redesign our acute Urgent and Emergency Care services.

Whilst this important work has delivered what it set out to, we have continued to struggle to admit patients in a timely way due to continued pressures on our hospital bed base, particularly at Queen's Medical Centre. The pressures that we have faced all year were exacerbated over winter when system flow became compromised and the number of medically safe patients in hospital increased significantly. During this period patients unfortunately waited longer than we would wish in our Emergency Department 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 our Chief Executive, and attended by leaders from across health and social care in Nottingham.

Improving timely access to emergency care remains one of our top priorities as we head into 2020/21. The early stage of the coronavirus pandemic has already significantly altered demand on our emergency care services which will almost certainly have an impact throughout the majority of 2020/21.

Cancer care: Our cancer services are amongst the largest in the UK and following the merger with the Treatment Centre in summer 2019 we are now receiving between 2,300 and 2,800 two-week wait referrals every month.

During the year we delivered strong performance against the cancer two-week wait, 14-day referral for breast symptoms to assessment, and the 31-day subsequent for drug and radiotherapy cancer standards. Whilst our 62-day referral to treatment performance has remained stable, we remain below the national standard. 31-day diagnostic to treatment and 31-day second or subsequent surgery treatment have continued to under-performed during the year due to the wait times for surgery.

The key focus for improving our performance against the under-performing cancer standards is eliminating surgical waits and reducing waits for diagnostic tests. Capacity is a limiting factor with recruitment drives in place across a number of our services to increase staffing numbers, which is challenging in some areas due to the national shortages for clinical staff in some specialties.

We remain focussed on progressing actions to mitigate the risks to our cancer standards on a month-by-month basis whilst addressing the underlying challenges. We are working to protect, where possible, cancer treatment during the coronavirus pandemic.

Winter preparedness: We had an £8 million investment in our acute bed base to ensure that the number of beds in 2019/20 was greater than it was in the previous year. We made the following changes in preparation for winter:

- Converting beds previously opened as escalation capacity into our core year-round bed base at both Queen's Medical Centre and City Hospital;
- Seasonal capacity opened for winter, predominately on the City Hospital to support increased respiratory demand over winter;

- Acute Medicine receiving area was opened at Queen's Medical Centre to support increase in same day emergency care;
- Two St Francis wards were opened at City Hospital as part of our plans to increase the acute bed base;
- We converted one of our surgical ward's at City Hospital to create an additional respiratory ward;
- Redevelopment of a former clinic space to expand and consolidate our assessment and admission area capacity at Queen's Medical Centre;
- The flu campaign and infection prevention activity were a success with over 80 per cent of our frontline staff vaccinated for flu – our best year yet;
- We worked in close collaboration with our system partners on attendance and admission avoidance schemes, which helped to drive an increase of capacity in the community with a focus on Care at Home whenever possible. We led system multi-agency discharge events (MADE) during key pressure periods in winter.

Elective care: Unprecedented demand for emergency care has continued to impact on routine elective activity during the year.

Waiting lists have grown and for the first time since June 2012 which meant we under-performed against the 18-week RTT (Referral to Treatment) standard in October 2019 with performance remaining below standard for the remainder of the year.

Our ability to recover elective activity has been compromised by the national pension issue which resulted in a reduction in the number of clinicians carrying out additional sessions.

Whilst we have patients waiting longer than we would wish, we have successfully eliminated the very long waits with zero patients waiting over 52 weeks from RTT from November 2019 onwards. The coronavirus pandemic will significantly impact on our elective care standards.

In general, there is uncertainty with regard to the size of the challenge that awaits us when the pandemic ends to recover operational performance standards.

Patients waiting below 18-weeks for planned operations:

2012/13	95.6%
2013/14	96.6%
2014/15	98.2%
2015/16	97.5%
2016/17	96.1%
2017/18	92.9%
2018/19	93.2%
2019/20 Up to December 2019	90.0%

Performance against our National Standards

Quality measure (% unless shown)	Target 2019/20	2017/18	2018/19	2019/20	Trend
Eligible patients having Venous Thromboembolism (VTE) risk assessment	≥95%	95	94.4	94.7	↑
Never Events	0	1	2	2	–
Patient safety alerts not completed by deadline	0	-	0	0	–
Clostridium difficile (NUH acquired)	≤120 in 19/20	101	68	152	↓
Clostridium difficile per 100k occupied bed days (rolling 12 months)	≤17.6	20.6	14	30.2	↓
MRSA bacteraemia (NUH acquired)	0	2	2	2	–
Safe staffing levels (overall fill rate)	≥80%	96.8%	95.4%	93.1%	↑
Number of wards below 80% fill rate	0	4	71	73	↓
Cleaning audit score	≥92.3%	-	-	95.6%	–
Same sex accommodation standards breaches	0	1	1	0	↑
% complaints responded to within the national standard of six months from receipt of the complaint	100%	100%	99.0%	99.0%	↓
% eligible patients who have dementia case finding applied	≥90%	94.2%	97.3%	97.7%	↑
12 hour trolley waits	0	2	7	277	↓
Ambulance handovers completed within 15 minutes	100%	57.4%	55.2%	73.6%	↑
% beds occupied by Delayed Transfers of Care	≤3.5%	4.1%	3.2%	3.6%	↓
Occupied beds for adult patients staying in hospital >=21 days	209 by March 2020	266	233	249	↓
18 weeks referral to treatment time - incomplete pathways	≥92%	92.9%	93.2%	93.3%	↑
Number of cases exceeding 52 weeks referral to treatment	0	34	94	14	↑
Diagnostic waiters, 6 weeks and over-DM01	≥99%	99.5%	98.8%	97.0%	↓

Quality measure (% unless shown)	Target 2019/20	2017/18	2018/19	2019/20	Trend
Breaches of the 28- day readmission guarantee as % of cancelled operations	0	3.8%	3.5%	7.5%	↓
Urgent operations cancelled more than once	0	0	0	0	–
2 week GP referral to 1st outpatient appointment	≥93%	95.5%	95.4%	93.7%	↓
14 days referral for breast symptoms to assessment	≥93%	97.4%	98.0%	98.4%	↑
31 day diagnosis to treatment	≥96%	97.0%	95.2%	92.7%	↑
31 day second or subsequent treatment (drug)	≥98%	99.0%	99.2%	99.5%	↑
31 day second or subsequent treatment (surgery)	≥94%	95.5%	87.8%	83.2%	↓
31 day second or subsequent treatment (radiotherapy)	≥94%	98.3%	98.5%	99.0%	↑
62 days urgent referral to treatment	≥85%	81%	80.0%	77.1	↓
62 days urgent referral to treatment (adjusted)	≥85%	83.5%	81.9%	76.8%	↓
62 day referral to treatment from screening	≥90%	92.0%	93.5%	85.1%	↓
Statutory planned preventative maintenance	100%	-	74%	75%	↑

Green - Target achieved

Red - Target not met

Green upward arrow - Improvement against previous year

Red downward arrow - Deterioration against previous year

We Listen We Care

Key Performance Measures

For the Trust Board to assure itself that key performance measures are being met they review monthly at Trust Board meetings a performance report and the Board Assurance Framework (BAF) – both are accessible on our website in our monthly Trust Board papers.
CQUINS, national performance standards, annual priorities incorporating our Quality Commitment are also key performance measures monitored by the Trust Board, and detail on achievements in year can be found throughout this report: national performance standards pages 42-44; CQUINS (below) page 45. The Corporate Governance Report, pages 15-31, identifies risks and uncertainty and how these are mitigated.

Commissioning for Quality and Innovation payment framework (CQUINS)

During the year we took part in 14 CQUIN schemes with a total value of £ 11 million. Due to COVID-19, we have not yet progressed end of year achievement assessments with our Clinical Commissioning Partnership, Public Health England and NHS England leads. Quarter 4 achievement is therefore based on an internal review by all scheme leads, commissioned by our CQUIN Steering Group. Our achievement assessment will be updated should this change following Clinical Commissioning Partnership, Public Health England and NHS England sign-off.

Commissioner	Scheme Ref	Division	CQUIN Schemes	Weighting	2019/20 Payment	Q1	Q2	Q3	Q4
CCGS	1	Corporate	Antimicrobial Resistance	0.40%	£ 1,993,668	£ 498,417	£ 498,417	£ 498,417	£ 498,417
CCGS	2	Corporate	Staff Flu vacinations	0.20%	£ 996,834	£ -	£ -	£ -	£ 996,834
CCGS	3	Family Health	Maximising Efforts for Reducing smoking at the time of delivery	0.25%	£ 1,246,042	£ 311,511	£ 311,511	£ 311,511	£ 311,511
CCGS	4	Medicine Division	Same Day Emergency Care	0.40%	£ 1,993,668	£ 498,417	£ 498,417	£ 498,417	£ 498,417
Total CCG				**1.25%**	**£ 6,230,212**	**£ 1,308,345**	**£ 1,308,345**	**£1,308,345**	**£ 1,308,345**
Specialised	1	Clinical Support	Hospital medicines utilisation		£ 1,079,000	£ 269,750	£ 269,750	£ 269,750	£ 269,750
Specialised	2	Medicine Division	Severe Asthma		£ 200,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000
Specialised	3	Surgery Division	Hep C Virus		£ 1,764,000	£ 441,000	£ 441,000	£ 441,000	£ 441,000
Specialised	4	Medicine Division	Cystic Fibrosis Self-management		£ 438,000	£ 109,500	£ 109,500	£ 109,500	£ 109,500
Specialised	5	Surgery Division	Cirrohisis		£ 200,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000
Specialised	6	Family Health	Neonatal Outreach Local CQUIN		£ 490,000	£ 122,500	£ 122,500	£ 122,500	£ 122,500
Total Specialised				**1.55%**	**£ 4,171,000**	**£ 1,042,750**	**£ 1,042,750**	**£1,042,750**	**£ 1,042,750**
PHE	1	Medicine	Identify and reduce local inequalities in AAA Screening Programme	0.42%	£ 23,828	£ 5,957	£ 5,957	£ 5,957	£ 5,957
PHE	2	CAS	Identify and reduce local inequalities in Breast Cancer Screening Programme	0.42%	£ 23,828	£ 5,957	£ 5,957	£ 5,957	£ 5,957
PHE	3	Surgery	Identify and reduce local inequalities in Diabetic Eye Screening Programme	0.42%	£ 23,828	£ 5,957	£ 5,957	£ 5,957	£ 5,957
Total PHE				**1.25%**	**£ 71,484**	**£ 17,871**	**£ 17,871**	**£ 17,871**	**£ 17,871**
Treatment Centre	1	Corporate	Staff Flu/Alcohol and Tabacco and Advice & Guidance	0.25%	£ 105,856	£ -	£ 35,285	£ 35,285	£ 35,285
Treatment Centre	2	Corporate	Alcohol and Tobacco Screening	0.60%	£ 254,055	£ -	£ 84,685	£ 84,685	£ 84,685
Treatment Centre	3	All	Offering Advice and Guidance	0.40%	£ 169,370	£ -	£ 56,457	£ 56,457	£ 56,457
Total Treatement Centre				**1.25%**	**£ 529,281**	**£ -**	**£ 176,427**	**£ 176,427**	**£ 176,427**
Total CQUIN 2019/20					**£ 11,001,977**	**£ 2,368,966**	**£ 2,545,393**	**£2,545,393**	**£ 2,545,393**

We have made good progress during the year in implementing quality improvements through the CQUIN scheme. We have continued to improve our uptake of the flu vaccination, to make ongoing improvements in the management and administration of antibiotics and have implemented a number of new initiatives through this year, including the implementation of a scheme to support new parents to reduce smoking at time of delivery of their baby.

There are two CQUIN schemes where we anticipate that we will not meet Q4 requirements. The first relates to the assessment of progress against the Same Day Emergency Care Standard and requires significant audit support from the clinical team which has not been possible to release through Q4 as a result of the pandemic. The second relates to provision of brief advice about smoking and the safe usage of alcohol of patients attending the treatment centre. We are pleased to note that despite this omission, patients continued to be asked about their smoking status and alcohol consumption, which suggests that staff remained vigilant in this regard but failed to accurately record the advice they gave.

Moving into 20/21, we will introduce brief intervention strategies across the Trust as part of our overarching prevention strategy which we believe will help us achieve this CQUIN.

Organisational structure

Our organisation is made up of clinical and corporate divisions.

The divisions are:

- Cancer and associated specialties
- Clinical Support
- Family Health
- Medicine
- Surgery

In July 2019 we were awarded the contract for delivery of services through the Treatment Centre (previously delivered by the independent sector).

In light of the contract award, we started work to review our divisional structures in order to integrate and improve service delivery. Preparatory work was completed in 2019/20 and we will implement the new structure during 2020/21 – full details will be provided in next year's report.

Sustainability Report

Commitment to Sustainable Development

During 2019/20, we continued implementing our sustainability strategy, which was approved by the Trust Board in November 2018. The strategy sets out a number of goals in the areas of water, waste and sustainable travel, carbon mitigation and adaptation; during the year we saw important progress in all of these areas.

Carbon and Energy

We reduced our carbon footprint by 9.97 per cent against the previous year; another record year for the Trust in terms of achieving carbon footprint reduction goal. This is on account of completely phasing out coal usage at the City Hospital and the ongoing decarbonisation of the national electricity grid.

Due to a national change in the accounting rules the City Energy Project was paused. Once approval to start was given by the Department of Health, we began working on the business case for our City Hospital energy centre. We believe that we will have completed, and had approved, the business case in the financial year 2020/21 with the final construction completed in the financial year 2022/23.

Sustainable Food

In 2019/20 the sustainable food programme delivered meals to our patients, visitors and staff in from sustainable sources. The service prioritises the sourcing of most of its food ingredients from local sources, contributing to a low "carbon mileage" in the meals we serve. To do this, we keep good relationships with suppliers, who are key and we know where our ingredients are from. As such, 65 per cent of food used on our Memory Menu is local/ British. There is no cost implication of using British produce year round. We have also worked to optimise the operation to reduce wastage; Patients order their meal three hours before meal service, which ensures we can tailor the order to the actual requirements in wards.

This initiative not only helps increase service resilience and sustainability of our services, but it also contributes to our ability to be an exemplar good social citizen through supporting the local economy. In the past few year's our sustainable food initiatives and catering services have won many awards, including:

- Runner up British Food Fortnight competition 2017/2018
- National Hospital Caterer of the year 2018
- Finalist Hospital Caterer of the year 2019
- Finalist Catering Service of the year 2019
- Winner at the patient network experience awards 2019
- Finalist Cost Sector Catering awards 2019
- Winner Health and Business awards 2019.

On top of this, we have been recognised by Love British Food and NHS Improvement's Baroness Dido Harding as exemplary in our ethos around patient and staff feeding.

Sustainable commuting

We continued to make incremental improvements to our travel plan with this year's focus being on the creating and promoting of more convenient/ sustainable means to commute to our sites via public transport, active travel and car sharing.

In the past year our Travel to Work Scheme grew by 24 per cent with 1,612 passes issued. This represents around half of the staff that commute by public transport, as per the 2018 Staff Travel Survey.

The Medilink Service continued to roll out its all electric fleet during this reporting period and the Council has been successful in procuring larger electric buses for this service. These larger buses should be implemented in 20/21.

As for active travel, we promoted active travel via a number of initiatives including Dr Bike, Cycle to Work scheme, bike maintenance classes and roadshows aiming to promote health, well-being and active travel.

Our Cycle2Work scheme allows staff to obtain a discounted bicycle for their commute to work, with 122 subscribers to the scheme this year.

Additional support to staff who cycle has been provided by the Dr Bike Sessions. These educational sessions provide staff with skills in bike maintenance, increasing their safety awareness whilst travelling by bike. More than 273 staff subscribed to this initiative during 2019/20.

We continue to liaise with local stakeholders in the city, such as the City Council and Highways England, to explore opportunities to develop local transport networks and to respond to major issues such as the temporary closure of Clifton Bridge, which caused major disruptions to commuters, many of them our staff.

We have been in discussions with these stakeholders over the future provision of additional Park and Ride sites that would benefit our staff.

Air Quality

The shift from coal to gas as the primary fuel for heating in city hospital and the expansion of the electric bus fleet continues delivering improvements to the local air quality area. In addition to this, we installed an innovative technology as part of a new emergency substation at Queens Medical Centre aiming to make the operation of this unit ultra clean. This is the first use of this technology, not only in the NHS, but also in UK and sets an important precedent for the contribution to air quality improvements.

Good Social Citizen Agenda

We are working in partnership with Nottingham City Council in a common vision of health via the County Council's Health and Well-being Board.

Since January 2020 we have increased our work with the council and other stakeholders to explore opportunities to help the council achieve its goal of being zero carbon by 2028.

Waste and Finite Resources Consumption

In line with our Sustainable Development strategy, we have implemented a number of initiatives around waste and water. We keep monitoring our water use to identify opportunities for water use reduction.

In terms of its waste agenda, we have an ongoing mission to implement and embed the waste hierarchy into its operations by firstly minimising waste production, then recycling as much as possible cardboard, paper, plastic and metals, and finally minimising the amount of waste going to landfill.

One of the key waste minimisation programs implemented in the year was the medicine recovery procedure in wards that is successfully preventing the disposal of pharmaceuticals issued that can be reused.

We also signed the NHS pledge to reduce plastics, and as such we have started a review on the areas where plastic could be reduced such as catering.

Expanding our sustainability portfolio

This year we were awarded the operation of the Treatment Centre. As such, we have started working in the expansion of its sustainability agenda to cover the operation of these facilities. A number of systems in the building have been refurbished to a more efficient operation.

This table details our full sustainability report:

AREA	2017-18	2018-19	2019-20
GREEN HOUSE GASES REPORT			
Total Energy Consumption (GJ)	**968,114**	**986,122**	**1,000,237**
Coal (GJ)	73,686	105,677	-
Natural Gas (GJ)	701,568	670,763	778,504
Electricity (Imported) (GJ)	103,083	105,656	117,830
Electricity (Produced) (GJ))	85,646	100,096	94,336
Gasoil (GJ)	4,131	3,930	9,566
Energy expenditure (£)	**11,102,048**	**12,419,169**	**10,618,482**
Total Business Travel (miles)	**1,137,392**	**1,237,951**	**1,189,176**
Car	784,932	863,143	970,514
Train	314,322	346,504	167,641
Airplane (domestic)	38,138	28,304	51,021
Carbon Emissions (TCO2eq)	**53,621**	**53,124**	**49,221**
Scope 1			
Coal	6,827	9,850	-
Natural Gas	35,890	34,276	39,758
Gasoil (GJ)	332	318	719
Scope 2			
Electricity Imported	10,067	8,308	8,366
Scope 3			
Business Travel Miles	506	373	378
WASTE MINIMISATION & MANAGEMENT			
Total Waste Produced (tonnes)	**5,112**	**5,166**	**5,123**
Waste recycled/reused	1,125	1,212	768
Waste to energy	1,055	1,148	715
Waste to recovery treatment*	2,276	2,121	2,451
Waste for alternative treatment	307	251	297
Waste to Landfill	348	434	893
Total Waste disposal expenditure (£)	**£1,353,906**	**£1,397,569**	**£1,331,525**
FINITE RESOURCE CONSUMPTION			
Total Water consumed (m3)	**686,462**	**653,072**	**673,318**
Water Imported (m3)	171,849	148,899	156,981
Waster Abstracted (m3)	514,613	504,173	516,337
Total Water Expenditure (£)	**£947,039**	**1,059,556**	**1,108,882**

Tracy Taylor
Chief Executive (on behalf of the Trust Board)
Date: 22/06/2020

Achievements against our key strategic objectives

Performance against key strategic objectives

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:

- patients
- people (staff)
- places
- partners
- performance
- 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.

2019/20 key strategic objectives

This is a summary of how we did against our main strategic objectives for 2019/20.

Milestones	Strategic Objectives	Achievement
Patients		
1.1 Delivery of the improvements and achievement of the goals set within the Clinical Outcome Improvement Programme	• Implement Improvement plans to improve outcomes where benchmark is low • Develop two QI leads within the quality governance team to support Divisional improvement plans	**Achieved**
1.2 Implementation of (and sustain) the identified actions in our CQC 2018/19 review to continue our work towards an overall rating of ‘Outstanding’ for the next inspection	• Review the patient safety strategy and identify three improvement projects to drive improvement from Requires Improvement to Good • Develop detailed action plan to respond to CQC findings and monitor to completion within agreed timescale • Identify the services we consider ‘Outstanding’ and develop plans to roll out the good practice across the organisation	**Achieved**

Milestones	Strategic Objectives	Achievement
1.3 Achievement of the goals set within the Patient experience Improvement Programme	• Roll out the Complaints with Compassion programme • Improve PALS provision at City Campus • Delivery of our patients' priorities as identified in our patient identified priority areas for improvement.	**Partially Achieved:** Good progress has been made with implementation of the patient identified priorities to improve patient experience particularly around dementia. Delays have been experienced around: 1) Securing funds for mobile phone charging points in central areas – bid submitted to NUH Charity February 2020 2) Updating policy to enable patients to be able to charge and use their mobile phones when an inpatient. This work is expected to be reviewed and picked up early 2020
1.4 Completion of the our Clinical Services Strategy aligned to the ICS Clinical service strategy	• Launch the Phase 1 Clinical Services Strategy priorities • Engage our clinical teams to develop our clinical service strategic priorities	**Achieved**
People		
2.1 Increase staff retention to 90% through improved staff engagement and strengthened leadership and culture	• Complete application for accreditation as a Magnet hospital • Implement the NHSI Culture and Leadership Programme • Roll out of Enabling Our Change Leadership Programme • Develop and implement new managers' promise and supporting tools • Roll out ESR self-service and launch manager self service	**Partially Achieved:** ESR manager self-service has not been rolled out as there is insufficient capacity within the People Information Team to support implemented and applications for funding have not been supported
2.2 Development and implementation of a robust people investment plans to enable delivery of services	• Development of longer term plans for all staff groups • Produce clear plans for the development of alternative roles • Implement a programme to support simplification and productivity	**Partially Achieved:** We have begun to develop alternative and transformational roles e.g. physicians associates and ACPs but there has not been a clear strategy for these roles as a result of the absence of an overarching recruitment and retention strategy.
2.3 Improvement of access to training and career development for all staff groups	• Establish talent management processes across the Trust • Roll out of career development tools • Implement new e:learning management system • Establish a programme of work to extend access to e:learning	**Partially Achieved:** Talent management conversations are in place within certain pockets of the Trust, but have not been rolled out due to capacity within the HR team. E-learning has been applied to some training topics and has been limited due to the skills of the supporting team. This has recently been addressed through dedicated e-learning training.
Places		
3.1 Implementation of the NUH Estates Strategy to improve building and infrastructure resilience and reduce critical infrastructure risk	• Completion of the A43 Cleaning Training Facility and implementation of stage two of the Cleaning Plan. • Further improvement of PPM performance (to 85%) and thereby management and mitigation of Estates risks. • Investment of capital to respond to risks with our Estate	**Partially Achieved** 1a - A43 Training Facility Complete 2b - On-going work to assess the critical backlog maintenance engineering issues has been progressing as part of a strategy plan to ensure technical programmes of work can be undertaken to address critical risk areas moving forwards within the EIRC capital plan

Milestones	Strategic Objectives	Achievement
	Infrastructure • Delivery of the Estates priorities identified in our 2019/20 capacity plan • Development of an updated Estate Strategy in response to the Trust and STP Clinical Strategy	3 -The EIRC capital allocation will have been fully spent by year end. 4 - Additional patient movement posts provided and appointed into to support Radiology. Phase 1 of Clinic 1 completed and operational.
3.2 Optimisation of our 'healthcare technology' by introducing a local (i.e. Trust-based) Health Technology Assessment (HTA) unit	• Development of the Business Case for a local HTA unit (or in partnership with the ICS) • Implementation of the HTA Unit with initial programme of work • Implementation of our plan for replacement medical equipment utilising the PMO 'matrix' system	**Partially Achieved:** • the Business Case for a local HTA unit drafted – going through approvals • two pilot HTA project successfully completed - achieved • Full implementation of replacement programme utilising the PMO matrix - achieved
3.3 Continued progression towards a Paperless Hospital and agreed Trust Digital strategy	• Completion of the whole trust voice/ data/ Wi-Fi network replacement at QMC, City and Ropewalk House • Conversion of the remaining Inpatient Risk Assessment and Admission Booklets (including Paediatrics and Critical Care) and additional inpatient documentation where clinically safe and efficient to do so from paper to electronic forms. • Implementation of a digital outpatient solution which will enable patients to have remote follow ups using digital questionnaires.	**Partially Achieved:** whole trust voice/ data/ Wi-Fi network replacement at QMC, City and Ropewalk House complete. Paperless hospital – progressing, deployment good.
Performance		
4.1 Sustain and recover (where necessary) performance against key constitutional standards	• Implement agreed operational changes to support delivery of the 2019/20 capacity plan • Deliver the recovery actions to improve emergency access performance in line with 2019/20 activity plan trajectory • Deliver planned actions to sustain the reduced number of elective patients waiting longer than 40-weeks at no more than 40 patients. • Deliver the recovery actions to achieve the 62-day adjusted standard in line with 2019/20 activity plan trajectory.	**Not Achieved:** See section on Operational Performance in the Annual Report
4.2 Improve patient flow and efficiency	• Deliver the Theatres efficiency programme to maximise productivity through theatres and beds • Deliver the priorities set out in the Emergency Care Transformation programme	**Partially Achieved:** • Theatre 23 opened Feb-20. Phase 3 of PA consulting theatre work complete. • Emergency Care Transformation Programme in place an aligned to and

Milestones	Strategic Objectives	Achievement
	• Develop and implement a plan for the roll out of same day emergency care services.	supporting delivery of the work of the Emergency Pathway Taskforce. • SDEC implementation underway supported by NHS Elect; SDEC maximisation plans in place.
4.3 Delivery of the 19/20 control total of £27.040m before conditional funding (£0m after conditional funding)	• Establishment and achievement of the 19/20 Financial Efficiency Programme (FEP) divisional 'stretch' target of £41m • Implementation of robust grip and controls plan • Management of pay expenditure and establishment in line with the agreed plan	**Achieved**
Partners		
5.1 Implement the NUH Partnership Plan	• Implementation of the strategic intents and associated deliverables for all ten priority partnerships outlined in the Partnership Plan. • Building of new or develop existing strategic relationships e.g. Tertiary network, NCSEM.	**Partially Achieved:** • Partnership plan implemented with key partnerships progressing e.g. NUH is a key partner in the ICS, ICS long term plan completed and submitted to regulators, ICS Clinical Service Strategy developed. NRC: Pre-consultation business case developed. SFH: Progress made in some areas e.g. Digital, executive to executive discussion on future direction and focus. UHL: Joint executive-led discussion. Ongoing joint work programme on fragile services. Other acute providers: Shift to developing regional solutions ourselves (e.g. Head & Neck) and move to lead acute provider models, regional models and network working. New Medical Directors forum commenced Sept 2019. NTU – development of leadership courses. UoN – joint research office being set up. • However, not getting the best out of all of our partnerships. More work needs to be done to improve our involvement with other partners.
5.2 Develop and implement the agreed roadmap milestones for the ICS and ICP	• Work with system colleagues to agree a plan to develop the governance and architecture of the ICS/ ICPs/ PCNs • Work with system colleagues to agree ICS and Greater Nottingham system plans. Implement agreed plans to deliver on the stated objectives and priorities for the system in 2019/20. • Work with system colleagues to develop a local 5 year plan with an implementation programme. • Work with system colleagues to develop and deliver an ICP transformation plan.	**Partially Achieved:** • Development of the ICS and ICPs continues with full NUH engagement. 2019/20 saw the establishment of the City & SN ICPs and 20 PCNs. The C&SN Transformation Group has been established. Senior Trust colleagues are engaged and leading work at all levels. • The strategic commissioner will be in place from 1st April. Exec to exec meetings established with strategic commissioner. • The ICS has commissioned Browne Jacobson to undertake a governance review as we go into 20/21. We have contributed to and identified a significant number of areas for development. • A stretching ICS 5 year strategy has been agreed in accordance with national requirements. NUH colleagues contributed to its development. • There continue to be significant financial and performance pressures across

Milestones	Strategic Objectives	Achievement
		the ICS and these are impacting the development of trust, culture and behaviours. • More work needs to be done to embed system working within our business as usual.
5.3. Embed the new business development framework and deliver the agreed business opportunities	• Refinement and delivery of the new standard operating and governance process for tender proposals • Development and delivery of a new Private Sector Delivery Model • Delivery of the Private Medical Insurance Income project • Delivery of the s106 project for the building of new properties in our catchment area.	**Achieved** • Training being undertaken across the Trust under the EISMA programme on new processes. • Private Partnership procurement concluded as no suitable offer – focus on internal NUH model with Treatment Centre and specialities. • All invoices to be submitted as planned by the end of the financial year. New PMI contracts to be in place by 1st April 2020. • S106 pipeline of applications established and principle that secondary care has a valid S106 claim agreed with the City Council. In negotiation for payments for specific developments.
Potential		
6.1 Joint clinical research management service (JCRMS) with University of Nottingham to oversee the development and delivery of patient based research across the partnership	• Agree and set up project plan, governance and working groups	**Achieved**
6.2 Develop and start implementation of a strategy to provide capability to all levels of NUH staff and patient representatives in applying the NUH consistent improvement and transformation methodology	• NUH QSIR programme will have provided training capacity in line with the 2019 / 20 NUH QSIR training plan. • NUH Trust Board will have completed NHSI "Leadership for improvement — board development programme". • NUH QSIR programme will have provided training capacity for all patient and carer representatives agreed within NUH Quality Improvement programmes of work.	**Partially Achieved:** • Two ICS QSIR Practitioner cohorts delivered to roll out transformation & improvement methodology but more work needs to be done to provide capacity for all patient and carer representatives. • QSIR Practitioner 101/107 trained • QSIR Fundamentals 300/797 trained • QSIR Associates 5/8 trained • 24 patients and carers trained • Trust board completed 3/4 modules of LFI
6.3 Deliver innovation support for all staff	• Establish and Chair a new Trust Innovation Committee/Review of intellectual property service provision including options for external service providers.	**Partially Achieved:** • Intellectual property assets reviewed and consolidated, priority support will be ring fenced for high ROI patents. Framework agreement in place with external patent agency in addition to NUH manager. Innovation • Committee will be launched in new fy as part of the R&I strategy refresh.

Milestones	Strategic Objectives	Achievement
6.4 Delivery of 2019-20 Learning and Education Strategy	• Demonstrate excellence in educational leadership and governance • Enhance and strengthen our learning environment and technology, supporting current and future workforce • Support, develop and empower our educators. • Build upon and identify new opportunities to work collaboratively with academic institutions, commercial organisations and ICS partners	**Partially Achieved** • An annual award for education and training has been discussed with Director of Communications and External Relations. It is understood that team is in the process of writing a proposal for new awards which will be shaped around our values. This award will be under Ambition. 2019 first NUH Apprenticeship Award and also a trainee award as part of NUH Honours • Health Educators Quality Group (HEQG) will provide quality assurance and triangulation of learner and trainer feedback, data and intelligence to enhance the student and learner training and education experience and share best practice. Additionally, the Undergraduate Medical Education team and Postgraduate Medical Education team triangulate student and trainee feedback to report to the Medical Education Senior team (MEST). • The Undergraduate Medical Education Team and Postgraduate Medical Education teams are working together to develop a Digital Learning Technologist role to support teaching and the development of technology in training and education. This will be a joint post. Development is at an early stage.

Our Patients

4Cs (Compliments, Complaints, Concerns and Comments)

2019/2020 is the ninth year that we have been using the 4C (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 the Quality Assurance Committee. The charts below describe the number of complaints received, the number referred to the Parliamentary Health Service Ombudsman (PHSO), the number of compliments and the five most common complaint themes for each year 2016/17 to 2019/20.

Number of local complaints and PHSO referrals

	2016/17	2017/18	2018/19	2019/20
Complaints	656	637	683	735
Complaints upheld	122 fully 177 partially	87 fully 129 partially	104 fully 199 partially	80 fully 198 partially
PHSO Contacts	76	75	70	53*
Investigations taken up by the PHSO	16	15	6	6*
Upheld PHSO referrals (In year)	0 fully 12 partially	0 fully 3 partially	0 fully 5 partially	0 fully* 1 partially*

*National PHSO annual data only available up to 30/11/2019.

Most frequent complaint themes

2016/17	2017/18	2018/19	2019/20
Standards of care (treatment)	Standards of care (treatment)	Standards of care (diagnosis)	Standards of care (treatment)
Standards of care (diagnosis)	Standards of care (assessment)	Standards of care (treatment)	Standards of care (diagnosis)
Complications during/after surgery	Standards of care (diagnosis)	Verbal Communication	Complications during/after surgery
Lack of communications regarding discharge	Complications during/after surgery	Complications during/after surgery	Standards of care (assessment)
Standards of care (assessment)	Verbal Communication	Lack of communication regarding discharge	Verbal communication

Total compliments

2016/17	2017/18	2018/19	2019/20
5892	6415	5703	5463

Reopened 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.

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Total complaints	159	237	193	146
Reopened	17	23	26	14
% resolved at first response	90%	91%	87%	91%

Examples of learning from complaints - from most frequent complaint themes:

Reason for complaint	Quality objective	Action taken
Standards of care - diagnosis	Improve clinical effectiveness	• A review of capacity and demand work was completed in the outpatient specialty. This resulted in a workforce change that led to virtual clinics. • New equipment purchased to aid in the identification of cleft palate. • Process implemented to improve timeliness of triage and to ensure that patients have a wristband issued within one hour of attendance.
Standards of care - treatment	Improve clinical effectiveness	• Clinical Educator changed practice to work directly with staff involved as a result of a complaint. • Patient experience shared with staff for reflection and learning. • All learning points from complaints are collated into a learning document. This is shared with the staff involved and wider team for continuous learning and improved good practice.
Verbal communication	Improve patient experience	• Patient and relatives experience anonymously shared with staff and added to induction program for awareness. • Surgical ward have reviewed their processes on how they communicate discharge plans with their patients and relatives. This includes implementing afternoon leadership rounds to ensure that the discharge coordinator or nurse in charge makes contact with relatives and carers early on in the process. • HCOP Liaison Service reviewed their DNAR systems and conversations. The service has liaised with surgical colleagues to agree who will undertake these discussions to improve standards of communication.
Complications during/after surgery	Improve clinical effectiveness	• Audit findings have shown that surgical team have improved their compliance of the use of the internal transfer document. The actions and recommendations from the audit have also been implemented. • Ward Sister has discussed with staff the use of anti-embolism stockings. Further checks have been implemented to ensure this is reviewed on handover. A full review of the nursing handover has also been completed.
Standards of care (assessment)	Improve clinical effectiveness	• A complaint regarding standards of assessment was shared at the specialty governance forum for reflection and learning by the wider team. • Staff have been updated on the Traffic Light Assessment Process and Resource Box to assist in providing care.

Improving complaint handling

In 2019/2020:

- We have continued to participate in the Peer Review process on a bi-monthly basis. This involves reviewing the complaint process and peer assessment of complaints handling. This year we have met our annual goal of reviewing 25 complaint files. Recommendations and learning from the peer review process have been implemented by the Complaints Team to improve local systems and processes;
- Patient stories, taken from complaints which have demonstrated learning within the organisation are presented monthly at Trust Board. Patient and relatives have attended Trust Board this year in person to share their story;

- The Complaints Team is actively engaged with the weekly Incident Review Meetings, led by the Patient Safety Team, to identify cases for escalation or joint investigation. The meetings also provide an opportunity for information sharing and triangulation of intelligence relating to complaints, incidents and claims;
- We have introduced new quality standards for checking all complaints letters before they are approved within the current signing off process;
- An internal review of complaints handling systems and processes has been done resulting in the development of the Complaints Quality Improvement Plan 2020/21. The plan outlines quality initiatives aimed at improving the overall quality of complaint investigations, timeliness of responses as well as improving shared learning;
- In partnership with our Patient Participation Group and Clinical Psychology Team, we have developed and delivered a Letter Writing Workshop which focusses on compassionate complaints handling.

Patient Surveys

During 2019, the results of the National Urgent and Emergency Care Survey 2018 and Children and Young People's Survey 2018 were published by the Care Quality Commission (CQC). A summary of our results is given below.

Urgent and Emergency Care 2018 Survey, published by the CQC in October 2019

Our response rate to the survey improved from the previous year. Overall, our patients felt listen to and confident in their care. We did significantly better than most Trusts in providing privacy and dignity to patients when discussing their conditions. The Medicine Division participated in a shared learning workshop and developed a plan for improving patient experiences in response to the survey feedback.

Children and Young People's 2018 Survey, published by the CQC in November 2019

Children and Young People feel they are well looked after in our services. We have seen a number of improvements since the last survey in 2016. The survey feedback identified the following areas where we are doing well:

- Speaking to children about their worries
- Children liking the hospital food
- Parent being able to prepare food and hot drinks using the available facilities
- Parents feeling there are enough activities for their child to do during their stay in hospital
- Children feeling wards are suitable for their age group
- Staff communicating information clearly about a child's condition or treatment

We also participated in the following national patient surveys during the year:

Maternity Services Survey 2019, published by the CQC in January 2020

The CQC results show our performance compared to 125 other acute Trusts. All sections scores in the antenatal, labour and birth and postnatal reports were in the expected range compared to other Trusts. We have seen an improvement in a total of nine questions when compared to the previous survey. The survey feedback identified the following areas where we are doing well:

- Partners being supported to stay as long as they wanted
- Women being given enough information about their physical recovery and information about changes to mental health
- Midwives giving active support and encouragement about feeding
- Women being able to see their midwife as much as they wanted
- Midwives being aware of a woman's medical history
- Women being offered a choice of where they have their baby
- Women feeling their concerns are taken seriously

The Family Health Division participated in a shared learning workshop and developed a plan for improving patient experiences in response to the survey feedback.

Adult In-patient Survey 2019

We are awaiting the publication of the national results of this survey by the CQC.

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?'

A total of 44,044 inpatient and day case patient FFT responses were received during the year with an overall recommend rate of 96.7 per cent. We also received 14,588 emergency department FFT responses with an overall recommend rate of 89.4 per cent.

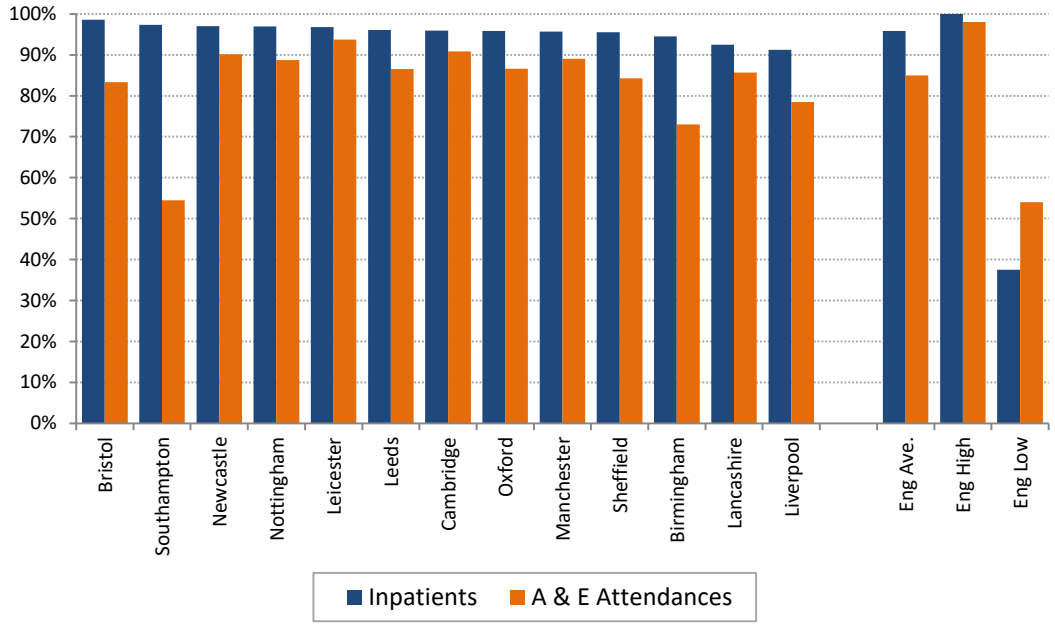
FFT Survey	Total Responses	% Recommended
A&E	14,588	89.4%
Inpatient & Daycase	44,044	96.7%
Outpatients	61,385	96.2%
Maternity (Antenatal)	1,070	99.3%
Maternity (Labour Ward/ Birthing Unit)	607	96.4%
Maternity (Postnatal Ward)	1,526	96.1%
Maternity (Postnatal Community Service)	1,948	99.6%

Learning from real-time feedback:

Here are some of the actions we have taken to improve patient experience in direct response to the FFT survey as well as our local surveys.

Communication	• The # hello my name is campaign is being promoted and is now included on all new ID badges • We have developed a new information video for patients Preparing For Surgery - Live Brief - YouTube • Patients and carers continue to be involved and contribute to our culture and values work across the Trust and offer advice on a range of projects and leaflets.
Food	• We have improved our food special diet menus and the availability of drinks and snacks. Our Memory Menu has been developed, implemented and promoted • We have focussed our efforts on improving nutrition. Our critical care team have menus on display for easy access and to help promote better patient choice • In response to feedback around requirements to have more assistance for patients at mealtimes, we have developed training through the Teams Helping Teams staff volunteering initiative. Support for mealtime assistance is available for wards who have requested this.
Sleep	• We have focussed on identifying what helps patients sleep well at home and replicating this in hospital where possible e.g. music, drinks, pillow, blankets etc • In response to feedback about noise at night and patients experiencing difficulties in sleeping we have produced 'Top Tips for Patients and Staff': https://www.nuh.nhs.uk/sleep-guidance-for-patients.
Pain	• A number of education and support sessions for staff have been and the development of a pain application is underway to enable staff to review, monitor and action pain care more easily.
Carers	• We have improved support for carers through working in partnership with the Carers Trust. We have set up new monthly carers support sessions at both QMC and City sites • We have introduced an Excellence in Dementia Discharge information ID Wallet Card for staff
Other	• In response to patient feedback around inactivity and having limited things to do during their hospital stay we have introduced fitness fiends and boredom busters • Pet Therapy visits help us reduce stress, anxiety, isolation, boredom and improve patient and staff experience.

% recommended provider trust (peer group) comparison April 2018-December 2019



Interpreting and Translation Services (ITS) 2019/2020

Interpreting and Translation Services continue to deliver efficiencies amid an increasing demand. The closing financial account for 2019/2020 is £479,000.

Compared to our baseline spend of £554,258 in 2013/2014, this year's savings realised £**75,258** over the duration of five years, we have managed to reduce our baseline spend by **£765,888** inclusive of the cost of the staff Interpreting and Translation team.

High level analysis

Over the last 12 months a shift in demographics has resulted in changing demand for languages. The top ten language bookings are as follows:

Language	***Total bookings***	***Increase on previous year***
Polish	*5462*	36%
Urdu	*1740*	20%
Arabic	*1540*	26%
Romanian	*1500*	7%
Kurdish (all dialects)	*1400*	70%
Farsi	*540*	40%
Punjabi	*396*	-10%
Mandarin	*394*	70%
Cantonese	*360*	10%
Tigrinya	*240*	90%

It is important to emphasise that demand on our Interpreting and Translation Services service has increased. In the financial year 2018/2019 we supported 15,000 hours of face to face interpreting and in 2019/2020 that increased to nearly 16,500 hours.

To make telephone interpreting easier we introduced a new App (WordSynk) that staff can access. It is hoped this will vastly improve the utilisation of telephone interpreting with the potential to realise further cost efficiencies.

We are also exploring how to make video remote interpreting more available in partnership with Nottingham Deaf Society at the request of the deaf community.

Our People

Culture and leadership programme

As an organisation we understand the importance of setting the right conditions through our culture and our leadership. The culture can be describe as 'The way we do things around here'.

In 2019 we started the NHS Improvement/ Kings Fund culture and leadership programme.

The evidence suggests that if we get the culture and leadership right across our organisation this directly impacts on a reduction in patient mortality and staff engagement.

The purpose of the programme is to follow a framework which includes three phases:

- The 'Discovery' phase this includes undertaking a diagnostic of the current state incorporating the perspective of patients, staff, stakeholders and the board on culture;
- The 'Design' phase which includes developing a strategic response to the outcomes of the Discovery phase;
- The 'Deliver' phase where you implement those things identified in phases one and two.

The programme focuses on five cultural elements:

- Vision and values
- Goals and performance
- Support and compassion
- Learning and innovation
- Teamwork

During 2019/2020 our focus has been on the Discovery and Design phase.

To assist with the collection of the data and the Discovery phase we recruited colleagues from across the organisation to be part of our Culture Change team, 55 colleagues in total from all different professions and backgrounds supported this. These colleagues received development to support them with the Discovery phase.

The Discovery phase started in February 2019 with a presentation to the board on the benefits of this programme of work and then was followed by a number of different approaches including:

- A leadership questionnaire to all staff asking colleagues to rate their leadership and that across the Trust; This questionnaire was also sent to partners that we work with;
- Carrying out focus groups with staff and volunteers as it was often difficult for staff to leave their areas of work we also took them to their areas via our trolley dashes;
- Interviewing all board members and non-executives;
- Other data that is also available was reviewed such as staff survey result, Workforce Race Equality Standard (WRES) data and General Medical Council (GMC) survey were amongst them.

This data was then analysed and themed around the five cultural elements and shared back with the organisation at a co design event that was arranged to seek additional feedback on the themes and to ensure that nothing was missed.

Following the co-design event we entered into Design phase in December 2019 and this involved pulling together a culture and leadership strategy to continue to support the organisation in areas that we do well in and to put plans in place to focus on areas identified under the five cultural elements that we need to improve.

The strategy was due to be launched in April 2020 following the anticipated release of the NHS People Plan, but was paused and is in the process of being reviewed to ensure our learning from COVID-19 is reflected in the strategy. However, the work across the five cultural elements continues and in some instances has been accelerated as a result of COVID-19. For example the development of the Well-being Centres and the wellbeing offer for staff, delivering learning and development differently, team working, witnessing TeamNUH values in action through compassionate leadership, and numerous examples of innovation.

Next expected the strategy will be launched later in 2020 and associated plans will begin to happen during 2020/2021.

NHS national staff survey

This year 38 per cent (5,899) of our staff responded to the National Staff Survey. The median national response rate is 47 per cent.

Highlights from our national survey results across 11 themes include:

- We are above average for four themes of which two (Safe Environment - Bully and Harassment and Safe Environment – Violence) we are within the best 20 per cent of benchmarked Trusts in the country);
- We are average for three themes are average;
- We are below average for four themes of which three (Quality of Appraisals, Quality of Care and Team Working) we are in the lowest 20 per cent of benchmarked Trusts.

The focus for improvements in 2020/21:

- Looking at car parking provision;
- Looking after staff health and well-being at work, including working flexibly and making reasonable adjustments for staff who need them;
- Making sure everyone has the same opportunity to progress their career;
- Making sure that everyone is treated fairly;
- Making sure staff have the resources to do their job;
- Making sure staff feel they can influence decisions and make improvements in their role;
- Improving the skill set of managers, including communication and visibility and ensuring that staff are supported in challenging times and recognised for their efforts.

Staff Friends and Family Test

Staff are invited to provide feedback on the quality of care and the likelihood of recommending Nottingham University Hospitals as a place to work through the Staff Friends and Family Test (FFT), the results of which are shown below.

Factor	Quarter one June 2019	Quarter Two September 2019*	Quarter Four March 2020
% of respondents would be extremely likely or likely to recommend our services to friends and family if they needed care or treatment	83%	83%*	87%
% of respondents would be extremely likely or likely to recommend NUH as a place to work.	54%	80%*	62%
*These values reflect only New Starters within the organisation as a sample group was chosen in Q2 to undertake the Staff FFT			

People Experience Group (PEG)

The six key priorities and subsequent areas of focus for PEG in 2019 (based on 2018 national staff survey results) were:

- Simplify Systems and Processes - Reviewing Trust wide systems and processes to suggest changes to ensure they are as efficient as possible, where the clear focus was to make roles manageable;
- Speak up! Listen up! - Bringing together a range of our staff, to scope how to build a culture of psychological safety within our teams which in turn will be used to inform part of the design phase of the NHS Improvement Culture and Leadership Programme;
- Improve Staff Wellbeing - the Wellbeing and Attendance Management Policy was re-written to make it more supportive. Supporting bespoke projects through working parties, to include staff hydration and Mental Health support for staff;
- Value and Recognition - A virtual group designed to share and communicate best practice value and recognition activities and initiatives across the Trust, linking into national and local days of celebration/events such as Valentines 'love our staff' Day and Team NUH Awards;
- Equality and Diversity – Continuation of the reference group and staff equality networks to ensure active discussion and action within all Equality, Diversity and Inclusion matters and regulatory requirements, ensuring a clear focus on protected characteristics where satisfaction has decreased;
- Embedding work - around managers standards, values and behaviours, appraisals and enabling our change programme within our Academy Board, to support the Culture and Leadership Strategy which will be launched in Spring 2020.

Progress in delivering on identified actions

Staff told us that they'd like **managers to have more support** in their roles and in turn be better able to support their teams. A new monthly 'market-stall'-style manager's induction was launched. We also re-launched our **appraisal format**, equipping managers with the tools to have effective conversations with their teams.

Staff told us they'd like us to **celebrate our inclusivity and diversity**. In June, we launched the Rainbow Badge, with over 3,000 pledges made by Team NUH.

We received over 1,300 comments and experiences relating to Mental Health in our 2018 National Staff Survey. Our Staff Mental Health Council, which uses the Shared Governance model, now has 17 active members. Our Council used what staff told us to inform our areas of focus for 2019/20. We signed the **Time to Change** workplace pledge in December 2019.

time to change
let's end mental health discrimination

Staff told us that wanted a fruit and vegetable stall, offering fresh and healthy choices and promoting cleaner air outside our main entrances. In July, we welcomed fruit and veg supplier Roots, Fruits and Shoots to both hospitals.

Staff told us that they'd like **more development opportunities** for administrative and support professionals. Our Surgery Division successfully piloted our first ever in-house administration academy, which has now been rolled out across the Trust.

Staff told us that they'd like to be better connected on-the-go, with easier signposting to key information such as their e-pay slip, and their Electronic Staff Record (ESR). In April, we introduced our **Staff App**, and over 2,000 of Team NUH have downloaded it to date.

Staff told us they wanted more to be done to address our ageing Estates and Facilities. We have invested in key roles, including Head of Estates and Facilities and Soft FM Professional Leads, with recruitment ongoing in all areas of our services. We've introduced handy-people to our service, increasing our number of multi-skilled support staff.

Staff told us that there is a lack of consistency in the behaviours and decisions made by our managers. We re-launched our **managers' standards** to bring greater consistency to how we do things across Team NUH.

Staff wellbeing

Our staff wellbeing programme continues to go from strength to strength, 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.

Numbers of staff engaging with staff wellbeing services has increased significantly over the past 12 months, particularly from wards and direct patient care services. Key areas of work/ action:

- Agreed year three actions for the Staff Wellbeing Strategy and continually reviewing progress against targets;
- Continued to develop our mental health offer, whilst ensuring the promotion of physical wellbeing as being intrinsically linked;
- Signed up to the Time to Change workplace pledge to end stigma in the workplace around mental health;
- Developing the work on menopause awareness and support for staff;
- Rewriting the Wellbeing and Attendance policy (due for launch in summer 2020);
- Completed research into staff hydration in recognition of the high levels of dehydration reported by staff – a Staff Hydration policy is now underway to be launched later in 2020.

Throughout the year the wellbeing team has delivered:

- A wide range of physical activity initiatives including walking challenges and events, onsite fitness classes and Couch to 5k programmes;
- Support to staff cycling to work– 122 bikes were accessed through our Cycle to Work salary sacrifice scheme, 273 bikes were serviced by our Dr Bike initiative;
- Mental health initiatives including 15 Coping with Stress workshops attended by 221 staff, two local department stress workshops with 33 attendees, and three eight week mindfulness courses;
- Support to staff to improve their overall wellbeing through the provision of 19 health check events including locally delivered health checks thanks to financial support from NUH Charity, completing health checks for 1,134 staff;
- Our Staff Physiotherapy team continued to deliver appointments to staff to address musculo-skeletal problems which were affecting their work, despite a reduced team;
- We held 13 Leading a Healthy Workforce training sessions for managers aimed specifically at how to look after the psychological wellbeing of staff. There was a statistically significant difference in manager confidence in dealing with members of staff experiencing mental health concerns;
- Re-launched our 12-week weight management programme;
- Delivered eating for wellbeing seminars on a range of topics;
- Launched a mobile weight management clinic;
- Developed and launched a new Let's Talk Mental Health workshop with the Staff Mental Health Council to raise awareness of mental health and suicide awareness and normalise conversations;
- Our Employee Assistance Programme has continued to be extremely well used, with 1,450 calls made to the service since March 2019 - 82.8 per cent of these were counselling related. The main category of calls related to mental health concerns, relationships and work related stress;
- 677 staff signed up to our financial wellbeing service with 59 staff accessing an affordable salary deducted loan, predominantly to help with debt;
- Launched a wellbeing bulletin for staff, in partnership with the Communications team – this will continue to be delivered quarterly and focus on a range of wellbeing topics;
- Launched eating well and mindfulness workshops for menopause;
- Continued to deliver our menopause awareness workshop.

Comments from staff…

"This course has given me the tools to use mindfulness to improve my emotional wellbeing, both at home and in the work environment (mindfulness course)"

"I really enjoyed the session and thought the size of the group and participation was really good. The content covered was really relevant and I found it all really useful (Leading a Healthy Workforce)"

"Thanks to Cycle to Work I was able to sell my car and now just come to work on my bike. It's a brilliant scheme"

"Just wanted to let you know that what you do really makes a difference".

Key priorities for 2020/2021

- Launch of the new Wellbeing and Attendance Policy and associated training;
- New menopause awareness training for managers and staff;
- Develop a suite of training modules for managers aimed at developing skills in looking after staff wellbeing;
- Continue to develop and expand the staff wellbeing programme utilising evaluation and monitoring of current services to identify areas of need.

Support for staff well-being during the COVID-19 pandemic

During the pandemic there are a number of things that we have implements to support staff:

- Developed a range of communications – self-care during COVID poster, staying hydrated infographic, all staff wellbeing bulletin, staff wellbeing FAQs, prompts and info sheets for managers;
- Promoted our EAP and Neyber for emotional, practical and financial support;
- Promoted the national wellbeing support services (wellbeing apps, national helplines);
- Delivered a range of wellbeing initiatives on line – seminars and training;
- Promoted physical activity with walking challenges, online physical activity campaign;
- Worked with local cycling agencies to provide 30 bikes (loans or donations) to staff, free bike servicing, tagged 250 bikes with security info and swapped 25 locks.

The clinical psychologists trained 150 members of staff in psychological first aid to support the work as well as offering support spaces to clinical areas and developing a range of written resources. We have created a COVID well-being intranet site as well as all the support offered via free parking and 24-hour food and the mutual aid work around donations etc.

Going forward all the wellbeing work will be overseen by our well-being steering group. There were already plans to extend our clinical psychologist post in the staff wellbeing team who will be working on training for line managers and rolling out more psychological first aid across the Trust, with the aim to get as many people trained as we can over the next couple of years. There is also work taken place to identity areas of improvement in staff rest areas and improving staff hydration (also work already identified before this period).

Well-being Centres

One of the responses that we have implemented to support our colleagues during the pandemic are two Wellbeing Centres, one at City and a second at Queen's Medical Centre.

The Well-being Centres have been supported by Nottingham Hospitals Charity and kind donations from outside of the organisation.

The purpose of the Well-being Centres are to:

- Signpost colleagues to information
- A place to rest and relax
- To provide a listening ear

The centres are manned by trained Well-being Centre Buddies from across the organisation who have accessed training delivered by our internal psychologists on Psychological First Aid. The psychologists are also supporting these colleagues with weekly check in's.

During the first six weeks of the centre's being open over 8,000 colleagues have visited the centres to access the support that is on offer.

Staff have really welcomed the use of the Well-being Centres and some of their feedback is below…

"The wellbeing room has been a godsend during this stressful time, a place to escape to friendly volunteers."

"Beautiful place it's great to have some where to get away. Thank you."

"What a lovely area. Thank you for providing a calm, safe space where staff can take a minute for their wellbeing."

"After a stressful morning on COVID wards the wellbeing room is a great space to come and sit away from the stress of the hospital. The drinks and snacks are an additional benefit, but ultimately it is the space that is most useful."

The coordination of the Wellbeing Centres has been a real team effort from across the organisation and been a wonderful example of colleagues coming together in these unpredicted times.

Equality and Diversity

Highlights for 2019/20 included:

During the year the team have

- continued to pledge 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;
- ran further bespoke training sessions on British Sign Language for front line staff in response to comments received from the deaf community;
- become an established partner on the Nottingham Autism Champions network, linked to Nottingham's Autism Strategy and continued to raise autism awareness and champion autism training covering employment and service delivery, through Autism East Midlands;
- successfully re-launched the 'Staffability' (Disability Staff Network) and LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, A-sexual and Allies) networks. Work is underway to create better synergy between all the staff networks including BAME (Black, Asian, and Minority Ethnic) staff network;
- For the second year we promoted diversity through holding an international nursing and staff event on the 31st May;
- 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) by hosting The Prince's Trust 'Get Into Hospitals' programmes and 'Project Search', which helps young people with learning disabilities into work;
- celebrated our inclusivity and diversity, by launching the NHS Rainbow Badge scheme, with over 2,800 pledges made by Team NUH. Our full allocation of badges was taken up within six weeks. https://www.nuh.nhs.uk/nhs-rainbow-badges;
- successfully launched AccessAble, with plans in place include the Nottingham Treatment Centre;

  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: https://www.accessable.co.uk (search Nottingham University Hospitals)
- successfully completed the fourth 'Future Leaders' programme, addressing under representation of BAME and other protected characteristics at senior leadership levels across Nottingham City;
- held an NHS community partnership roadshow event in August 2019 where the team were kindly hosted by the Baitul Hafeez Mosque, Sneinton Dale. We were warmly welcomed by Dr Irfan Malik, vice-president of the Nottingham chapter of Ahmadiyya Muslims and members of the community;
- partnered with Notts Trans Hub to review our Gender Diversity inclusion, to recognise gender fluidity and non-binary identity as a result of public feedback at Notts Pride 2019. An ongoing programme of work, including staff awareness, training, and gender neutral toilet provision is underway;

- run a successful pilot of Prince's Trust Care Certificate HCA programme for our Institute of Nursing and Midwifery. Further programmes will run in 2020/21;
- supported Lilya's Legacy #hospitalweartocare project and campaign: A young patient with autism, Lilya Coleman Jones was being treated on one of our wards. Lilya was affected by the noise and identified that this was coming from the televisions. Lilya realised that headphones and splitters could help reduce anxiety for patients and reduce noise across all wards. Full details here: https://www.nuh.nhs.uk/lilyas-legacy-hospitalweartocare;
- recognised Black History Month and South Asian Heritage Monthby recording and publishing videos of staff who are BAME role models. The inspirational interviews were told in staffs own words;
- again visited Jimma Hospital in Ethiopia. In November a small team of dedicated staff, including the new Jimma Link lead, Kate Martin and Chief Operating Officer Lisa Kelly, went to Jimma Hospital Ethiopia as part of our annual commitment to visit. These visits continue to serve as excellent developmental opportunities for our staff in honing skills in challenging resource poor circumstances. In 2020 we hope to welcome Jimma staff to Nottingham University Hospitals, continuing our exchange programme;
- in partnership with other statutory organisations, held our third public equality partnership event in recognition of Disability History Month with the theme of 'Disability: Leadership, Resistance and Culture'. Planning for the 2020 event is already underway;
- actively promoted the 'Time to Talk' Day on 6th February including drop-in sessions, encouraging staff to have conversations about mental health to challenge prejudice and stigma;
- welcomed David Edgley from Nottingham Rainbow Heritage to the Trust who, in February, provided training to staff on Hate Crime and LGBT awareness;
- promoted International Day of Women and Girls in Science by providing a video of Claire Greaves Chief Scientist, who explained the importance and reason for International Day of Women and Girls in Science;
- marked Holocaust Memorial Day on January 17th with the planting of a memorial tree by our Chief Executive Tracy Taylor which was attended by members of staff and Nottingham Liberal Synagogue;
- continued our support of our LGBT (Lesbian, Gay, Bisexual and Trans) staff and community. In February 2020, our Chief Executive raised the rainbow flag to demonstrate the Boards commitment to inclusion and raise awareness of LGBT History Month, drawing attention to the health inequalities that adversely affect the LGBTQIA+ communities;
- recognised International Women's Day on March 11th and published our third Gender Pay Gap report on the same day https://www.nuh.nhs.uk/gender-pay-gap.

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.

We are committed to creating a culture where staff feel able to speak up about any concerns they may have. So, in 2016 we appointed our first Freedom to Speak Up Guardian as a stand-alone role to provide independent and impartial advice and support to colleagues.

Handling of cases

Our Speak Up policy makes it clear that all cases will be handled with the strictest of confidence and outlines the types of concerns the Guardian can support staff with.

During the year there were a total of 51 cases reported to the Freedom to Speak Up Guardian; an 8 per cent increase from the previous year. Key themes emerging within those cases included culture, leadership and quality of care.

Nursing staff remain the group reporting the highest number of concerns, followed by doctors, midwives and administrative staff.

The Freedom to Speak up Guardian works closely with senior leaders to make improvements to policy and practice with the aim of improving the experience of our staff and the quality of care they provide.

Culture

We have a dedicated internet site with key contacts and information on speaking up, including frequently asked questions, speak up guidance and escalation processes. Various actions taken to contribute to a more open and supportive culture during the year include:

- **Increasing Visibility**: The Guardian has open door access to the Chair, Chief Executive, Executive Lead and Freedom to Speak Up Non-Executive Director, supported by regular quarterly meetings;
- **Supporting vulnerable groups**: We know from our staff survey results there are some groups of staff who are less likely to speak up. The Guardian has fostered strong links with the BAME Staff Network to increase confidence in speaking up.
- **Communication and engagement**: there is regular use of the staff newsletter, Trust Briefing, to raise awareness of Freedom to Speak Up and point staff to the web page that contains information and guidance. We use a variety of means to promote the Guardian role, including posters, induction, social media and attendance by the Guardian at key staff meetings;
- The Guardian carried out a number of walk around sessions during Speak Up Month in October 2019, and in early 2020 presented to matrons and middle management teams, along with trainee health care assistants, to generate awareness of Freedom to Speak Up.

Measures to support good practice

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. Based on feedback, the role of Speak Up Champions has been refreshed, a robust training programme introduced, including line management agreement for protected time to carry out the role.

Feedback

Comments on support provided by the Guardian has been overwhelmingly positive. 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 and this will be a focus of attention in the 2020/21 Freedom to Speak Up delivery plan.

Health and Safety

Ensuring and maintaining ensuring the health, safety and welfare of our staff, patients, students, contractors, visitors and members of the general public is of paramount importance to the safe operation of our services.

Through the organisations health and safety policies and health and safety compliance review process the Trust has set out its systems and arrangements for health and safety; which have been designed ; to so far as is reasonably practicable, ensure the Trust meets it's legal and statutory obligations.

During the year there were a total of 3,332 health and safety incidents reported via our Datix Risk Management system; which is an increase of 35 incidents on the previous year (2018/19).

Of the 3,332 incidents; 43 fell within the definitions of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and so were reported to the Health & Safety Executive in accordance with our statutory duties. This number compares to 41 incidents reported in the previous year; with 32/43 being over seven day reportable incidents. All incidents were subject to review and investigation with a view to ensure that learning and where necessary improvements are put in place to mitigate the risk of a reoccurrence.

We maintain the view that a large proportion of accidents are preventable and so a large amount of effort and resource is put into reviewing incidents that occur with a view to promote awareness and learning which is expressed through changes to our policies, improvements to our health and safety arrangements/ compliance systems and in our training and awareness programmes.

Any arising health and safety concerns are reported to the health and safety team and are monitored by our Health and Safety Committee through to resolution.

During the year there have been a number of successful initiatives undertaken;

- Full roll out of our internal health and safety compliance Review process with 247 areas now taking part in measurement of compliance against agreed health and safety policies and standards;
- Development and implementation of our phase one health and safety audit programme;
- Establishment of enhanced Conflict Resolution Training (Level 2) for our higher risk areas;
- A full review of our health and safety training programmes and modes of delivery in order to enhance their effectiveness;
- A full review of our health and safety committee structures and redesign to maintain effectiveness and accountability.

NUH Honours Awards

We celebrated our staff in December at our annual NUH Honours awards, sponsored by Nottingham Hospitals Charity. More than 400 staff enjoyed an evening recognising the incredible contributions of staff, volunteers and community partners.

The prestigious awards were handed out in 16 categories celebrating our staff and supporters, ranging from Team of the Year, to Inspiring Staff Wellbeing and Community Champion awards.

Tracy Taylor, Chief Executive said: "Very many congratulations to the record-breaking 1,200 staff, patients and fundraisers who were nominated this year, and to our shortlist and winners who have been recognised for delivering outstanding care to our patients and for their dedication to NUH.

"I would also like to thank to our fantastic Nottingham Hospitals Charity and to our individual awards sponsors for making this memorable evening possible. It is important to say 'thank you' to the brilliant Team NUH for all they do throughout the year for our patients, their families and carers. I truly am proud to be part of Team NUH."

Held at the East Midlands Conference Centre at the University of Nottingham, the ceremony was hosted by BBC Radio Nottingham presenter, Sarah Julian. The annual Team NUH awards were made possible thanks to the support of Nottingham Hospitals Charity and to sponsors who contributed to the evening's showcase.

Barbara Cathcart, Chief Executive of Nottingham Hospitals Charity, said: "We'd like to say a huge 'congratulations' to all the winners of this year's Team NUH Awards. As one of the judges I can testify that we always receive so many inspiring entries, it can be very difficult to choose just one winner. Well done to all those who were nominated and shortlisted, and a special recognition to the winners. We are delighted to fund this year's awards for the thirteenth year and for the opportunity to meet our hospitals' star employees and supporters."

The 2019 Team NUH Awards winners are:

Apprentice of the Year Award: Katelyn Burrows

Aspiring for Excellence: Alissa Morris

Chairman's Award: Lesley Riley

Community Champion Award: Super George's Army

Compassion in Action Award: Andrew Gee

Fundraiser of the Year Award: Liz Roper

Innovation, Research and Improvement Award: Joseph Manning

Inspiring Health and Wellbeing Award: Sandra Newcomb and Susan Sale

Leader of the Year Award: Joe Fowke

Patient Safety and Quality Award: Adult Home Parental Nutrition Team

Respect and Inclusion for Everyone Award: Hui Sian Tay

Team of the Year Award: Voluntary Services

Trainee of the Year Award: Michelle Attz

Unsung Hero Award: Karen Marshall

Volunteer of the Year Award: Elaine Watson

Working Together Award: Acute Pathway Nursing and Medical Team

The Chairman also presented two additional awards for special recognition:

Trish Cargill, Chair of our Patient Partnership Group

City Hospital League of Friends

Our Volunteers

Our volunteering scheme continues to benefit from the popularity of volunteering having the added value of volunteers enhancing our services delivered.

It is essential that volunteers are recruited, inducted and supported properly. Not only does this ensure volunteers feel valued and supported, but ensures volunteers, staff and our patients remain safe and receive outstanding hospital experiences.

By far ward and clinic volunteering continues to be the most popular placements within our volunteer scheme. Volunteers continue to enhance the services offered by staff across all campuses, covering a variety of duties from initial meet and greeting, practical assistance in general day to day duties, along with one of our core duties of meal time assistance.

On Tuesday 10th March 2020 there were 1,322 registered and guest volunteers currently all working to enhance patient care and promote our values. This again is a rise on the previous year's figure.

Noticeable events and projects

- After the refurbishment of our Emergency Department, a new Meet and Greet/ internal response volunteer desk was created with volunteers offering a front of house Meet and Greet service, whilst also supporting, on request, areas in the Department, like Majors, at times of high demand supporting with patient flow;
- Volunteers were asked this year to help support our new doctor's intake morning. Volunteers helped over 400 doctors by sign posting/ escorting new doctors around the Trust with some buddying as required;
- As part of the Stop the Bleed project, volunteers did extra training and helped facilitate training by acting as patients so that staff and volunteers could learn the basics of stopping life threatening bleeding to give time to get injured individuals to the hospital and save a life;
- Volunteers joined a focus group looking at what it's like to be part of Team NUH. The group leaders wanted to discover what we we're doing well in the opinion of the volunteers, and where we could make positive changes via the focus group feedback;
- Helped the Emergency Department carry out a patient survey to better understand why people are attending the Department to inform our future planning of services. Volunteers were asked to be the first point of contact and assist patients struggling to complete the survey. The survey lasted three days and operated between the 6am – midnight;
- We hosted the Royal College of surgeons exams during the year, with around 70 patients, 50 consultant assessors from across the county and 150 potential candidates attending volunteers where asked to help with sign posting/escorting around the Trust with some buddying as required;
- Volunteers have now been requested to help within critical care departments which includes Adult Intensive Care (Queen's Medical Centre), Ward E12 (Queen's Medical Centre) and Critical Care Department (City);
- Supported interviews, with volunteers acting as a patient representative. Volunteers took part in clinical role play scenarios as cancer patients to observe the candidates' consultation and people skills;
- A number of volunteers joined focus groups to help support the Trust's desire to create the right culture for Team NUH;
- Helpforce is a Community Interest Company, founded in 2016 by Sir Thomas Hughes Hallett, Chair of Chelsea and Westminster NHS Foundation Trust. It was set up to support the development of 21st

century volunteering at national scale in collaboration with the NHS, charities and the patients and communities it serves. We have collaborated with Helpforce's national recruitment programme and gained 192 expressions of interest to volunteer at our Trust with 32 individuals now placed as volunteers;

- Volunteers again assisted the Nottingham Hospitals Charity with this year's Robin Hood Marathon, and are also now working with the Charity at its new Queen's Medical Centre Charity Hub shop;
- Over the last year our Physiotherapy Department has held a service evaluation project in departments at both hospitals. Volunteers were asked to help with the service evaluation project via helping patients assessing what attributes they feel an excellent Physiotherapy Department should have whilst completing a 22 question survey. The service evaluation project was held over two months;
- Four volunteers took part in the Nurse and Midwife of the Year Tram bridge event, handing out supplements for the Nurse and Midwife of the Year Awards promoting nominated staff;
- Volunteers were asked to help with a Discharge Lounge project that aims to improve efficiency within both of our Discharge Lounges via making observations from a patient perspective and feeding back to the project leads;
- Macmillan Nurses at both of our hospitals requested help from volunteer's with stocking up leaflets, making up information packs for two hours per week;
- Patient-led assessments of the care environment are a self-assessment of a range of non-clinical services which contribute to the environment in hospitals. Again over a couple of months multiple volunteers participated in the assessments;
- A long established Health Care of the Older Person volunteer completed a yoga training course and has now identified four exercises which are now being supplied with seated patients on these specialist wards.

Annual Volunteer Long Service Awards

The Volunteer Long Service Awards continues to be the highlight in our volunteer calendar again held at the Crown Plaza Hotel Nottingham hosted by Trust Chief Executive Tracy Taylor and Trust Chairman Eric Morton.

The awards were generously sponsorship again this year by both our hospital Leagues of friends.

There were 81 volunteers eligible for long service awards this year ranging from 5 years up to 35 Years.

This year's noticeable achievements were Elaine Barlow, a Spiritual and Pastoral care volunteer who received a long service award for staggering 35 years of volunteering and Lindsey Gingell and Audrey Turner, volunteers at Lings Bar, who both received long service awards for 25 years' service.

Volunteer support for spiritual and pastoral care

We currently have around 120 volunteers supporting our spiritual and pastoral care department, some on a weekly basis, and others on a monthly basis. Many of the volunteers have been with the department for a number of years and the spiritual and pastoral care department are extremely grateful for their volunteers continuing service and commitment.

In terms of recruiting new volunteers, part of our process of selection involves prospective volunteers attending a two-day ward visitors' training course, which is run three times a year and attendance is usually around the half dozen mark. The course includes sessions on listening skills, faith and cultural awareness, and thinking through aspects of grief and loss. As well as this we go through the various 'practicalities' of the role – things like information governance and infection control. These courses prove to be very helpful in terms of giving a flavour of what is involved in volunteering with us.

Over the last year the spiritual and pastoral care department also provided opportunities for their volunteers to reflect on their practice in a more formal way by offering half-day training sessions on topics that are pertinent to their role.

One final event to mention is the annual Rededication Service, where a good number of spiritual and pastoral care volunteers attend in order to commit to be with the department for the year ahead. It also gives the chaplains the opportunity to express their support and appreciation for volunteers.

This is certainly a highlight volunteers from differing faiths and backgrounds come together to offer words of re-commitment, before joining together over a shared lunch.

The Pears youth volunteer project

The Pears youth volunteer project began in January 2019 with the aim of building on existing voluntary services to integrate youth volunteering into our wider volunteer programme, to design volunteer roles around the needs of young people, and ensure young people have a voice in hospital services. A total of 46 youth volunteers were recruited onto the acute medical healthcare of the older person wards at the Queen's Medical Centre and provided 630 of volunteering over a 12 month period. Extra training was provided over and above the mandatory training provided by the trust through a week long summer school, one to one and small group training sessions totalling 600 hours per head of the volunteer population. The scheme offered AQA accreditation which was accessed by 15 volunteers.

Macmillan Volunteers

It has been another successful year for our Macmillan Information and Support Service who now have 11 volunteers across both sites. On average the services' volunteers give between two to three hours of support each week taking messages, re-stocking the service's information points and putting together patient information packs.

Volunteers help to ensure the service runs efficiently and enriches the services provide Additional training was supplied this you to our volunteers which included; HOPE facilitators training and Stop the Bleed.

This year, two of the Service's Volunteers – Caroline Kenyon and Alan Woods were nominated for a Team NUH award for outstanding performance.

The Nottingham Stoma Support Group, Queen's Medical Centre

The Nottingham Queen's Medical Centre Stoma Support Group continues to meet monthly in Clinic 2. They have 40 members in the group and have managed to maintain excellent attendance with new volunteers coming along as a result of promotion events and referrals from the E14 stoma nurse team and via social media interest.

The group has been running for 31 years and is considered to be a model for the UK in terms of the programme.

The Stoma Support Group programme has a wide range of visiting speakers covering stoma management and suppliers of Ostomy products and some non-medical talks.

The Group are also having an artist working with them as part of the Colostomy UK national initiative "Active Ostomates".

At the committee meeting on 15 February 2020 our Treasurer reported that the group had a bank balance of £2,015.02.

A few speakers are from charities and we give them a donation for coming to speak to the group.

We have produced a leaflet entitled "Top tips for staying away from home" that we have sent to the Colostomy UK national team.

Meet and Greet volunteers

Over the last year we have continued to strengthen our Meet and Greet volunteer service by recruiting more volunteers and expanding our Meet and Greet services to cover the Emergency Department at the Queen's Medical Centre and Physiotherapy entrance at City Hospital.

Having our uniformed polo-shirt volunteers with the Meet and Greet services at the vanguard across the Trust and continues to offer instant points of assistance for visitors, patients and staff. It would only be fair to highlight that in the initial stages of the polo-shirt introduction, a small amount of Meet and Greet volunteers did have various oppositions to the change in design and whilst we have worked through these now. It cannot be emphasised enough the need to now safeguard our one look volunteer uniform and continue to maintain its role out whilst continually advertising the positives to all.

We currently have 157 Meet and Greet volunteers aged between 18 to 91, 104 volunteers are based across the Queen's Medical Centre, 48 volunteers within the City hospital and 4 volunteers at Ropewalk House.

Meet and Greet Volunteers cover 181 sessions, based on the minimum standard three hours volunteer shift, Meet and Greet volunteer's hours covered each week are:

All hospital entrances continue to be extremely busy areas with the volunteer Meet and Greet service being in greater demand every year. Meet and Greet volunteers continue to be our first line ambassadors offering wayfinding, escorting and wheelchair conveyance along with acting as response volunteers helping wards, clinics with various requests for support in times of service high demand.

Our volunteers support a large number of our patients on a daily basis. Below are some statistics on the amount of directions given, escort duties, wheelchair journeys supplied by our Meet and Greet volunteers across all campuses from April 2019 until the end of February 2020.

Directions given	Wheelchair journey's	Patient's escorted
229,091	5,580	15,602

Summary

Increasingly in our modern society employers and employees are becoming more aware of the issues of work-life balance, the dynamic nature of the economy and the now prevalent short term nature of work contracts and working hours. With this increased knowledge and understanding employers are now starting to implementing policies intended to reduce the pressure of work on individuals with the continued thinking that an improved work-life balance will help create a more productive and happier workforce.

Hence more and more employers are now starting to offer their employees time away from their roles to volunteer within the local community or for mainstream volunteer originations and charities. There is also an increasing trend with the short term nature of work contracts for employers to look more favourable on applications where individuals undertake volunteering whilst seeking work or new careers.

Volunteering is truly about working in partnership which means listening to service needs and providing volunteering opportunities to service theses needs whilst achieving our long term plans and immediate and wider associations.

Our Performance

Emergency Planning

Core Standards

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 / Improvement North Midlands who confirmed the award based upon the supporting evidence of compliance. This status award is a positive indicator of the quality of our EPRR arrangements and plans.

In conclusion, the EPRR Lead for Nottinghamshire Clinical Commissioning Group concluded: "It was recognised that some good work had taken place since last year's assessment and demonstrated a Trust wide commitment to EPRR and as a result, to meeting the core standards".

Training and Exercising

Throughout the year the Trust participated in a number of internal and external exercises culminating in Exercise Chimera. This exercise was a practical, Trust wide participation exercise designed to test the recently revised NUH Critical and Major Incident Plan. The exercise generated a great deal of assurance around the effectiveness of the arrangements as well as some areas for further clarity and improvement which have been enacted.

Also in year work has been undertaken to further strengthen the EPRR Annual training plans; specifically around two key areas:

1. The response to a deliberate / accidental hazardous contamination incident which was delivered to all members of the Emergency Department Staff.

2. Senior Command training to increase the knowledge and understanding of the Trust's Critical and Major Incident Plan and the role of the Hospital Incident Command Team. The training was delivered through five modules based around the Joint Emergency Services Interoperability Programme (JESIP). This training enabled a commonality in the way we operate, train and respond, and to develop joint working practices with other Category 1 and 2 responders in response to an incident.

Incident Response

During this year the Trust has responded effectively to a variety of presenting incidents. The latter part of the year has been dominated by the Trust's response to the COVID19 pandemic. The Trust was heavily involved from the early stages of the incident; planning for individual cases alongside all local health partners, through to working with others to isolate early suspected cases and to establish community testing. This was followed by a larger scale response which culminated in activation of our Major Incident Command and Control functions alongside our Pandemic Response Plan.

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

We are currently transitioning to use of Everbridge (a mass communication platform) for our Critical and Major Incident call out arrangements with the aim of embedding a more efficient process for notifying staff members of an incident as well as sending real time and regular updates as the incident progresses.

Business Continuity Management

Over the last year an ongoing project to transition to a revised Business Continuity Plan (BCP) template across the Trust was completed. This includes the Trust Business Impact Analysis (BIA) which reflects the prioritised list of activities by service.

The BIA and each individual BCP have all been activated during the response to COVID19 pandemic. Service curtailment was necessary across the Trust as well as expansion/surge planning in some areas such as Critical Care and laboratory services.

As part of the incident response staff have been redeployed across the organisation in order to support critical services, and changes have been made to premises use as well as usual working patterns.

During the recovery phase of the incident, each plan will be reviewed in light of the actions taken during the pandemic in order to capture the organisational learning for future reference.

In January 2020 an audit of the Trust's BCP arrangements was completed and a formal report issued. Whilst the report identified Significant Assurance around the ISO Compliant process of Business Continuity Planning being rolled out within the Trust; it also identified limited assurance for the routine testing of Business Continuity Plans during the year. Actions were agreed and implemented to ensure that all BCPOs were written and approved to the ISO 22301 format after which these would undergo testing and review during 2020/21.

Our Partners

Integrated Care System

What is the ICS?

The Nottingham and Nottinghamshire Integrated Care System (ICS) is a partnership of a wide range of organisations that provide health and social care services to the people of Nottingham and Nottinghamshire.

We're joining forces with other NHS organisations, councils and voluntary sector partners to coordinate services around the needs of each person. More and more people need care across a lot of different settings, whether they're visiting clinics or hospitals, living in nursing homes or at home with a carer. We want to make sure our entire care system is well coordinated and working together to give each person the care they need.

The development of ICS's is a national strategy that is set out in the published NHS Long Term Plan. Nottingham and Nottinghamshire has made good progress and was confirmed nationally as one of the first ten ICS's and is recognised as an ICS Accelerator.

Our role in the ICS

Within our strategic objectives we have recognised the importance of working closely with our partners to both realise our organisation objectives and importantly; to provide sustainable services that meet the needs of the population we serve.

Our commitment to working in partnership is captured within our Partners promise 'we will support the improvement of the health of the communities we serve through strong system leadership and innovative partnerships to deliver integrated models of care'.

In 2019/20 the ICS has operated at a number of levels:

- One ICS covering the Nottingham and Nottinghamshire population;
- Three Integrated Care Partnerships (ICPs) covering Mid Notts, South Notts and, Nottingham City populations; and
- 20 Primary Care Networks (PCNs) across Nottingham and Nottinghamshire.

We are an active member of the ICS and the developing ICPs providing strong system leadership and supporting resources. Our senior leadership team is represented in various roles throughout the system as we continue to integrate system working within our business. We have contributed to the significant work undertaken during the year to agree the ICS Outcomes Framework, ICS strategic direction and ICS Clinical Services Strategy.

We have been active in supporting each of the three ICPs; contributing appropriately as they go through their own development routes.

The PCNs were newly established during 2019/20 and are continuing to develop. Whilst the early stages were focused on integration at primary care level we are proactively working with partners to understand how we can work with PCNs to integrate primary and secondary care relationships where appropriate.

Working with partners across the ICS we are investing in what we know works best for our local community, like focusing on preventing illnesses and providing more services closer to where people live.

Achievements in 2019/20

The integration agenda has continued to progress during 2019/20. Achievements in 2019/20 include:

- Implemented many of the ICS infrastructure requirements of the Long Term Plan; including system-wide governance arrangements; dedicated leadership; system capabilities for population health management, workforce transformation and digitisation; joint financial governance and collaboration; streamlined commissioning; capital and estates planning at system level; combined System Oversight Framework.
- Information sharing to improve practice, efficiency and outcomes; including:
  - Real time booking of social care assessments are now live from hospitals across whole ICS reducing time taken for complex discharge patients;

    - Shared record viewing now part of business as usual for Clinicians across all health providers and Notts County Council Social care teams.
- Preventing Strokes in Greater Nottingham:
    - Proactively identifying people at risk of stroke through atrial fibrillation using risk stratification. Through intervention early work has prevented estimated 75 strokes and 25 deaths.
- Enhanced Care in Care Homes – Pilot in Rushcliffe:
    - A&E attendances down by 29 per cent; admissions down by 23 per cent.
- Multi-Disciplinary Team working in Primary Care:
    - Better health and social care outcomes and reductions in costs; 13 per cent more people supported at home - admissions to hospital down 12 per cent from the cohort.
- Call for Care:
    - Crisis response within two hours helping to de-escalate crises, 1,520 avoided attendances at A&E; 613 avoided admissions and reduced length of stay in 216 cases.
- Covid-19:
    - Implemented a system major incident response structure, working in partnership with health, social care and wider system partners.
    - Implemented significant transformation initiatives to:
        - Re-configure the hospital estate to support COVID patients;
        - Make use of independent sector estate to maintain critical hospital services;
        - Fast tracked roll-out of digital outpatient appointments;
        - Reduce number of medically safe for discharge patients in the hospitals.

Looking Forward 2020/21

The response to COVID-19 has accelerated a number of parts of the integration of our system working whilst in other aspects has slowed some parts. As we progress through the year we will have to work together as a system to:

- Build upon and ensure sustainability of the transformation initiatives that have been rapidly stepped up;
- Evaluate what has been paused, re-set and develop a path to restoration;
- Continue to develop the partnerships that are needed to underpin a population focused approach; and
- Shift the focus of service delivery to become more preventative, proactive, and person-centred.

Nottingham Hospitals Charity

This year communities across Nottingham joined the nation in applauding our NHS, recognising the work of the incredible people who put themselves on the frontline of our battle against coronavirus.

During a time of national emergency we have been immensely proud to be there for our hospitals, providing added assistance to staff when it mattered, so that they could continue to provide care and treatment for patients during the most momentous and challenging time the NHS has ever seen.

We could only have achieved this with the support of our many generous donors who recognised and championed their #NottinghamNHSHeroes through our emergency appeal.

As the official charity for Nottingham's hospitals we are able to ensure that donations go directly to help those areas within our amazing hospitals that are close to people's hearts, providing over £3.5 million funding in total during the last year.

Highlights:

#NottinghamNHSHeroes emergency appeal

At a time of national emergency we launched our #NottinghamNHSHeroes emergency appeal within days of the COVID-19 pandemic starting in the UK.

Turning our charity offices over for food and provisions storage, we assisted the distribution of essential food packages for NHS staff that faced bare supermarket shelves after long shifts caring for patients. We funded the provision of vital wellbeing areas to give staff respite during breaks from intense activities on their wards.

With the support of businesses such as Waitrose and John Lewis, local celebrities such as Jake Bugg and Vicky McClure and sports clubs ranging from the Nottingham Gaelic Athletic Club to Nottingham Forest Football Club the local community of Nottingham helped us raise £100,000**.**

Enhancing patients' experience at our hospitals

We passionately believe that added extras which the NHS is not able to fund can make a real difference to the way that patients experience their time in our hospitals. This is why over the last year we funded £1.2 million for a wide range of services, from activity projects for young patients at Nottingham Children's Hospital, to complementary therapies for terminally ill patients at our Hayward House palliative care centre, to vital counselling services for bereaved families at our Zephyr's centre. Focused on the person, these services have helped thousands over the last year, making their hospital stays better and more bearable.

Nottingham Children's Hospital, a fundraising success story

The incredible success of our £3million Big Appeal for Nottingham Children's Hospital saw several landmarks achieved over the last year.

The Big iMRI part of the appeal has successfully met its target and the construction of a brand new intraoperative iMRI suite, where neurosurgeons will provide state of the art treatment for children with brain tumours, is underway and will be operational later this year.

In addition, through the Baby MRI part of the appeal we have provided funding for a vital new MRI incubator which will be able to help our neonatal paediatricians give the best possible care for our tiniest patients.

Our Places

Tomorrow's NUH

The Department of Health & Social Care published the Health Infrastructure Plan (HIP) in September 2019. This will deliver a long-term, rolling programme of investment in health infrastructure, including capital to build new hospitals, modernise our primary care estate, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate.

At the centre of the HIP will be a new hospital building programme, to ensure the NHS' hospital estate supports the provision of world-class healthcare services. Under this approach, the Government has committed to build and fund 40 new hospitals over the next ten years. Six major projects were given the go-ahead immediately in the first wave (HIP1), with a further 21 schemes in the second wave (HIP2), some involving more than one new hospital, given the green light to go to the next stage of developing their plans.

Nottingham University Hospitals NHS Trust has been identified as a HIP 2 scheme which will enable us to take forward our exciting reconfiguration programme. We are a clinically led organisation with a vision is for be known for our pursuit of outstanding health outcomes and excellent patient and staff experience.

At this stage we are exploring all options including developments on our City and QMCs campuses to future proof these Hospitals for the next 60 years. To support these plans £5m of seed funding is being provided which will allow us to undertake work to develop and agree with system partners the future clinical operating models for our services leading to a number of estate configuration options and the production of a Programme Business Case.

We are currently working to agree what our future clinical operating model will be so we can plan our infrastructure developments around this. Once we have done this we can then look at the options on how we can achieve this through the major investment and redevelopment of our hospital infrastructure. We are aiming to have completed all of the work needed to inform the Programme Business Case by early 2021.

It will be important that we engage with our teams across the organisation to complete this programme as one of the key tests we will have to demonstrate is how our preferred investment option is owned and supported by our clinicians. There is a risk to the timeline if we can't engage effectively with our teams and we are considering how we best do this over the coming months taking in to account the current requirements to manage the COVID-19 response. We are currently planning on the assumption we can do this in an agile way and therefore we will complete the necessary work this year. This will be reviewed carefully by the programme team going forward.

Following engagement with our clinical teams we will begin to share our ideas with local people and gather their feedback to help shape our plans.

This is a very exciting time and we hope that the end result will be an environment that matches the outstanding care we provide in hospitals that our patients and our staff deserve and can be proud of.

Security

This year has seen some significant changes been introduced to the way in which our security team operates; the most significant is the introduction of two new forms of PPE, these being: new and enhanced stab vests and body worn CCTV. These enhancements to PPE are a direct response to the increasing number of incidents of violent and aggressive behaviour from patients and visitors against our staff. Since introducing CCTV we have seen a marked reduction in incidents that escalate to violent and aggressive behaviour. Both of these introductions are becoming best practice for all those who work in a security function across most industries and organisations.

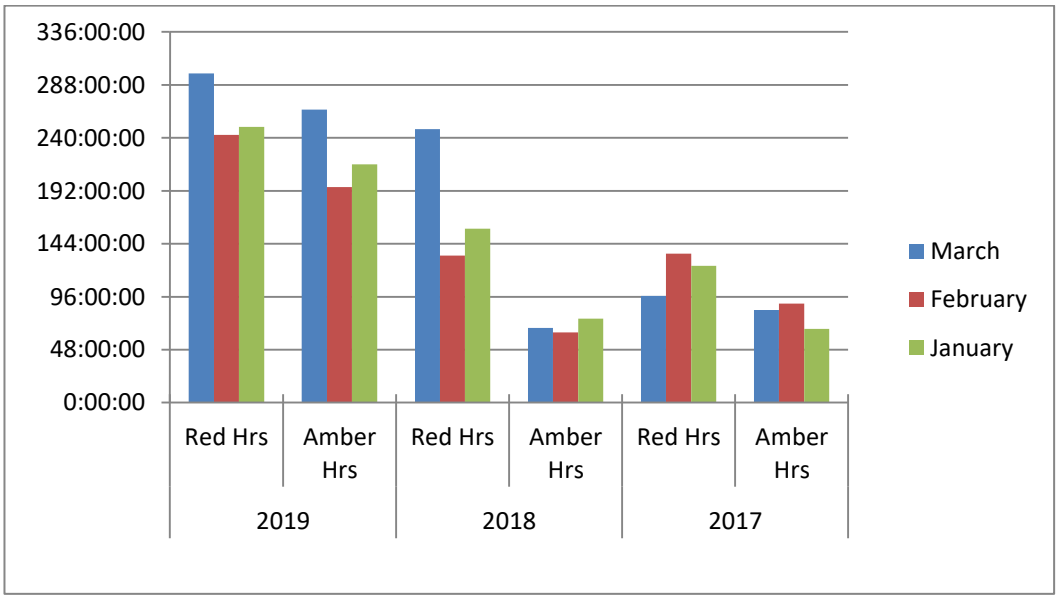
Our partnership with Nottingham Police service has allowed us to develop a facility within our Emergency Department for the police from Nottingham and adjoining counties to work from, and use as, an Operations HUB. The initiative gives greater police presence in the Emergency Department and provides a sense of further security and support to the staff working in areas of increased risk.

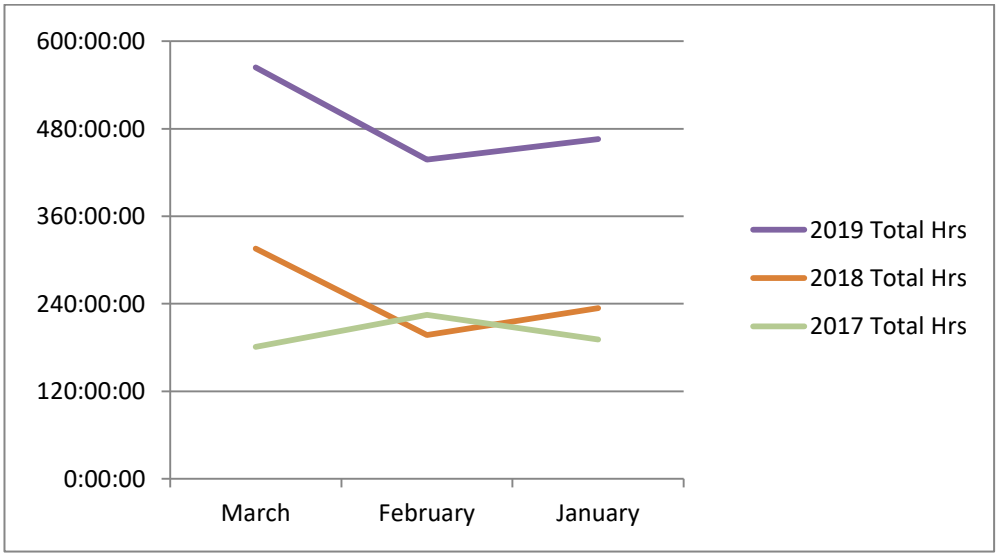
The designation of: Red and Amber watch determines the level of security response requested by our staff.

Red Watch is requested when a patient is displaying: violent and aggressive behaviour, has no capacity (Mental Capacity Act assessment), under DOLS, under the Mental Health Act or poses a danger to themselves and others. Any of these diagnoses may require the patient to be restrained or prevented from leaving (in their best interest). In all Red watches there is a requirement for the minimum of two security staff to be present to assist clinical staff.

Amber Watch is not used as much as the Red Watch as it is more of an over watch of patients and is carried out by one security officer who is always on duty within the Emergency Department.

	2019			2018			2017		
	Red Hrs	**Amber Hrs**	**Total Hrs**	**Red Hrs**	**Amber Hrs**	**Total Hrs**	**Red Hrs**	**Amber Hrs**	**Total Hrs**
March	298:30:00	265:30:00	**564:00:00**	248:00:00	67:45:00	**315:45:00**	96:52:00	84:07:00	**180:59:00**
February	242:40:00	195:15:00	**437:55:00**	133:19:00	63:41:00	**197:00:00**	134:55:00	89:55:00	**224:50:00**
January	249:55:00	216:05:00	**466:00:00**	157:47:00	76:17:00	**234:04:00**	123:57:00	67:00:00	**190:57:00**





The increase in security response and incidents of violent and aggressive behaviour have been discussed with our police partners and both parties agreed this is due to the increase of synthetic drug use and associated criminal activity in the Nottinghamshire area.

Other security related trends within our hospitals have been mainly focused on the thefts of medical gasses, bicycles and most recently the theft of vehicle catalytic converters, which is a national trend.

In response to these new trends we have invested in new CCTV to monitor the external gas stores and have also installed security electronic check points to ensure that regular physical checks of these stores are carried out.

We are discussing further plans to expand our CCTV footprint and a full independent engineer's survey of the CCTV system was carried out to fully inform us on what improvements can be made.

Our security management team are engaging with external training providers to develop a bespoke training package for security officers to cover a more detailed understanding of mental health, clinical restraint techniques and conflict resolution techniques. This will be an addition to the CRT Level 3 training which is mandatory for the officers and delivered by the Nottingham Healthcare NHS Trust.

We have won the contract to operate the Nottingham Treatment Centre which sits on the Queens Medical Centre campus. This acquisition is still going through its transformation process and plans are being developed to integrate all support services into the current establishment, this may see an increase in security resources.

Going forward there are plans to further develop the technical security measures and our physical security footprint to respond to current and potential security threats.

Our Potential

Digital Services

We have delivered many digital 'products' over the last ten years; from ground-breaking mobile technology for clinical teams; to cutting edge, specialist clinical systems; innovative collaborations across multiple organisations for clinical benefit (e.g. EMRAD); and a progressive network infrastructure.

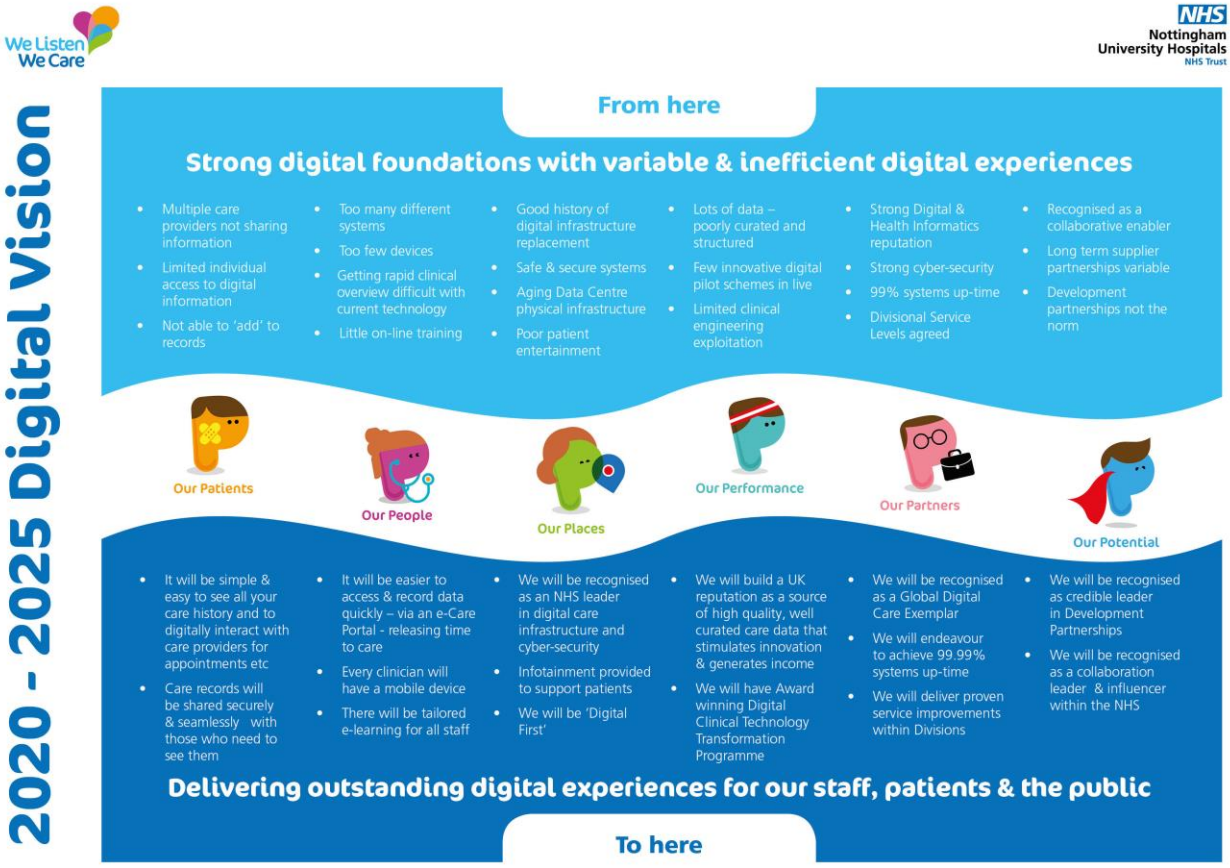
In the last couple of years we have not met the emerging digital expectations of our staff, our patients, and the public we serve: all of whom live their lives now in a Digital Age that demands a radically different approach. That said, since the COVID-19 pandemic we have made some dramatic changes; more on that later.

Although some of those expectations have been fairly basic, budgetary constraints have created a lack of adequate, sustainable technology re-fresh programme, which in turn has resulted in often unreliable, slow to access, multiple, disconnected applications on aging devices in fixed locations and often not always supported. This year our renewed Digital Strategy sets out how we intend to resolve these basic environmental issues. There may, however, be a more fundamental opportunity.

Our Digital Goal

Following consultation with our stakeholder groups, our over-arching goal is:

To deliver outstanding digital experiences to our staff, our patients and the public we serve.



We've consulted extensively and taken advice and steer from a variety of sources. These include, stakeholder consultations; governmental and NHS national policy, plans and priorities; local Integrated Care System priorities; external advisors; and extensive research into the latest industry leading technologies. This has created a series of ambitions we've articulated in our Digital Vision.

Today, we are an organisation with strong digital foundations but delivers variable and inefficient digital experiences. The vision sets out against each of our 6P's, the current state and the future expected state. Each of these relatively simple statements are ambitious and multi-faceted. They focus upon the 'experience' expected rather than a particular 'product' delivered.

We believe that using this approach we can both enhance the digital experience and save money.

This vision has been signed off by our Trust Board and will be implemented during 2020/21.

Finally, with the world in the grip of a pandemic, there has been a need for us to work differently and quickly adapt. And as a result, the way we use technology has changed. We will take this learning through to 2020/21 and amend our Digital Strategy as needed.

Some examples of those rapid changes are linked to the number of our staff who have the ability to work from home At the beginning of March there were, on average, between 15 and 30 external connections to our systems from our staff every hour of the day. Now, between 6am and 6pm there are over 1,600 external connections from our staff every hour of every day – and over 200 connections every other hour of the day – these are people working from home and connecting remotely to do their work.

At the beginning of March, we had not heard of MS Teams. There are now over 6,000 meetings via Teams and more than 90,000 chat messages every week - it has become a regular feature of our daily lives. In the clinical arena, NerveCentre has adapted to meet our growing need for more accurate data about our patients and clinical teams have worked with Dr Doctor to do virtual clinics with patients. And that doesn't even cover the 3,000+ devices the Digital Services team have delivered to enable us to work from home.

Research and Innovation

Our Research and Innovation department is responsible for leading, managing and developing clinical research in every part of our hospitals.

In 2019/20 we continued to be at the forefront of clinical research development in the country based on National Institute for Health Research (NIHR) data. We carried out a total of 472 clinical trials involving 14,415 adults and children. We are now the third most active research hospital in England.

Clinical research is part of everything we do as a teaching hospital, bringing the skills of front-line NHS staff in every profession together with scientists, academics, data analysts and industry partners to ensure that our patients can benefit from the latest advances in clinical care.

In the last year we were particularly pleased to see the contributions of nurses in our research workforce recognised with three national awards.

We were one of the most successful hospital trusts in the country in the NIHR 70@70 programme which was set up to mark the 70th anniversary of the NHS. The programme selected 70 nurses and midwives from across the country with the aim of enabling more professionals to get involved in clinical research.

Currently over 400 of our nurses, midwives, doctors and health professionals are directly involved in helping to deliver research trials each year. The 70@70 programme is designed to open up new opportunities to support the world-class research taking place in Nottingham.

One of those selected for the programme, Dr Sarah Brand, Senior Research Nurse for our Renal and Transplant Unit, is using her 70@70 role to explore how clinical research can be more integrated within frontline nursing practice, sharing research skills with all nursing staff and making research part of "business as usual". Sarah, who is based at Nottingham City Hospital, said: "I am delighted to have been awarded a prestigious NIHR 70@70 Nurse Research Leader role. This gives me the chance to influence the development and embedding of a culture of research within our nursing teams – a culture which is the foundation of evidence-based nursing practice and excellent patient care."

Awards were also given to Aquiline Chivinge, Ambulatory Care Pathway Matron, and chair of our BAME (Black, Asian and Minority Ethnic) Shared Governance Council, and Dr Louise Bramley, Clinical Lead for Research and Innovation at our Institute of Nursing and Midwifery Care Excellence.

In 2019/20 our key performance achievements were:

Key Performance Indicators	2019/20	
	Target	Actual
Minimum % of patients offered the opportunity to participate in research	30%	20%
Number of patients recruited in NIHR studies	14,000	14,115
Total Research and Innovation Income	£26M	£25.9M

Research following patient need

Our research portfolio and activity prioritises diseases which have a high prevalence in our region. 2,685 cancer patients helped deliver 106 different research studies. The NIHR Nottingham Biomedical Research Centre is strategically aligned to the clinical needs of the Nottingham and Nottinghamshire population: more than 15,000 patients suffering from respiratory, gastrointestinal, hearing loss and musculoskeletal disorders benefited from access to innovative therapies.

NIHR Nottingham Biomedical Research Centre (BRC)

The Nottingham Biomedical Research Centre is our centre of excellence which was set up in 2017 to fast-track scientific developments from the research laboratory to patient care.

In the last 12 months our research has produced breakthrough results for understanding why some patients develop a fatal respiratory illness, Idiopathic Pulmonary Fibrosis (IPF); in our understanding of Tinnitus, a hearing condition for which there is no cure; a genetic link between the health of our guts and hardening of the arteries which can lead to heart disease; and the impact of some cancer drugs on hearing loss.

During 2019/20 the Nottingham BRC carried out 406 translational research projects, supported 197 early researchers in their careers and published 437 research articles available to all researchers which will help to develop new treatments for patients.

NIHR Nottingham Clinical Research Facility (CRF)

Our Clinical Research Facility provides the equipment, skilled staff and dedicated facilities to enable us to carry out experimental medicine research.

The facility is part of a network of facilities across the country that have been selected by the NIHR to increase our capabilities in complex research into new drugs and therapies.

Nottingham hosted the national conference for all Clinical Research Facilities across the UK and Ireland. The conference heard from scientists and researchers at the cutting edge of new medicine and from Nottingham the 400 delegates learned about our work with young people in developing a new treatment for childhood constipation. The volunteer group swallowed harmless mini-capsules that show up on MRI scans to track their digestion. One in ten children and young people suffers from constipation at some point and the problem becomes chronic in a third of them, with 27,500 per year needing hospital treatment in England alone.

Up to now, there has been no completely safe and efficient way of tracking the movement of food through the gut, so possible reasons for constipation have been hard to diagnose.

The ‘MAGIC’ (MAGnetic resonance imaging in paediatric constipation) programme has been designed by experts at the birthplace of MRI in Nottingham. The study involved some of our gastroenterology experts, the University of Nottingham and the Nottingham BRC.

The ‘Magic Bean’ mini-capsules are made of a medical-grade plastic shell and are smaller than Tic Tacs to make them easy for children and young people to swallow. They do not dissolve in the gut, and are filled with a MRI-visible liquid that stands out clearly in the scan pictures of the gut.

In 2019/20, the Nottingham CRF delivered 503 projects, a 22 per cent year on year increase in Nottingham’s experimental medicine activity with the largest growth in therapeutic areas outside the BRC such as cancer, neurology and renal diseases.

Links with the Life Sciences Industry

We recruited 316 patients in 76 contract commercial studies in 2018/19. The new business development team made significant progress in leveraging strategic partnerships at local, national and international level to drive innovation and financial growth.

Priorities for 2020/21

We are a research hospital, with clinical research taking place in each of the Clinical Divisions as well as in our centres of research excellence.

In 2019/20 we set out four key priorities to ensure that local patients continue to benefit from better healthcare, treatments and technology which our research provides. These included aligning clinical research with the needs of the wider health system in Nottingham.

For 2020/21 our ambitions include supporting the development and delivery of novel COVID-19 treatments; launching the Nottingham Health Science Partners as a vehicle for greater joint working and alignment with our local partners in research; increasing our partnerships with industry to ensure that we provide new treatments and better evidence to improve the health of our local communities; and increasing the number of members of Team NUH who are research active through our Research Futures School, which supports research careers for all professional groups.

Highlights from the year…

Hat-trick of national research awards for NUH doctors

Consultant Neurologists Drs Akram Hosseini and Radu Tanasescu and Consultant Respiratory physician, Dr Sherif Gonem, are among a select group of doctors who have been awarded grants by the Medical Research Council (MRC). The Clinical Academic Research Partnerships (CARP) is a new initiative which aims to support more NHS clinicians to take part in clinical research.

For her research project, Dr Akram Hosseini, Consultant Neurologist, will be harnessing powerful Magnetic Resonance Imaging (MRI) – an area in which Nottingham leads the world – to study the build-up of iron in patients' brains, a factor which contributes to the development of Alzheimer's disease.

There are 850,000 people in the UK living with dementia – many of whom have Alzheimer's disease – a devastating condition that causes gradual decline in memory, thinking and reasoning skills and therefore disruption to their daily lives.

Dr Hosseini said: "It is a golden opportunity to draw on the physics expertise at the Nottingham Sir Peter Mansfield Imaging Centre, for clinical studies and biomedical sciences. Professor Richard Bowtell and I will be working together to apply new MRI sequences to investigate dementia.

"I'm grateful to work at a leading medical centre and be able to conduct clinical research using high resolution MRI in a study that is meaningful to patients."

Dr Radu Tanasescu and his study team will be using MRI and clinical data routinely collected from people with Multiple Sclerosis (MS) and apply AI (Artificial Intelligence) techniques to identify models that predict MS outcomes. AI will be used to extract hidden-information from MRI scans.

Where patients have given consent for their data to be used, the researchers will analyse information about the patients' clinical condition, their demographics and MRI scans, using AI.

The study team's IT specialists will train a computer to use mathematical models to predict whether a person's MS will mean greater disability or cognitive impairment over the long-term.

The AIMS study will take advantage of a collaborative environment which includes the Nottingham MS clinic and research programme and its international exposure and networking, the NIHR Nottingham Biomedical Research Centre and the University of Nottingham.

Dr Tanasescu said: "I feel very honoured to be the recipient of this award. The CARP award involves collaborative high-quality research partnerships with established leading biomedical researchers.

"We intend to harness more valuable information from routine MRI scans and existing NHS clinical data with our study, which makes the research cost-efficient. I am aware of the complexity and challenge the clinical application of AI entails, but through collaboration and support from AI experts and a robust plan

of external validation, we aim to make a breakthrough. This can provide a tool for informed decision-making and personalised treatment in MS."

Dr Tanasescu added: "We hope this study will have in the end a direct benefit for patients – it is not science for the sake of it. And we aim to expand our knowledge of Multiple Sclerosis using real-world clinical data."

Respiratory Consultant Dr Sherif Gonem is based at Nottingham City Hospital.

The CARP award is enabling him to work with respiratory medicine Professor Dominick Shaw on a retrospective study to improve the early warning system used to monitor patients on respiratory (lung disease) wards.

Drawing on five years of existing patient data to predict potentially life-threatening events occurring during a hospital stay, the study also aims to reduce the rate of false alarms. As a result, doctors and nurses should be able to better manage their workloads.

Sherif's study will draw on the expertise of computer scientists, and use AI and machine learning – where computer programmes access data and use it learn for themselves - to analyse anonymised data generated by the existing Nerve Centre clinical system.

He said: "I'm very pleased to be one of the three recipients of CARP. It's a great opportunity and I hope my research project will have a positive impact on patients with lung disease both in Nottingham and further afield."

Professor Stephen Ryder, Clinical Director of Research & Innovation said: "It is a fantastic achievement for our colleagues to have been successful in this new area of research funding. We are already one of the most research-active hospitals in the country, and the quality of our research is recognised nationally and internationally."

"We know the importance of supporting clinicians at every stage of their careers to take part in research, and the CARP funding is an excellent opportunity for front-line staff to bring their skills and knowledge to clinical research."

Nottingham joins national research programme for asthma and COPD

Patients in Nottingham and across the East Midlands with respiratory illnesses including asthma and COPD are benefitting from a pioneering new research programme.

Researchers in Leicester and Nottingham are part of the UK's first dedicated data hub for respiratory illnesses that is enabling cutting-edge research for health discoveries to give patients across the UK faster access to pioneering new treatments.

The BREATHE Health Data Research Hub for Respiratory Health is one of seven data hubs set up to improve the lives of people with debilitating conditions by linking up different types of health data to make it more easily accessible and user-friendly for research. Researchers from centres of excellence based at NUH and in Leicester are joining with partners from across the UK, including the NHS, academia and charities to develop the new Hub.

Professor Ian Hall, COPD lead for the BREATHE Hub and Director of the NIHR Nottingham Biomedical Research Centre said: "I am delighted that researchers in Leicester and Nottingham will be playing a major role in helping the national Hub deliver its objectives. This builds on a decade of close collaboration between the NIHR Nottingham and Leicester Biomedical Research Centres, and on the extensive links we have already put in place across the UK. Ultimately our aim is to accelerate access to relevant health data to facilitate research into lung diseases and to improve patient care."

Patients, researchers and clinicians are working together to explore the safe and ethical use of health data for research into specific diseases including cancer, Crohn's disease and asthma. They will also enable access to data for trialling new treatments and support improvements in clinical care. Patients will be involved in decisions about how their data is used to ensure the benefits are returned to the NHS and the wider UK community, and existing rules for accessing data safely and securely will continue to apply.

The Health Data Research Hubs are part of a four-year £37million investment from the UK Government Industrial Strategy Challenge Fund (ISCF) announced in November 2017 led by UK Research and

Innovation, to create a UK-wide system for the safe and responsible use of health-related data on a large scale. The hubs will also stimulate further economic growth through greater research activity.

Each hub was selected following an open competition by an independent panel involving patient and public representatives. They were assessed against criteria that included the potential for impact, the innovative uses of data, plans for involving patients and the public, and the value for public funding.

We took our research to the zoo this year

Our orthopaedic surgeons swapped their operating theatres and clinics for a day out at the zoo in the hope of encouraging young people and their families from across the East Midlands to take part in the international CORE-Kids research trial.

Their research is funded by the NIHR and involves children from around the world looking at how broken bones (fractures) are treated in children aged 5-15. Overall, researchers are hoping to speak to over 300 children and families over the next year.

Ben Marson, Orthopaedic Surgery registrar at Nottingham Children's Hospital and NIHR Doctoral Fellow explains: "Children and young people who suffer a fracture may be living in pain and may miss out on doing activities they enjoy such as playing sports and generally being active."

"These kinds of injuries may mean that children experience disrupted sleep, they may need to take time off school, and their general happiness can be affected. And 10 per cent of children who suffer from a fracture won't make a full recovery a year after their injury."

Ben added: "With CORE-Kids, which is an international study, we will be finding out which outcomes – or results – are the most important ones to measure."

"This will mean that we will shape all future research trials on children's fractures. This should lead to better care and management of these children through better evidence-based medicine."

The CORE-Kids trial will also help to provide more consistent standards of treatment and follow-up after a fracture.

Twycross Zoo was chosen as a popular location to help raise awareness of this research trial among parents and children affected by fractures.

Draft 2020/21 Annual Plan Milestones (subject to review and agreement by the Trust Board)

The Board had drawn up a set of Annual Plan milestones towards the end of 2019, however, in light of the COVID pandemic we are now reviewing them in line with our COVID recovery plans, to ensure we capture the learning and transformation in these plans prior to formally finalising them. The milestones will be shaped around our six P's and will have an overall Executive Director lead to own and deliver against the priorities set.

The updated Annual Plan milestones should be available in the coming months. They will be accessible to the public via our Trust Board papers on our website.

Financial Performance

2019/20 Financial Headlines

We are 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	Description	Target	Performance	Variance	Duty
		£m	£m	£m	£m
Control Total Pre FRF/PSF	Financial Control Total Delivered	(26.9)	(28.8)	(1.9)	Met 1
Break Even Duty	Expenditure does not exceed income	0.8	0.9	0.1	Not Met 2
External Finance Limit (EFL)	How much more (or less) cash NUH can spend over that which it generates from its activities.	39.0	6.9	32.1 Underspend	Met
Capital Absorption Rate	NUH is required to pay a dividend to DHSC of 3.5% of its average relevant net assets (Cost of Capital)	3.50%	3.50%	0.0%	Met
Revised Capital Resource Limit	NUH must not spend more than the limit set	49.2	49.1	0.01	Met

1 Allowable miss as a consequence of cost of Covid-19 annual leave accrual not funded.

2. The Trust was required to deliver a £0.9m surplus, as a consequence of receiving £0.8m 18/19 bonus PSF funding in 19/20, after initial control totals were set. However the Trust did not achieve cumulative break even taking one year with another.

NUH reported an in year surplus of £0.9m. The Trust achieved in year financial balance, but failed to achieve its cumulative break even duty.

Summary of financial performance

Each NHS Trust is required to ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account. NHS Trusts should normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year. Although we reported an in year surplus, this was not sufficient to return us to a cumulative break even position, which at 31 March 2020 stood at deficit of £46.4m, so failed to meet the strict criteria of the breakeven duty.

We delivered a £28.8m deficit before Financial Recovery Funding (FRF), £1.9m adverse to the original control total of £26.9m agreed with NHS Improvement, as a consequence of the unfunded COVID-19 related increase in our untaken annual leave costs (£2.4m). However, NHS Improvement confirmed this item was an allowable miss against our pre FRF control total. We therefore effectively met our financial control target for 2019/20 and was therefore able to recognise, in full, the FRF available for the year of £27.9m.

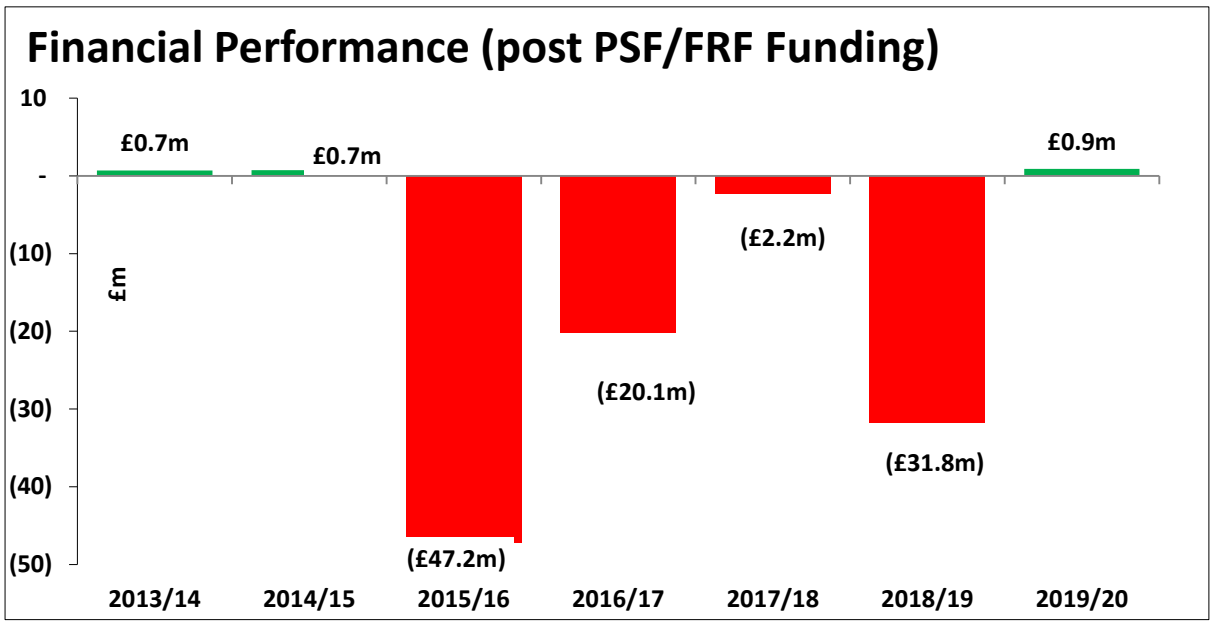
In addition and as a consequence of hitting its control total, we were also allocated “additional Financial Recovery Fund/COVID-19 funding” of £1.8m, allowing us to report an overall surplus of £0.9m (which represented a £48,000 surplus against our control total).

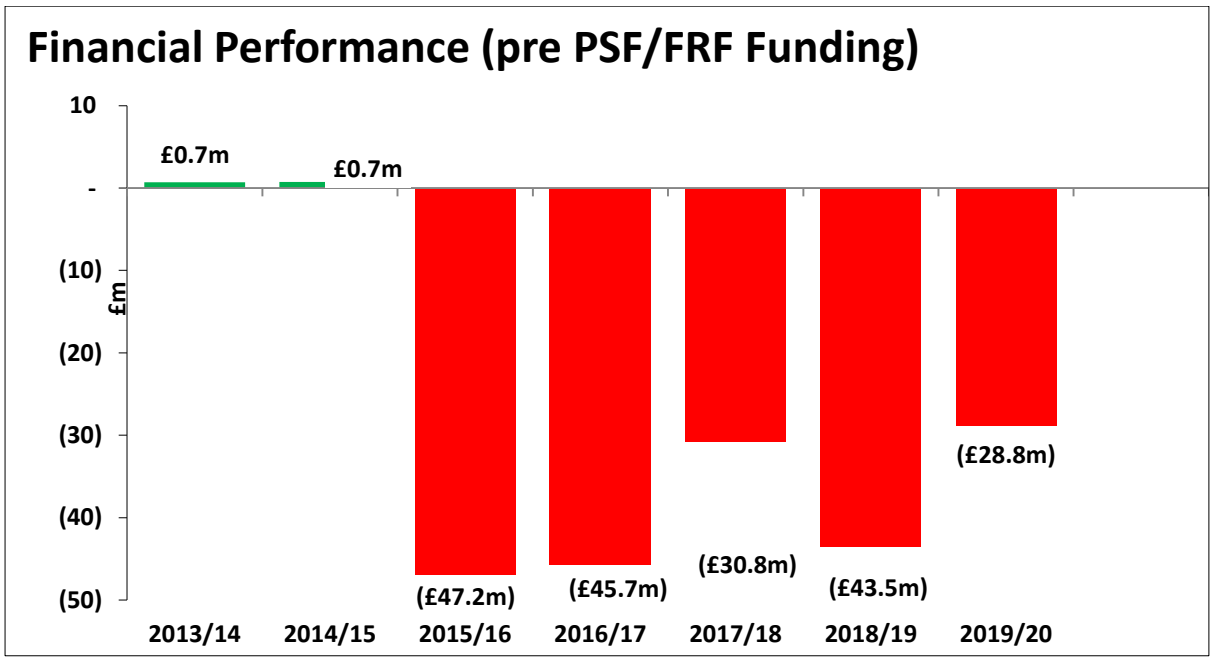
We are required to meet certain financial duties in order to demonstrate appropriate financial stewardship and control. The performance of these is shown in the table above.

Since being established, we have established a strong financial performance, delivering annual surpluses up to 2014/15 and delivering its financial control totals in all years, with the exception of 2018/19. Like most acute providers, nationally, we have been exposed to unprecedented

operational and financial pressures over the last five years, culminating in the COVID-19 response in March 2020. Despite this, we were still able to report a small surplus of £0.9m for the first time in five years in 2019/20, following losses incurred in the previous four years of £47.2m (15/16), £20.1m (16/17), £2.2m (17/18) and £31.8m (18/19).

Our underlying (pre PSF/FRF) financial position and our financial position after the distribution of FRF funds are shown below. The planning round for 2020/21 was suspended for four months nationally until the end of July 2020, as the NHS prioritised its response to COVID-19. Prior to the outbreak, NHS Improvement's expectation was that we would achieve at least break even, after receiving FRF funding.





Our consolidated financial position includes the operating surplus of our private subsidiary, Hospital Pharmacy Services Nottingham (HPSN) Ltd (£0.8m), in accordance with the group accounting standards.

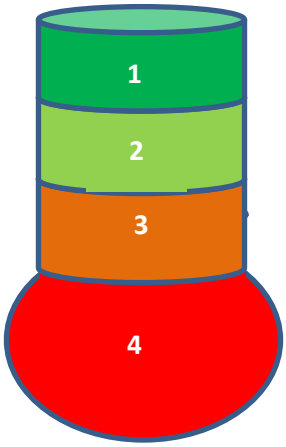
The Trust delivered cost improvements of £33.0m

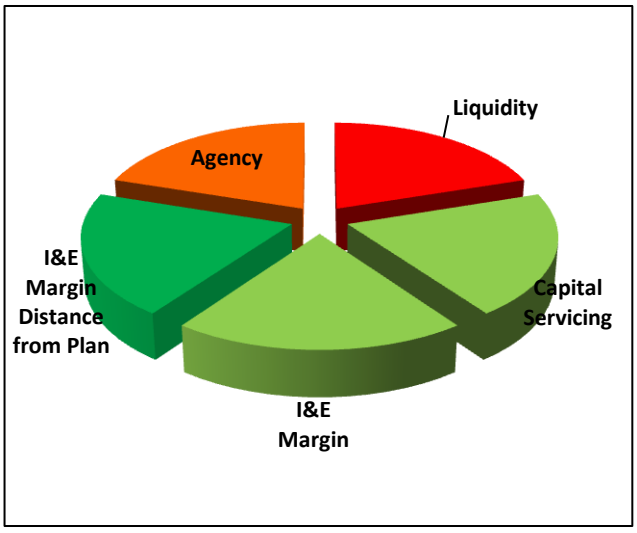
We delivered efficiencies of £33.0m in 2019/20 (2.8 per cent of income) against a CIP plan of £37.0m.

NHS Improvement measures use of resources through the Single Oversight Framework (SOF). We 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). Despite scoring at least two in three of the five indicators, we only scored four for liquidity and the override in the calculation prevented us from scoring more than three, as a consequence.

Use of Resources

NUH Overall Use of Resources 3



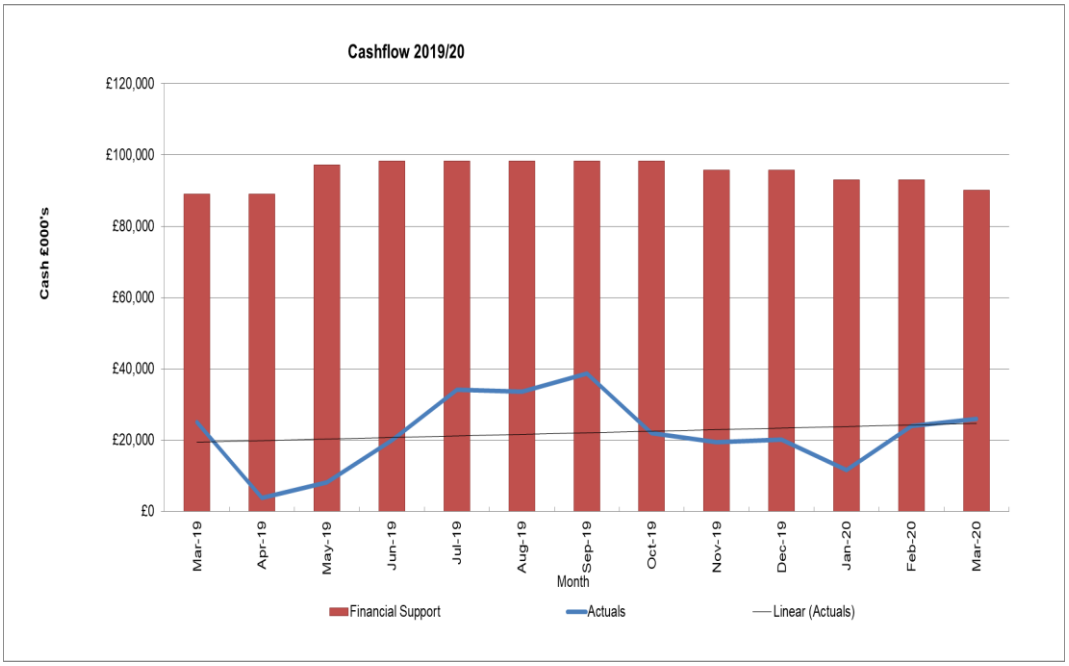


The Trust had a cash balance of £25.0m at 31 March 2020. We remained within our cash limit set by Department of Health and Social Care

Our cash position remained stable in 2019/20, without the requirement for significant revenue support. The end of year cash balance was £26.0m compared with an opening position of £25.1m, an increase of £0.9m, which triangulates with net new borrowing, through interim revenue support loans of £0.6m. We operate within the NHS finance regime, which enables all providers to access revenue support. The nature of financial support available to providers under section 42A of the National Health Service Act 2006 changed on 1 April 2020, such that all existing interim revenue and capital loans were extinguished and replaced with public dividend capital. Although this removes the

liability of the Trust to repay this debt, PDC dividend does currently attract a higher cost of capital (3.5%) than the cost of servicing the loans (1.5%).

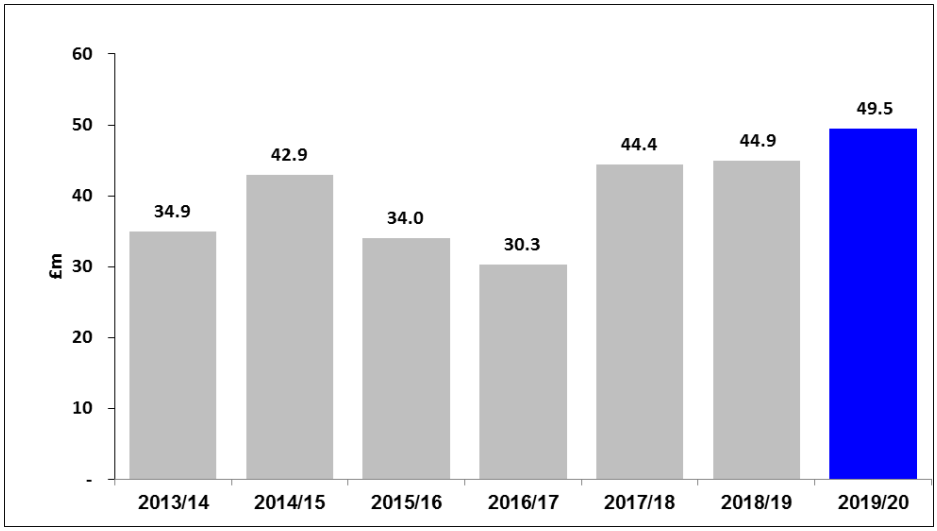
Cash



We invested more than £49.1m in its capital infrastructure in 2019/20 as patients continued to be treated in the best possible clinical environment, including ensuring that we were able to safely and rapidly respond to the COVID-19 outbreak and protect our patients and staff. To this end we invested £1.2m of COVID-19 related capital equipment to supplement revenue investment of £3.6m.

The Trust invested over £49.1m in capital infrastructure and equipment in 2019/20 and remained within the limit set by the DHSC.

Capital Investment



Income

Our turnover increased to £1.2b – an increase of £156m (15 per cent).

Patient Care Income (£1.033 billion)

Our income is mainly generated from CCG Commissioners for the delivery of acute (£555.4m) and NHS England for specialised patient care activities (£455.4m). This represented a £142.2m (16 per cent) increase on the levels received in 2018/19.

The main changes in service delivery underlying this increase in our income were:

- Redesign of our emergency pathway and increased emergency capacity, increased income earned by £12.4m for all emergency admissions (5 per cent increase);
- The awarding of the Treatment Centre contract which was previously held by a private provider, increased our contracted income by £37.5m, this is payment for the activity that we delivered from the 29th July when the contract was mobilized;
- We benefited from tariff price increases £41.8m, this is offset by increases in costs for staffing (including the pay award) and inflationary pressures;
- We have included notional income and expenditure of £27.8m in relation to the increase in the NHS employer's pension contribution increase from 14.38 per cent to 20.68 per cent for the year, the increased expenditure has been funded by the Department of Health and Social Care;
- Expenditure on pass through high cost drugs and devices increased by £11.6m.

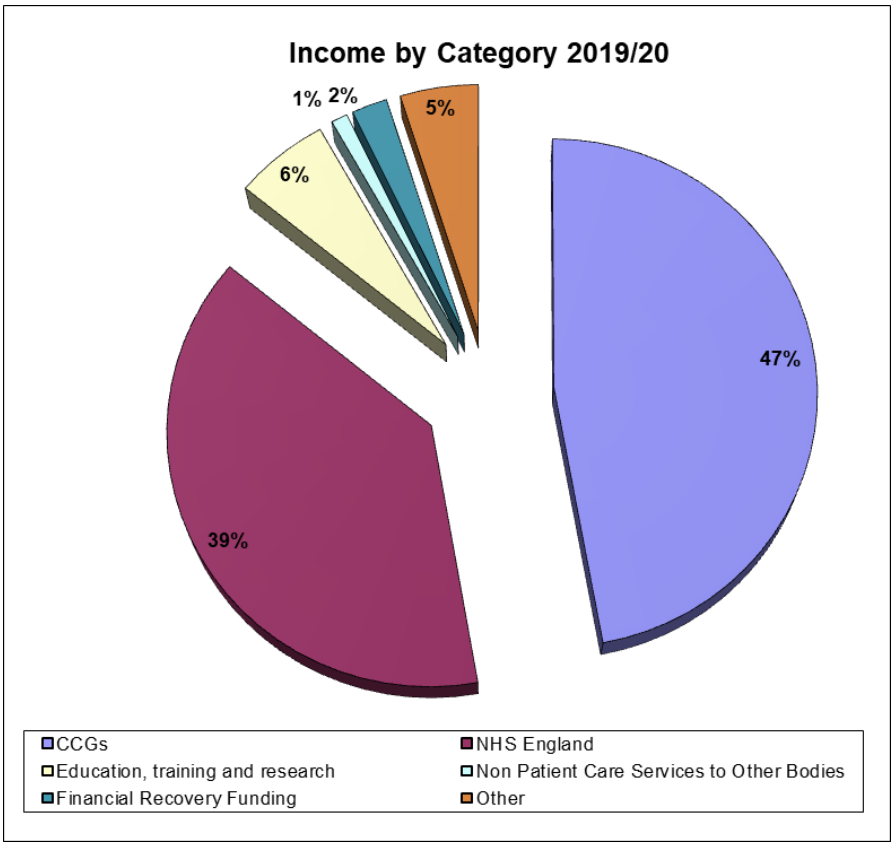
The impact of the COVID-19 pandemic affected activity levels, however, in line with national guidance the Trust and Commissioners agreed funding arrangements which ensured that our financial position was not adversely impacted by reductions in activity during March.

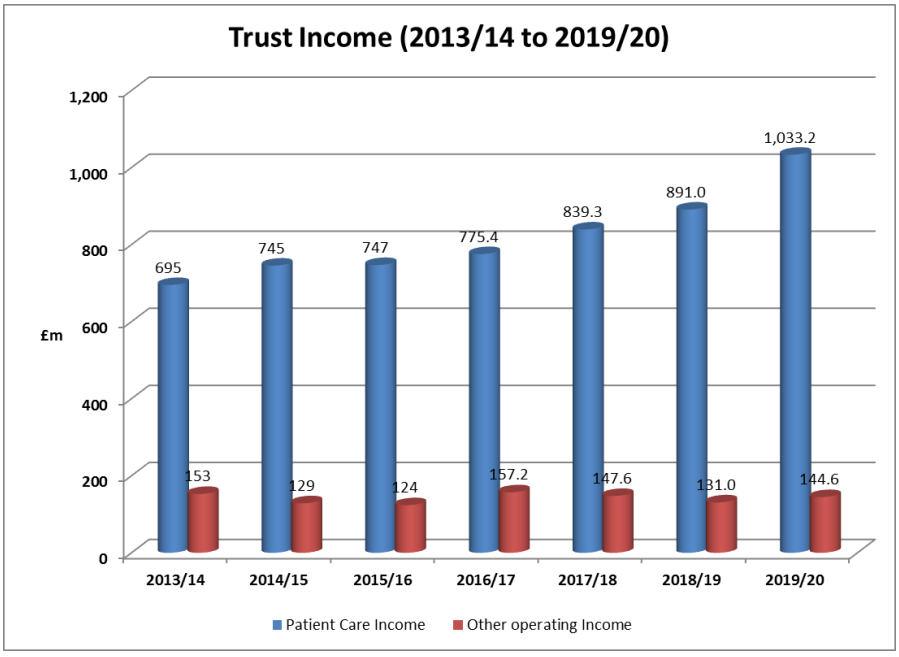
For April to July, the national NHS standard contract was suspended and replaced with 'block' funding arrangements through commissioners to allow providers to focus on delivering patient care during this challenging period and ensure costs could be covered.

Non-patient care income (£144.6m)

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, we received significant investment for these services. Other operating income increased by £13.7m in 2019/20, mainly in relation to a year on year increase in; PSF/FRF funding received (£14.6m), marginal rate emergency tariff funding (MRET) (£3.4m) and increase in education and training income (£2.2m); offset by a reduction in non-patient care services to other bodies (£6.6m), mainly associated by the transfer of patient care services relating to the Treatment Centre, which meant we no longer charged service costs to the third party provider.

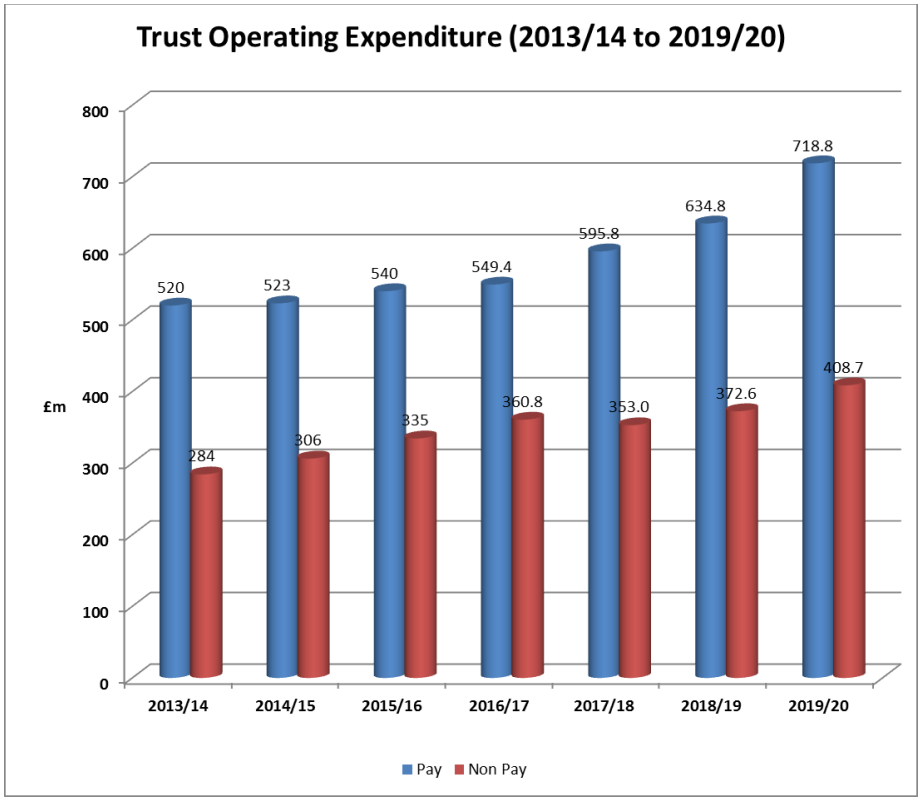
An analysis of the sources of income by type and trend analysis in 2019/20 is shown in the graphs below:





Expenditure

Expenditure (including non-operating items) of £1.18bn were incurred in delivering our services in 2019/20 compared with £1.06m in 2018/19; an increase of £120m (11.3 per cent). A trend analysis of operating expenses is shown in the graph below:



Staffing costs increased by £84.0m (13 per cent), which included £27.8m relating to an increase in employer contribution rate for NHS pensions (14.3 per cent to 20.6 per cent). The overall size of our workforce increased by 761 WTE to 15,678 employees in 2019/20, with the main increases being within medical, nursing and healthcare as over 500 staff transferred from Circle Nottingham Limited with the granting of a five year contract by NHS Commissioners to Nottingham University Hospitals for the provision of services at the QMC Treatment Centre with effect from 29 July 2019.

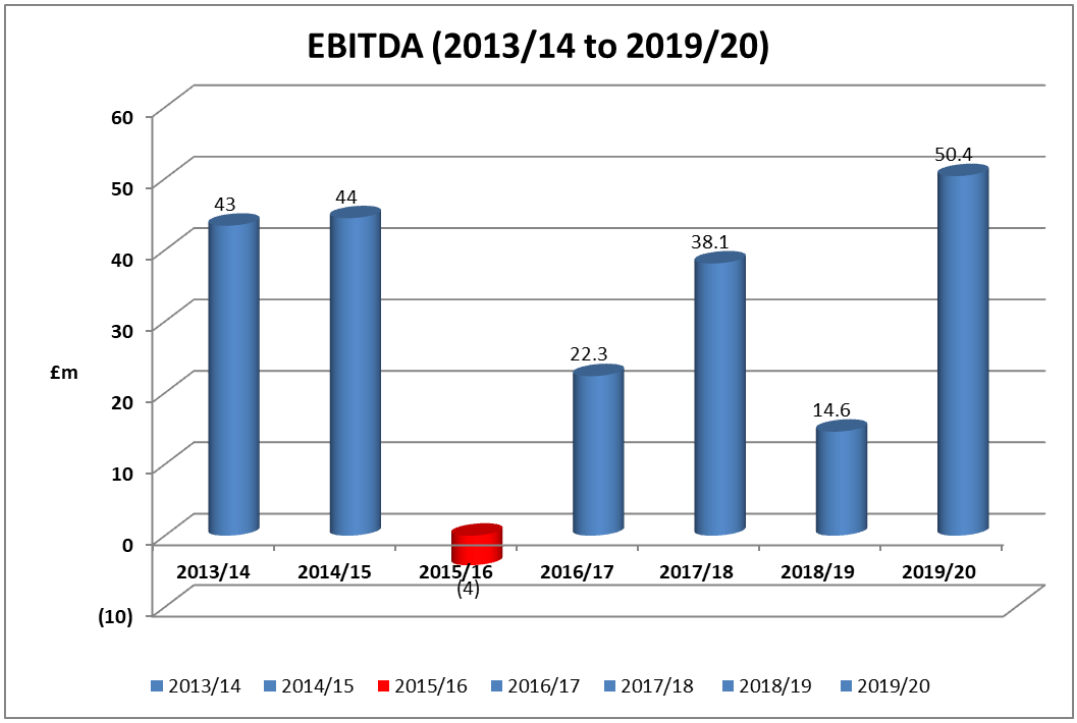
As a large teaching Trust, academic and teaching costs contribute to our higher pay bill, although benchmarking information indicates that there is still an opportunity to improve the efficiencies in the use of staff resources.

We strengthened our financial pay and non pay control environment by ensuring we only recruited into budgeted posts when they became vacant and implementing initiatives including No PO, No Pay and No Payment of Carriage policies.

Our underlying non-pay expenditure increased year on year by £35.3m (excluding non-operating items), representing an increase of 9.5 per cent, mainly associated with delivering front line care (clinical supplies and services, including medicines - £22.3m), education and training (£5.8m), depreciation (£3.7m) and premises expenses (£2.8m). We actively worked to reduce the supplies and services costs by securing best value prices on purchases. Our ageing estate has contributed to a higher level of backlog maintenance, which will only reduce as we implement our capital investment strategy to renew and modernise its estate.

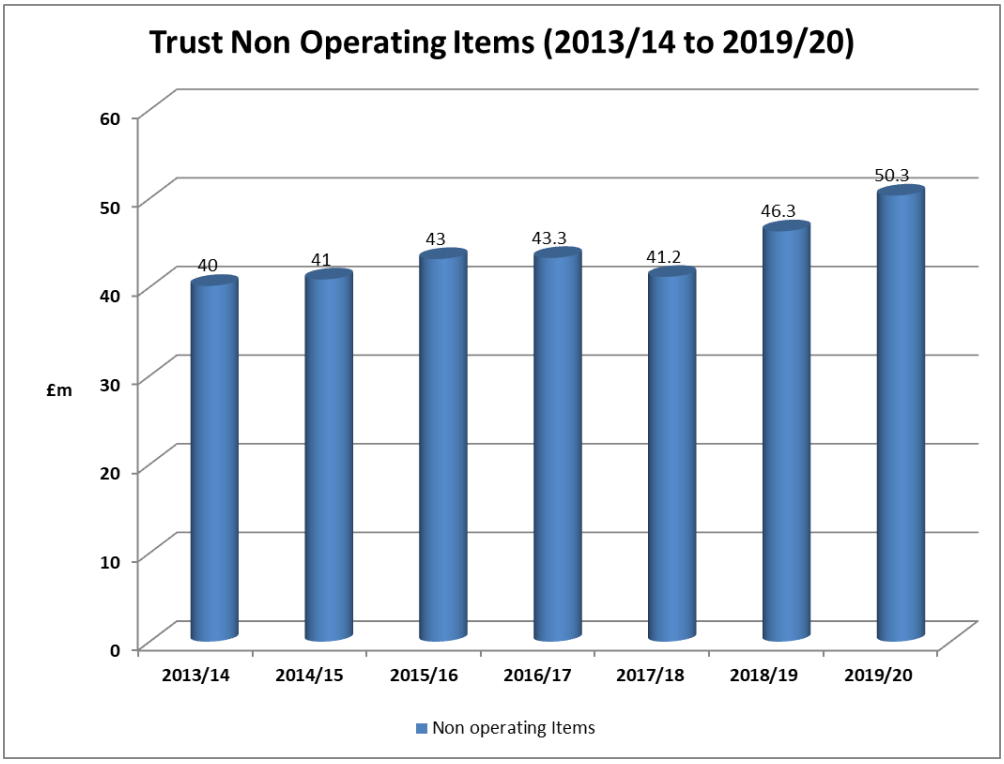
EBITDA

EBITDA is defined as earnings before interest, tax and dividend. Our financial position recovered to the extent that we were able to report a surplus EBITDA of £50.4m in 2019/20, its highest level for six years.



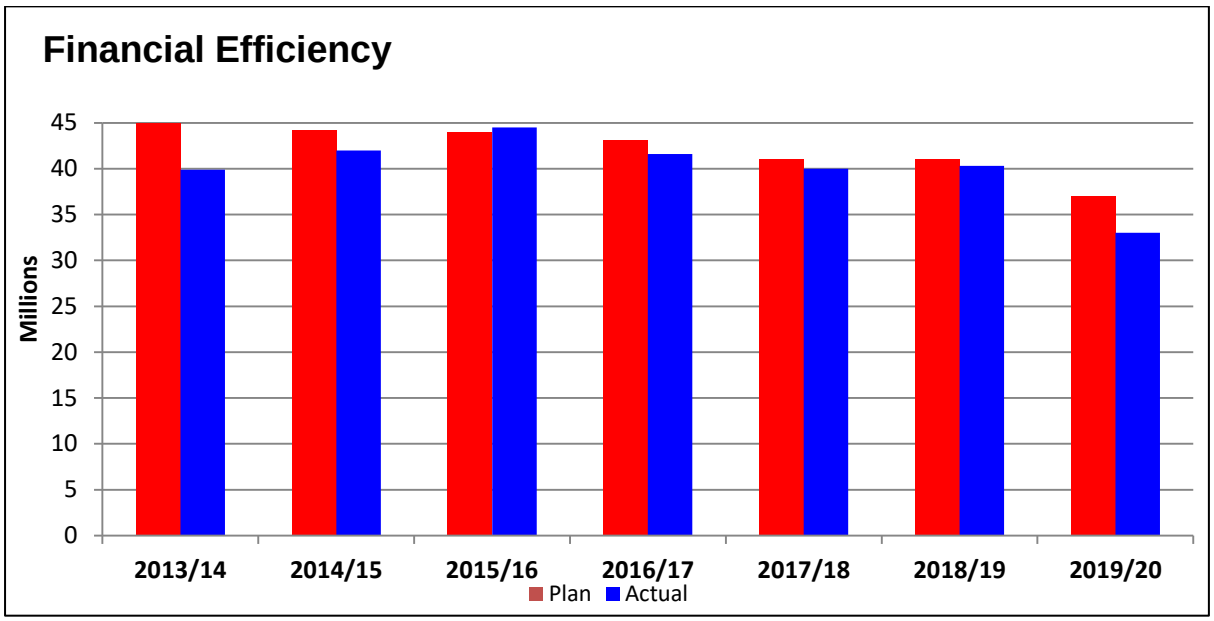
Non-operating Items

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 £3.7m as a result of annual capital investment in short life assets (IT and medical equipment), which consequently attract a higher annual depreciation charge. Depreciation provides a fund for asset replacement when they reach the end of their economic life.



Financial Efficiency Plans

We achieved £33.0m savings against a target of £37m.



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

Work stream	Plan (£000s)	Actual (£000s)	Variance (£000s)
Bed Efficiency	1,269		(1,269)
Cost Control	5,200	3,252	(1,948)
Medical Pay & Productivity	3,653	945	(2,708)
Medicines Management	1,873	2,645	772
Nursing & Midwifery	3,112	263	(2,850)
Other Income - Clinical	718	4,334	3,616
Other Income - Non-Clinical	5,113	3,772	(1,341)
Other Non-Pay	1,988	847	(1,141)
Outpatient Efficiency	2,882		(2,882)
Procurement	6,863	5,970	(893)
Technology	2,111	319	(1,792)
Theatres Efficiency	3,585	213	(3,371)
Workforce Other	2,633	10,453	7,820
Total	**41,000**	**33,013**	**(7,987)**

Division	Plan (£000s)	Actual (£000s)	Variance (£000s)
Cancer & Specialties	5,888	5,798	(91)
Clinical Support	7,573	6,670	(903)
Corporate	2,193	4,235	2,043
Estates and Facilities	2,163	1,913	(251)
Family Health	7,472	3,037	(4,435)
Medicine	7,966	5,359	(2,606)
Surgery	7,746	6,001	(1,744)
Total	**41,000**	**33,013**	**(7,987)**

Carter efficiencies have been a key driver of FEP plans for 2019/20 through a variety of initiatives, especially by the use of the Model Hospital system. This can be seen in both schemes developed independently by our Divisions, as well as the savings achieved through the Wave and Getting It Right First Time' (GIRFT) programmes. The Model Hospital remains a key source of information to identify and secure opportunities for further productivity improvement. In 2019/20, we have saved £17.3m of its year-end amount of £33.0m against the various Carter efficiency headings. These savings can be seen below:

Carter Efficiencies (£000's)	
Carter Area	YTD Actual
Carter Corporate and Admin	1,061.5
Carter Estates and Facilities	589.2
Carter Hospital Medicine and Pharmacy	2,544.7
Carter Imaging	80.6
Carter Pathology	1,170.5
Carter Patient Pathway	3,251.8
Carter Procurement	5,654.4
Carter Workforce (AHP)	6.0
Carter Workforce (Medical)	610.4
Carter Workforce (Nursing)	230.1
Carter Workforce (Other)	2,096.1
Grand Total	**17,295.3**

The level of savings delivered in 2019/20 were lower than achieved in previous years (£33.0m in year versus £40.0m in the previous two) and lower than our annual plan (£33.0m delivered versus £37.0m agreed in our annual plan and a £41.0m stretch target).

Over the course of 2019/20 a number of changes impacted the delivery and the recording of financial efficiency savings, including a tightening of reporting standards for financial efficiencies, such that they are now only reported where the savings are against expenditure agreed as part of the annual plan. At the same time we implemented a vacancy control process and committed to an exercise that reduced the number of unfunded posts held across our Divisions. Previously posts no longer required would have been declared a financial efficiency; in the current year such posts have been used to offset historically unfunded posts. In 2019/20 we agreed a block contract with our lead Commissioners. This combined with capacity constraints has led to lower levels of additional income efficiencies being possible. Increased activity above the plan would have incurred expenditure but no additional income.

These changes to the control environment (and therefore the ability to increase assurance that savings recorded are differentiated from windfall opportunities) may go some way to describe how we recorded FEP has reduced whilst the control total has still been achieved.

It is clear identifying opportunities to save, especially recurrently, has become increasingly challenging and has led to a revised strategy for 2020/21 and the following years. We have committed to following an approach focused on Quality Improvement and waste reduction. This has been aligned to the agreed culture and leadership development programme. A temporary pause has been put on the divisional performance meetings and financial efficiency measures are only being progressed where they support our COVID-19 measurers and recovery and restoration planning.

Corporate Services

The cost of running our corporate back office services is lower than most other NHS trusts. Human Resources and Finance costs, for example, are below the national 'Carter' average. We have continued our partnership East Midlands Shared Service, in sharing best practice and helping to support business continuity, in relation to financial transaction services.

Service Line Reporting

We actively use service line reporting line reporting and patient level costing to manage speciality and divisional financial performance and to inform financial efficiency programme opportunities, including identifying costs of cross organisational clinical pathways.

The table below presents a summary of the margins achieved by each of our service lines in 2019/20. 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.

Service Line	2019/20 Margin – Surplus (Loss) £m	2018/19 Margin – Surplus (Loss) £m	2017/18 Margin – Surplus (Loss) £m	2016/17 Margin – Surplus (Loss) £m	2015/16 Margin – Surplus (Loss) £m	2014/15 Margin – Surplus (Loss) £m
Medicine	(7.7)	(23.1)	(14.1)	(25.0)	(29.1)	(22.7)
Cancer	4.9	(1.2)	(2.6)	4.5	(1.6)	(2.1)
Surgery	(9.0)	(20.7)	(13.8)	(11.4)	(10.2)	(2.4)
Family Health	(5.9)	(5.9)	(8.2)	(11.5)	(12.5)	(1.7)
Support Services (Diagnostics, Theatres and Critical Care)	(5.1)	5.5	2.5	0.6	3.8	2.0
Nottingham Treatment Centre	2.7					
Central and Corporate	20.3	13.5	33.5	22.3	1.6	26.9
Pharmacy Company (HPSN)	0.7	0.1	0.5	0.4	0.8	0.8
Total	**0.9**	**(31.8)**	**(2.2)**	**(20.1)**	**(47.2)**	**0.8**

Significant progress was made in developing the detail of the 2019/20 annual plan, which was developed with our clinical leaders and aimed to both improve emergency care and financial performance. Prior to operational pressures and preparations for the impact of COVID-19 patients in March, progress had been made particularly around understanding the capacity constraints facing the Trust and also in agreeing contracts with key commissioners, which provided for greater certainty over our income. We continue to work closely with our system partners to develop a fully integrated and effective care system within a financial system control total.

Property Valuation

Following the full site revaluation of our property undertaken in 2018/19, an interim valuation was been completed by our valuers, Gerald Eve in 2019/20, which only resulted in a small decrease in the value of land and buildings (1.4 per cent), despite the capital investment that took place in 2019/20.

Capital Investment Programme

As one of its core financial statutory duties, we are not allowed to incur more capital expenditure than its capital resource limit set by the Department of Health.

During the year, we completed over £49.5m of capital investments as patients continued to be treated in the best possible clinical environment, including ensuring that we were able to effectively and rapidly respond to the COVID-19 outbreak.

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

Capital Investment Scheme	**Benefits**	**Value in 2019/20 (£m)**
Minor Medical Equipment Replacement	Replacement of medical equipment that has reached the end of its useful life to modernise services	6.6
Major Medical Equipment Schemes	Replacement of X Ray rooms, CT, MRI, etc.	4.5
ICT Managed 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 compatible, which means less compliancy issues for core mobile applications and reduces the risks of security vulnerabilities for considered legacy operating systems.	1.0
ICT - Digitising Health Records	Continued Programme of digitising Health Records.	2.3
Other IT Investment	Hardware and software additions improving clinical and corporate information and services	2.5
Estates Regulatory Compliance	Improvements to buildings and infrastructure, patient environments and health and safety compliance	10.8
CITY - Brachytherapy Facility	Relocation of brachytherapy at City Hospital to release a spare bunker for the Linac replacemet programme.	0.5
Seedcorn Developments	Capital Investment to improve services and save revenue monies	0.2
Interoperative MRI scanner - Building Works	Part of £6.315m capital funds to deliver a two room intraoperative MRI (iMRI) scanner between the existing MRI building and the new A Floor (modular) Theatres. £2.579m of the total allocation has been donated by Nottingham Hospitals Charity and UoN.	0.8
Clinic 1 expansion (AMRU)	Conversion of ambulatory/ outpatient space (previously AMRU) into additional bed capacity on the QMC site. This capacity is in prime location to be connected to ward B3, which is led by Acute Medicine, to create an expanded assessment unit which will support an improvement in access to short stay assessment bed capacity from the Emergency Department and direct GP admission routes	5.5
Treatment Centre - Equipment (Including ICT & Endoscopy Equipment)	Replacement of the equipment that was required to deliver the services at the NHS Treatment Centre.	7.5
COVID-19 Capital Expenditure - £1.157m total spend; PDC received for £0.468m	Urgent capital spend to enable the Trust respond to the Coronavirus Pandemic.	1.2
Other Developments	Small schemes, including those funded from charitable donations	6.1
Total Capital Expenditure		**49.5**
Book Value of Assets Disposed of		(0.1)
Charitable Income		(0.3)
Total Capital Expenditure		**49.1**
Capital Resource Limit (CRL)		**49.2**
CRL Underspend		**0.1**

Better Payments Performance Code (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 per cent of invoices. We achieved 86 per cent of the value and 85 per cent by volume of the invoices we processed**,** which still benchmarks in the upper quartile of all providers.

Balance sheet events

Impact of the Reforms to the NHS Cash Regime effective from 1 April 2020

DHSC announced that all interim revenue and capital loans would be extinguished on 1 April 2020 and replaced by Public Dividend Capital. Therefore there is no longer a requirement to repay outstanding loan balances reported at 31 March 2020, creating an adjusting event after the reporting period.

The financial outlook

In 2019/ 20 the NHS has had to respond to the greatest global health emergency in its 72 year history, which saw the fastest and most far reaching re-purposing of NHS services, staffing and capacity. We had to redirect our patient care services to caring for many confirmed COVID-19 positive inpatients each day, many of whom needed rapidly expanded critical care support. Since the Level 4 national incident was triggered in January, we have of course continued to look after those patients who had other important non-COVID related health conditions. Despite real national concern going in to the pandemic, every coronavirus patient needing care in our hospitals, including ventilation, was and continues to receive it.

The COVID-19 response has of course presented us with many unique financial challenges alongside the operational pressures. It came on top of an already difficult trading environment, which had included higher than planned non-elective admissions and lower elective care as a consequence. We, like all providers, were forced to postpone elective inpatient admissions and outpatient appointments, to allow it to create the capacity and redeploy our resources into treating the expected numbers of COVID-19 patients. This significantly reduced the income we would have received from treating our 'normal' elective activity from commissioners, as well as unplanned costs of delivering care to this cohort of patients.

Despite having to contend with these circumstances, we were still able to report a very credible financial position at 31 March 2020, by being able to report a small surplus; the first time we have achieved financial balance in five years. In doing so, we also met our financial control total with our regulator, NHS Improvement. Our underlying operating financial position recovered to the extent that the Trust was able to report a surplus EBITDA of £50.4m in 2019/20, its highest level for six years.

Regrettably coronavirus looks set to be with the us for some time to come, but as we enter the second phase in the NHS's response at the start of 2020/21, the challenge will be one of safely stepping up non-COVID urgent services as soon as possible and working with our system partners across the ICS to create capacity for the resumption of at least some routine non-urgent elective care. Emergency care as well as elective admissions has significantly reduced during the outbreak period. A rebound in emergency demand is therefore expected in the first quarter of 2020/21, which if it happens, non-elective patients will potentially hospital beds which have not had to be used for that purpose over the last months, putting further pressure on beds and capacity, including elective care.

An operational restoration and recovery plan has been developed and is being implemented which is aligned to the national direction issued by the overall NHS Chief Executive, Simon Stevens. It includes key programmes of work and action plans that are needed to support our transition out of the COVID phase and ultimately into business as usual. The restoration and recovery plan will effectively become the vehicle for our 2020/21 plan.

To support the development of plans as we adapt to the new operating environment, we are preparing a restoration and recovery framework, which:

- Let's go of the systems and processes we have stopped which were/ are now unfit for purpose;
- Restores services and process where they are needed in a "new norm";
- Builds on and improves new ways of working we and partners, have started doing during COVID;
- Stop doing activities that are very specific to COVID at the right time

NHS Improvement wrote to Chief Executives confirming that they had suspended the national planning timescales for 2020/21 as part of COVID-19 response. Commissioners were asked to agree set block contracts with NHS providers to cover the period 1 April to 31 July 2020 to support revenue expenditure in providers and interim financial plans have been set for Trusts until 31 July based on these block arrangements. No new revenue business investments will be entered into (unless related to COVID-19 / approved by NHS Improvement) and Trusts will continue to be reimbursed for COVID related expenditure and reasonable additional items.

All providers moved to block contract payments 'on account' for an initial period of 1 April to 31 July 2020, with suspension of the usual payment by results national tariff payment architecture and associated administrative/ transactional processes. A national top-up payment has also been issued to providers where modelling of the expected cost base is higher. These changes in the financial operating framework have created considerably financial uncertainty to supplement the ongoing COVID-19 impact to create a potentially very turbulent trading environment for the trust in 2020/21.

The planning for restoration and recovery and the delivery of service is aligned to the three stages shown below.

Apr – May 2020	Jun – Oct 2020	Nov 2020 onwards
Phase 1: Immediate restoration	**Phase 2:** Covid and non-Covid in steady state	**Phase 3:** Covid and winter plan
Financial regime focussed on ensuring liquidity in the system and enabling COVID response	Likely extension of current financial arrangements but with tighter controls as recovery gets underway	No further information available as to how the financial regime will work in the second half of the year

Continuing to Embed a Quality Improvement Approach

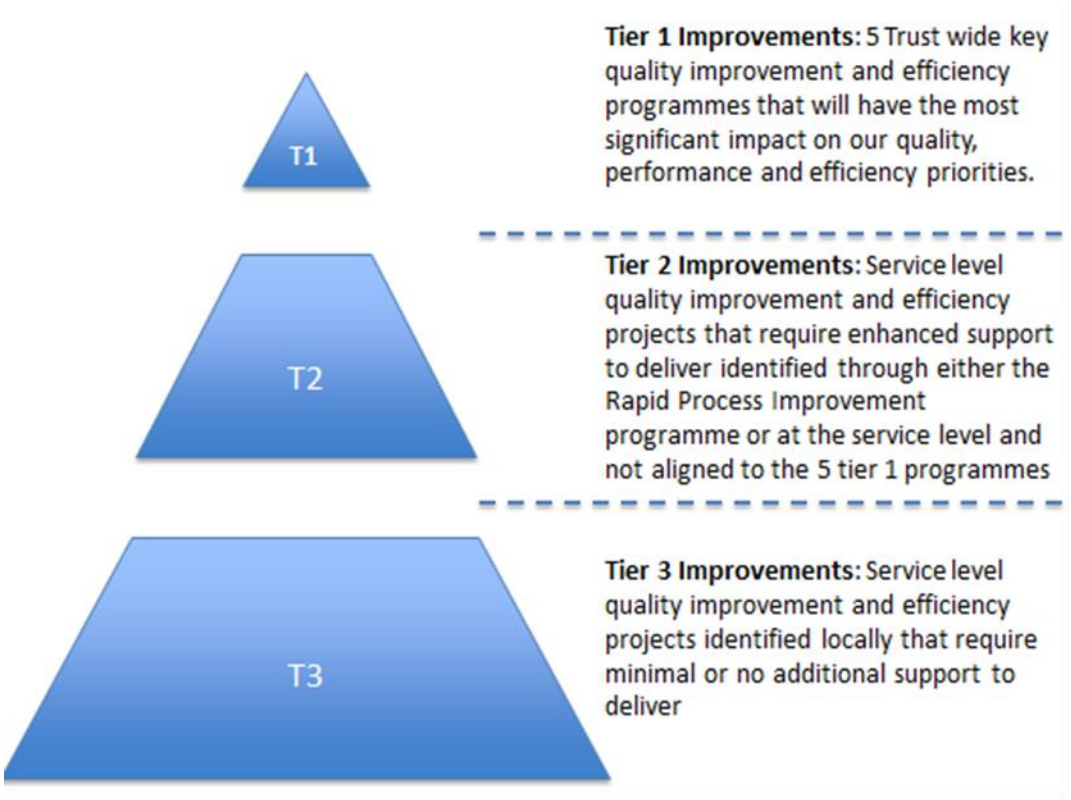
Quality improvement underpins our approach to restoration and recovery.

As already noted delivery of financial efficiencies in 2019/20 were lower than in previous years (£33.0m in year versus £40.0m in the previous two) and lower than that required as part of our annual plan (£33.0m delivered versus £37.0m agreed in our annual plan and a £41.0m stretch target). The difficulty in identifying opportunities to increase the level of savings and to make those savings recurrent has led to a revised strategy for 2020/21 and subsequent years. We have committed to following an approach focused on quality improvement and waste reduction.

During the COVID-19 period, we 'paused' the work we would normally be doing to drive opportunities for 2020/21, and to allow Divisions to concentrate on service plans to respond to the coronavirus outbreak. However, we are still progressing the identification and realisation of financial efficiencies where possible without impeding the response to COVID-19. Where specialty staff are available, work has continued to review opportunities for improvement. Our financial efficiency team has continued to meet virtually with key members of staff and have been sensitive to operational pressures when setting timelines for work to be completed.

We are trying to 'lock in' beneficial changes that have been brought about during the COVID-19 outbreak period and to enable greater capacity, a number of changes to patient pathways have been enabled. We are not in a position to invest more in key resources (beds, theatres or staff) and so need to remove all waste from existing processes to meet our patient needs. This includes schemes that are driven by better use of our beds and different ways of delivering outpatient clinics. We are asking questions like what can we learn from how we have responded to the current situation and what should we continue to do when we return to normal.

This approach has been aligned to an agreed culture and leadership development programme. The Quality Improvement and waste reduction programme is set out below.



Our 2020/21 draft annual plan shared with the Trust Board and NHS Improvement has an indicative savings target of £25m, with an ambition to improve on that number.

Capital Investment

We, and the Integrated Care System (ICS), have been notified of a new national approach to capital funding for 2020/21. Capital funding has been allocated to and will be managed through the ICS. As a result we do not have a specified capital allocation for 2020/21 and is now working with the ICS and partners to agree a capital framework to support the prioritisation of the ICS capital allocation.

Whilst providers remain legally responsible for maintaining their estates and for setting and delivering their organisational level capital investment plans, every ICS will have to account for ensuring overall capital spending across their system remains within these budgets. Consequently, organisational plans and the deployment of discretionary emergency capital will ultimately need to be consistent with these budgets and reflect system-wide discussions on prioritisation.

Every ICS is expected to spend within their envelope. Capital requirements agreed as part of COVID-19 costs will be funded on top of these envelopes. Where in-year reporting indicates a potential overspend then ICS's will be expected to agree local actions to address potential overspends, supported by their regional teams

Aligned with the ICS Strategic Plan all schemes will be categorised as follows:

- Projects expected to be funded from the issued ICS capital envelope;
- Projects where there is an identified funding source and process underway to access the funds for example the National Rehabilitation Centre and HIP2;
- Projects where there is currently no identified funding source and may require local prioritisation should funding become available.

The ICS capital allocation amounts to £85m.

Our plan submitted to NHS Improvement and the ICS of £106m includes the following:

- Category 1 schemes: internally funded £39.8m, including £3.1m of charity funded schemes, leaving a net requirement of £36.5m from the ICS envelope;

- Category 2 schemes where funding has been approved or applied for, which includes the £3.3m approved loan for developing the business case of the National Rehabilitation Centre (NRC) (£15.9m); and
- Category 3 schemes with no formally identified source of funding totalling £43.1m.

Going Concern

The Accounts have been prepared on a 'going concern' basis. It is reasonable for the Directors of Nottingham University Hospitals NHS Trust to conclude that the clinical services we provide 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.

We have adequate resources to continue as a going concern for at least 12 months from the annual report and accounts submission deadline. Although the financial planning process for 2020/21 was paused, interim financial plans have been set for Trusts until 31 July 2020 based on these block arrangements. We will continue to operate within the NHS Finance regime from a cash perspective through a combination of our existing internal working capital and financial support offered by the Department of Health and Social Care, linked to our agreed Income & Expenditure (I&E) plan. We remain a going concern and have taken steps to ensure this remains the case. We have made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 2020 and remains committed to making best use of resources, working with its partners across the health and care system.

The Finance Team are reviewing and modelling the implications for our income and expenditure and cash plans for 2020/21 in light of this new NHS England 2020/21 planning guidance, as part of the development of a longer term five year financial model, which will signpost the way to financial sustainability. We remain committed to achieving recurrent financial balance as soon as soon as possible, building on this year's performance. We, and the wider integrated care system, remain committed to developing a fully integrated and effective care system within a financial system control total.

In conclusion

Our vision remains to be outstanding in delivering health outcomes and patient and staff experience. Our response to the pandemic gives us the opportunity to deliver many changes which will move us closer to realising this vision. This will build on the break even financial performance achieved in 2019/20 and the rating we received from our most recent CQC review (February 2019) of 'Good.'

We, along with our partners in the ICS, remain committed to making the best use possible of our limited capital and revenue resources, in achieving sustainable financial recovery and returning to recurrent financial balance as soon as we can.

At the time of writing this review we, like all NHS local systems and organisations, are working to step up non-COVID urgent services as we exit phase one and enter phase two of our restoration and recovery plan and start to gradually emerge from the service lockdown arising from COVID-19. The changes in the financial operating framework, in part induced by the response to Covid-19, have created considerably financial uncertainty to supplement the ongoing pandemic impact, which creates a potentially turbulent trading environment for us in 2020/21.

Beyond that, the scale of the financial challenge of achieving year on year recurrent financial balance remains huge, as we progress with the identification and realisation of financial efficiencies where possible without impeding the response to COVID. Significant transformation in the way services are provided and delivered and strengthened financial controls and accountability for operational and financial performance are still required. To this end we are continuing on our path of financial recovery in 2020/21. We remain committed, together with the wider integrated care system, to giving our patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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 2019/20 Group Accounting Manual issued by the Department of Health and Social Care. They represent a "true and fair view" of our activity in 2019/20, 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.

We are 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

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

KPMG charged a fee of £79,950 (excluding VAT) and £12,000 (excluding VAT) for the Trust and HPSN respectively for the statutory audit and £1,000 (excluding VAT) for the Quality Accounts.

We have not received any non-audit services from KPMG in 2019/20.

Annual Governance Assurance Statement

The Annual Governance Assurance Statement is printed in full in the Trust's 2019/20 Annual Accounts.

Fraud awareness

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

Foreword to Accounts

The Accounts for the year ended 31 March 2020 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.

Tracy Taylor
Chief Executive (on behalf of the Trust Board)
Date: 22/06/2020

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;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use 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.

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 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, and 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 (on behalf of the Trust Board)
Date: 22/06/2020

Rupert Eggington
Chief Financial Officer (on behalf of the Trust Board)
Date: 22/06/2020

Independent auditor's report to the 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 2020 which comprise the Consolidated Statement of Comprehensive Income, Group and Trust Statement of Financial Position, Group and Trust Statement of Changes in Taxpayers Equity and 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 2020 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 2019/20.

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 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 2019/20. 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 2019/20.

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 www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

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

As explained in the statement 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 10(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 December 2019 and updated in April 2020 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 25 June 2020 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 cumulative deficit and failure to achieve its statutory three-year 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 for the year ended 31 March 2020 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
Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham B4 6GH
25 June 2020

Glossary

Acute Care is specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.
Acuity The measurement of the intensity of care required for a patient delivered by a registered nurse. There are six categories ranging from minimal care to intensive care.
Admission the point at which a person begins an episode of care, e.g. arriving at an inpatient ward.
Ambulatory care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.
A&E (Accident & Emergency) see Emergency Department.
Board Assurance Framework (BAF) is a key mechanism which Trust Boards should be using to reinforce strategic focus and better management of risk.
Cannulation intravenous cannulation involves putting a "tube" into a patient's vein so that infusions can be inserted directly into the patient's bloodstream.
Care Plan a plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy.
Care Quality Commission the organisation that make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.
Carbapenem resistant organisms are a group of germs which can live harmlessly inside the bowel and, except for their resistance to antibiotics, are identical to our normal gut bacteria. Carrying them in the bowel is not a direct risk to patients. They are only a danger if they cause infections.
CCG (Clinical Commissioning Group) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clinical Governance is a framework that ensures that NHS organisations monitor and improve the quality of services provided and that they are accountable for the care they provide.
Clinical Negligence Scheme for Trust (CNST) is a scheme for assessing a Trust's arrangements to minimise clinical risk for service users and staff. Trusts need to pay 'insurance' which can offset the costs of legal claims against the Trust. Achieving CNST Levels (1, 2 or 3) shows the Trust's success in minimising clinical risk and reduces the premium that the Trust must pay.
Clinician is a person who provides direct care to a patient such as a doctor, nurse, therapist, pharmacist, psychologist etc.)
Commissioner is responsible for getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc.
Commissioning is the process of identifying a community's social and/or health care needs and finding services to meet them.
Community Care aims to provide health and social care services in the community to enable people live as independently as possible in their own homes or in other accommodation in the community.
Co-morbidity is the presence of two or more disorders at the same time. For example, a person with depression may also have diabetes.
CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. This means that a proportion of our income depends on achieving quality improvement and innovation goals, agreed between the Trust and its commissioners. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients, a principle fully supported at all levels of the hospital.
Diagnosis is identifying an illness or problem by its symptoms and signs.
Discharge is the point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan (see Care plan).
Emergency Admission when a patient admitted to hospital at short notice because of clinical need or because alternative care is not available.

Emergency Department is a hospital department that assesses and treats people with serious and life-threatening injuries and those in need of emergency treatment. Also sometimes called A&E (Accident & Emergency).
Friends and Family Test (FFT) launched in April 2013, the FFT question asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.
General Medical Council: The General Medical Council (GMC) works to protect patient safety and support medical education and practice across the UK. They do this by working with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems.
General Practitioner (GP) is a family doctor, usually patient's first point of contact with the health service.
GIRFT (Getting it Right First Time): Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing.
Health Care Assistants (can also be referred to as Health Care Support Workers) are non-qualified nursing staff who carry out assigned tasks involving direct care in support of a registered/qualified nurse. There are two grades of Health Care Assistants, A and B grade. A grades would expect to be more closely supervised, while B grades may regularly work without supervision for all or most of their shift, or lead on A grade.
Human Resources is a department found in most organisations that works to recruit staff, assist in their development (e.g. providing training) and ensure that staff work in good conditions.
Information Management and Technology (IM&T) refers to the use of information held by the Trust, in particular computerised information and the department that manages those services.
Intermediate Care Services are services that promote independence, prevent hospital admission and/or enable early discharge. Intermediate care typically provides community-based alternatives to traditional hospital care.
Model Hospital: The Model Hospital is a free digital tool from NHS Improvement available to all NHS provider trusts. It supports the NHS to provide the best patient care in the most efficient way. It allows trusts to compare their productivity and identify opportunities to improve.
Mortality means death rate. In the NHS it is used when referring to the expected death rate for conditions or procedures.
Multidisciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.
Non-Executive Director is a member of the Trust Board. They act a two way representative. They bring the experiences, views and wishes of the community and patients to the Trust Board. They also represent the interests of the NHS organisation to the Community.
NHS England (NHSE) leads the NHS in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.
NHS Improvement (NHSI) is responsible for overseeing foundation trusts and NHS provider trusts, as well as independent providers that provide NHS-funded care. They offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, they help the NHS to meet its short-term challenges and secure its future.
Nursing and Midwifery Council: The Nursing and Midwifery Council, NMC, make sure nurses, midwives and nursing associate have the skills they need to care for people safely, with integrity, expertise, respect and compassion, from the moment they step into their first job.
Out of Hours (OOH) is the provision of GP services when your local surgery is closed, usually during the night, at weekends and Bank Holidays.
Palliative care is an area of healthcare that focuses on relieving and preventing the suffering of patients.
Primary Care is the care will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Risk assessment identifies aspects of a service which could lead to injury to a patient or staff member and/or to financial loss for an individual or Trust.
Royal College of Nursing: The Royal College of Nursing is the world's largest nursing union and professional body.
Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).
Serious Untoward Incidents (SUI) is to describe a serious incident or event which led, or may have led, to the harm of patients or staff. Members of staff who were not involved in the incident investigate these and the lessons learned from each incident are used to improve care in the future.
Stakeholders are a range of people and organisations that are affected by or have an interest in, the services offered by an organisation.
Tertiary Care is when a hospital consultant decides that more specialist care is needed. Mental Health Services are included in this (see also Secondary care).
TTO (To-take-out) are medicines supplied by the hospital pharmacy for patients to take with them when they are discharged (see discharge) from hospital.
Triage a system which sorts medical cases in order of urgency to determine how quickly patients receive treatment.
Urgent Care Centre is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent care centres primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency department visit. Urgent care centres are distinguished from similar ambulatory healthcare centres such as emergency departments and walk in centres by their scope of conditions treated and available facilities on-site.
Whistle-blowing is the act of informing a relevant person in an organisation of instances or services in which patients are at risk.

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Consolidated Statement of Comprehensive Income

		Group	
		2019/20	2018/19
	Note	£000	£000
Operating income from patient care activities	3	1,033,229	891,002
Other operating income	4	144,616	130,950
Operating expenses	7, 9	(1,165,843)	(1,045,766)
Operating surplus / (deficit) from continuing operations		**12,002**	**(23,814)**
Finance income	12	349	248
Finance expenses	13	(4,086)	(3,593)
PDC dividends payable		(11,005)	(11,337)
Net finance costs		**(14,742)**	**(14,682)**
Other gains / (losses)	14	(61)	95
Corporation tax expense		(177)	(30)
Surplus / (deficit) for the year from continuing operations		**(2,978)**	**(38,431)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	16	**-**	**-**
Surplus / (deficit) for the year		**(2,978)**	**(38,431)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(4,750)	(8,055)
Revaluations	24	1,474	33,095
Total comprehensive income / (expense) for the period		**(6,254)**	**(13,391)**
Surplus/ (deficit) for the period attributable to:			
Nottingham University Hospitals NHS Trust	SoCIE	(2,978)	(38,431)
TOTAL		**(2,978)**	**(38,431)**
Total comprehensive income/ (expense) for the period attributable to:			
Nottingham University Hospitals NHS Trust		(6,254)	(13,391)
TOTAL		**(6,254)**	**(13,391)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period	SoCIE	(2,978)	(38,431)
Remove net impairments not scoring to the Departmental expenditure limit	8	3,010	6,717
Remove I&E impact of capital grants and donations		851	(57)
Remove 2018/19 post audit PSF reallocation (2019/20 only)	*	(835)	-
Adjusted financial performance surplus / (deficit)	56	**48**	**(31,771)**
Add back 2018/19 post audit PSF reallocation (2019/20 only)	*	835	-
Actual financial performance surplus / (deficit)	56	**883**	**(31,771)**

* NHSI excluded additional PSF income for 18/19 from 19/20 Control Total

Statement of Financial Position

	Note	Group 31 March 2020 £000	Group 31 March 2019 £000	Trust 31 March 2020 £000	Trust 31 March 2019 £000
Non-current assets					
Intangible assets	17	8,746	14,591	8,746	14,591
Property, plant and equipment	19	545,161	531,571	545,161	531,571
Receivables	29	8,698	5,672	8,698	5,672
Total non-current assets		**562,605**	**551,834**	**562,605**	**551,834**
Current assets					
Inventories	28	25,414	22,066	23,381	20,175
Receivables	29	89,328	66,760	95,283	68,839
Cash and cash equivalents	32	25,990	25,127	24,118	23,952
Total current assets		**140,732**	**113,953**	**142,782**	**112,966**
Current liabilities					
Trade and other payables	33	(157,148)	(125,156)	(163,052)	(127,268)
Borrowings	35	(94,639)	(31,027)	(94,639)	(31,027)
Provisions	38	(2,480)	(1,881)	(2,480)	(1,881)
Other liabilities	34	(16,579)	(15,859)	(16,579)	(15,859)
Total current liabilities		**(270,846)**	**(173,923)**	**(276,750)**	**(176,035)**
Total assets less current liabilities		**432,491**	**491,864**	**428,637**	**488,765**
Non-current liabilities					
Borrowings	35	(23,889)	(89,234)	(23,889)	(89,234)
Provisions	38	(5,359)	(2,715)	(5,359)	(2,715)
Total non-current liabilities		**(29,248)**	**(91,949)**	**(29,248)**	**(91,949)**
Total assets employed		**403,243**	**399,915**	**399,389**	**396,816**
Financed by					
Public dividend capital	SoCIE	431,309	421,727	431,309	421,727
Revaluation reserve	SoCIE	89,372	97,053	89,372	97,053
Income and expenditure reserve	SoCIE	(117,438)	(118,865)	(121,292)	(121,964)
Total taxpayers' equity		**403,243**	**399,915**	**399,389**	**396,816**

The notes on pages 10 to 64 form part of these accounts.

Tracey Taylor
Chief Executive Officer
Date 23/06/2020

Consolidated Statement of Changes in Equity for the year ended 31 March 2020

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019	**421,727**	**97,053**	**(118,865)**	**399,915**
Surplus / (deficit) for the year	-	-	(2,978)	**(2,978)**
Other transfers between reserves	-	(4,405)	4,405	**-**
Impairments	-	(4,750)	-	**(4,750)**
Revaluations	-	1,474	-	**1,474**
Public dividend capital received	9,582	-	-	**9,582**
Taxpayers' and others' equity at 31 March 2020	**431,309**	**89,372**	**(117,438)**	**403,243**

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018	**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 2020

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019	**421,727**	**97,053**	**(121,964)**	**396,816**
Surplus / (deficit) for the year	-	-	(3,733)	**(3,733)**
Other transfers between reserves	-	(4,405)	4,405	**-**
Impairments	-	(4,750)	-	**(4,750)**
Revaluations	-	1,474	-	**1,474**
Public dividend capital received	9,582	-	-	**9,582**
Taxpayers' and others' equity at 31 March 2020	**431,309**	**89,372**	**(121,292)**	**399,389**

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

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018	**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**

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

		Group		Trust	
		2019/20	2018/19	2019/20	2018/19
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		12,002	(23,814)	11,074	(24,003)
Non-cash income and expense:					
Depreciation and amortisation	7	35,350	31,655	35,350	31,655
Net impairments	8	3,010	6,717	3,010	6,717
Income recognised in respect of capital donations	4	(307)	(1,235)	(307)	(1,235)
(Increase) / decrease in receivables and other assets		(24,872)	3,517	(28,391)	3,242
(Increase) / decrease in inventories		(3,348)	(376)	(3,206)	(439)
Increase / (decrease) in payables and other liabilities		24,830	26,735	28,409	26,086
Increase / (decrease) in provisions		3,236	(370)	3,236	(370)
Corporation tax paid		(29)	(123)	-	-
Net cash flows from / (used in) operating activities		**49,872**	**42,706**	**49,175**	**41,653**
Cash flows from investing activities					
Interest received		349	248	349	248
Purchase of intangible assets		-	(4,893)	-	(4,893)
Purchase of PPE		(41,423)	(36,965)	(41,423)	(36,965)
Sales of PPE		22	157	22	157
Receipt of cash donations to purchase assets		-	1,102	-	1,102
Net cash flows from / (used in) investing activities		**(41,052)**	**(40,351)**	**(41,052)**	**(40,351)**
Cash flows from financing activities					
Public dividend capital received	SoCIE	9,582	7,304	9,582	7,304
Movement on loans from DHSC		520	20,033	520	20,033
Capital element of finance lease rental payments		(1,748)	(1,849)	(1,748)	(1,849)
Capital element of PFI & other service concession payments		(583)	(519)	(583)	(519)
Interest on loans		(1,917)	(1,386)	(1,917)	(1,386)
Other interest		(35)	(11)	(35)	(11)
Interest paid on finance lease liabilities		(200)	(254)	(200)	(254)
Interest paid on PFI & other service concession obligations		(1,849)	(1,835)	(1,849)	(1,835)
PDC dividend paid		(11,727)	(12,071)	(11,727)	(12,071)
Net cash flows from / (used in) financing activities		**(7,957)**	**9,412**	**(7,957)**	**9,412**
Increase / (decrease) in cash and cash equivalents		**863**	**11,767**	**166**	**10,714**
Cash and cash equivalents at 1 April 2019		**25,127**	**13,360**	**23,952**	**13,238**
Cash and cash equivalents at 31 March 2020	32	**25,990**	**25,127**	**24,118**	**23,952**

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 2019/20 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 2020, the Trust is reporting a post Financial Recovery Funding (FRF) surplus of £48,000 (on an adjusted financial performance (*control total)* basis). The Trust therefore met its break even financial control target for 19/20. DHSC provided the Trust with new net revenue loans of £0.9m, comprised of new loans draw down of £9.3m and repaid loans of £8.4m. The planning round for 2020/21 has not been completed, nationally or locally, due to the COVID 19 outbreak. NHSI's original target for the Trust was for a pre FRF deficit of £20.1m, to secure an equivalent value of FRF funding and therefore was set a break even control total after FRF, as in 2019/20. The planning round was suspended on 17 March 2020 and for the first four months of 2020/21 the Trust, alongside all other providers, will be financed through a block funding arrangement.

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 2019/20 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 2020 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 Basis of Consolidation

Nottingham Hospitals 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.

Note 1.3.1 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 Queen's Medical Centre and Nottingham 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.

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 31st March 2019 was £4,596,000. The liability provided for at 31 March 2020 is £7,831,000.

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).

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care 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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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 performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

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 in the QMC hospital campus, which it provided until 29th July 2019.

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

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

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

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

Private Finance Initiative (PFI) transactions

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 Years	Max life 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 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 where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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 Years	**Max life 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 CO_2 emissions. The Trust has opted out of this scheme by participating in the European Union Emissions Trading Scheme (EUETS) which operates on similar principles.

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

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

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 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.17.3 Derecognition

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

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

Note 1.18 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 negative 0.50% (2018-19: positive 0.29%) 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 0.51% (2018-19: positive 0.76% 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 0.55% (2018-19: positive 1.14% 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% (2018-19: positive 1.99% 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% (2018-19: positive 1.99% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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 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% - 2018-19) 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 2019/20.

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 2019-20.

- ***IFRS 16 Leases***

Application required for accounting periods beginning on or after 1 April 2020, 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.

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	
	2019-20	**2018-19**	**2019-20**	**2018-19**	**2019-20**	**2018-19**
	£000	£000	**£000**	**£000**	**£000**	**£000**
Income	1,177,533	1,021,755	312	197	1,177,845	1,021,952
Surplus / (Deficit)	(3,733)	(38,552)	755	121	(2,978)	(38,431)
Net Assets:						
Segment net assets	399,389	396,816	3,854	3,099	403,243	399,915

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

The income of HPSN Ltd in 2019-20 is £ 35.409m, of which £35.097m is from Nottingham University Hospitals NHS Trust (99.1%).
The comparative figures for 2018-19 are £29.379m, of which £29.088m is from Nottingham University Hospitals NHS Trust (99.0%).

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 1.1

Note 3.1 Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Acute services		
Elective income	153,301	141,068
Non elective income	292,392	255,901
First outpatient income	44,892	39,092
Follow up outpatient income	87,989	72,276
A & E income	32,357	27,900
High cost drugs income from commissioners (excluding pass-through costs)	118,186	105,531
Other NHS clinical income	261,589	214,312
Community services		
Income from other sources (e.g. local authorities)	5,354	5,138
All services		
Private patient income	3,313	2,296
Agenda for Change pay award central funding*	-	10,065
Additional pension contribution central funding**	27,807	-
Other clinical income	6,049	17,423
Total income from activities	**1,033,229**	**891,002**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	453,884	384,742
Clinical commissioning groups	555,401	479,839
Department of Health and Social Care	22	10,088
Other NHS providers	10,512	3,043
NHS other	228	578
Local authorities	5,354	5,243
Non-NHS: private patients	2,385	1,790
Non-NHS: overseas patients (chargeable to patient)	928	506
Injury cost recovery scheme	4,256	4,335
Non NHS: other	259	838
Total income from activities	**1,033,229**	**891,002**
of which:		
Related to continuing operations	1,033,229	891,002
Related to discontinued operations	-	-

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

	2019/20	2018/19
	£000	£000
Income recognised this year	928	506
Cash payments received in-year	-	-
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	152	64

Note 4 Other operating income (Group)

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	26,456	-	**26,456**	26,365	-	**26,365**
Education and training	44,382	984	**45,366**	42,484	670	**43,154**
Non-patient care services to other bodies	12,040		**12,040**	18,325		**18,325**
Provider sustainability fund (PSF)	18,138		**18,138**	11,768		**11,768**
Financial recovery fund (FRF)	8,206		**8,206**	-	-	**-**
Marginal rate emergency tariff funding (MRET)	3,368		**3,368**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	6,285	-	**6,285**	6,859	-	**6,859**
Receipt of capital grants and donations	-	307	**307**	-	1,235	**1,235**
Charitable and other contributions to expenditure	-	2,521	**2,521**	-	2,914	**2,914**
Rental revenue from finance leases	-	-	**-**	-	-	**-**
Rental revenue from operating leases (see note 11.1)	-	765	**765**	-	854	**854**
Other income	21,164	-	**21,164**	19,476	-	**19,476**
Total other operating income	**140,039**	**4,577**	**144,616**	**125,277**	**5,673**	**130,950**
of which:						
Related to continuing operations			**144,616**			**130,950**
Related to discontinued operations			**-**			**-**

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

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	4,272	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 2020 £000	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 and two motor vehicles. The sales proceeds of £22k (Statement of Cash Flows) were received and the Net Book Value of the equipment assets disposed was £84k (note 19 PPE) resulting in a profit on loss on disposal of £61k (note 14 Other gains / (losses)).

Note 6.1 Fees and charges (Group)

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2019/20	2018/19
	£000	£000
Income	4,379	4,205
Full cost	(4,659)	(4,227)
Surplus / (deficit)	**(280)**	**(22)**

Note 7 Operating expenses (Group)

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	6,742	6,708
Purchase of healthcare from non-NHS and non-DHSC bodies	3,314	2,128
Staff and executive directors costs	718,808	634,729
Remuneration of non-executive directors	97	73
Supplies and services - clinical (excluding drugs costs)	121,100	125,043
Supplies and services - general	9,466	7,257
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	133,417	107,163
Inventories written down (see note 46)	371	361
Consultancy costs	1,966	1,484
Establishment	8,191	8,434
Premises	32,186	29,217
Transport (including patient travel)	5,056	5,030
Depreciation on property, plant and equipment (see note 19)	29,505	25,046
Amortisation on intangible assets (see note 17)	5,845	6,609
Net impairments (see note 8)	3,010	6,717
Movement in credit loss allowance: contract receivables / contract assets	1,750	1,118
Change in provisions discount rate(s) (see note 38)	220	(56)
Audit fees payable to the external auditor		
audit services- statutory audit *	106	128
other auditor remuneration (external auditor only)	4	28
Internal audit costs	192	211
Clinical negligence	28,786	30,652
Legal fees	615	621
Insurance	816	780
Research and development	26,651	27,178
Education and training	10,972	5,216
Rentals under operating leases (see note 11.2)	3,493	1,479
Redundancy (see note 9)	45	174
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	5,062	4,924
Charges to operating expenditure for off-SoFP PFI schemes	4,230	4,701
Car parking & security	277	179
Hospitality	163	171
Losses, ex gratia & special payments (see note 46)	546	293
Other	2,841	1,970
Total	**1,165,843**	**1,045,766**
of which:		
Related to continuing operations	1,165,843	1,045,766
Related to discontinued operations	-	-

* Included with the Group audit fee - the amount relating to HSPN Ltd is £12k for 2019/20, and £13k for 2018/19

Note 7.1 Other auditor remuneration (Group)

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	4	28
Total	**4**	**28**

Note 7.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £5.0m (2018/19: £0.2m).

Note 8 Impairment of assets (Group)

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	-	2,754
Changes in market price	3,010	3,963
Total net impairments charged to operating surplus / deficit	**3,010**	**6,717**
Impairments charged to the revaluation reserve	4,750	8,055
Total net impairments	**7,760**	**14,772**

An Interim Valuation of the Trust's Property estate was conducted by Gerald Eve LLP an independent firm of professional Valuers who have decided it would be appropriate to make adjustments in recognition of the economic downturn precipitated by the current pandemic situation. In particular, the Valuers have taken into account the most recent published set of BCIS cost data, published on 27th March 2020, which shows their provisional all-in TPI for Q1 2020 reducing from 335 to 330 and Location Factors for Nottingham and Gedling reducing from 1.05 to 1.04 and from 1.01 to 1.00 respectively. In addition, the Valuer has applied a -10% reduction to land value to reflect their assessment of the likely effects of the COVID19 shutdown on development land pricing. For avoidance of doubt, the impairments over £135k in 19/20 included:

- Land City hospital £1.4m;
- Land QMC hospital £0.7m;
- Roads / Service areas / Footpaths City hospital £0.5m;
- Modular Theatres QMC £0.5m;

Total Impairment £3.010m

Note 9 Employee benefits (Group)

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	548,364	508,190
Social security costs	49,578	45,807
Apprenticeship levy	2,599	2,408
Employer's contributions to NHS pensions	91,461	59,477
Pension cost - other	274	158
Termination benefits	45	174
Temporary staff (including agency)	47,346	39,132
Total gross staff costs	**739,667**	**655,346**
Recoveries in respect of seconded staff	-	-
Total staff costs	**739,667**	**655,346**
of which		
Costs capitalised as part of assets	1,141	1,320

Note 9.1 Retirements due to ill-health (Group)

During 2019/20 there were 4 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £121k (£389k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2020, is based on valuation data as 31 March 2018, updated to 31 March 2020 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:

https://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 employer contribution rate for 2019/20 is 20.6%.

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.
The future minimum lease receipts due has fallen due to the cessation of the lease with Circle Nottingham Limited of 25 years from 4 September 2013 terminated on 29 July 2019.

	2019/20	2018/19
Buildings	**£000**	**£000**
Operating lease revenue		
Minimum lease receipts	602	758
Contingent rent	163	96
Total	**765**	**854**

	2019/20	2018/19
Buildings	**£000**	**£000**
Future minimum lease receipts due:		
- not later than one year;	60	165
- later than one year and not later than five years;	91	470
- later than five years.	18	3,741
Total	**169**	**4,376**

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.

	2019/20	2018/19
Buildings	**£000**	**£000**
Minimum lease payments	1,791	464
Total	**1,791**	**464**

	2019/20	2018/19
Other	**£000**	**£000**
Minimum lease payments	1,702	1,015
Total	**1,702**	**1,015**

	2019/20	2018/19
Total	**£000**	**£000**
Operating lease expense		
Minimum lease payments	3,493	1,479
Total	**3,493**	**1,479**

	2019/20	2018/19
Buildings	**£000**	**£000**
Future minimum lease payments due:		
- not later than one year;	911	453
- later than one year and not later than five years;	784	1,108
- later than five years.	-	129
Total	**1,695**	**1,690**
Future minimum sublease payments to be received	-	-

	2019/20	2018/19
Other	**£000**	**£000**
Future minimum lease payments due:		
- not later than one year;	842	771
- later than one year and not later than five years;	2,770	2,376
- later than five years.	418	879
Total	**4,030**	**4,026**
Future minimum sublease payments to be received	-	-

	2019/20	2018/19
Total	**£000**	**£000**
Future minimum lease payments due:		
- not later than one year;	1,753	1,224
- later than one year and not later than five years;	3,554	3,484
- later than five years.	418	1,008
Total	**5,725**	**5,716**
Future minimum sublease payments to be received	-	-

Note 12 Finance income (Group)

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	349	248
Total finance income	**349**	**248**

Note 13 Finance expenditure (Group)

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,995	1,490
Finance leases	200	254
Interest on late payment of commercial debt	35	11
Main finance costs on PFI schemes obligations	960	994
Contingent finance costs on PFI scheme obligations	889	841
Total interest expense	**4,079**	**3,590**
Unwinding of discount on provisions	7	3
Total finance costs	**4,086**	**3,593**

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

	2019/20	2018/19
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	35	11

Note 14 Other gains / (losses) (Group)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	95
Losses on disposal of assets	(61)	-
Total gains / (losses) on disposal of assets	**(61)**	**95**
Other gains / (losses)	-	-
Total other gains / (losses)	**(61)**	**95**

The Trust disposed of medical equipment and two motor vehicles. The sales proceeds of £22k (Statement of Cash Flows) were received and the Net Book Value of the equipment assets disposed was £84k (note 19 PPE) resulting in a profit on loss on disposal of £61k (note 14 Other gains / (losses)).

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/<defict> for the period was <£3.7> million (2018/19: <£38.6> million). The trust's total comprehensive income/<expense> for the period was <7.0> million (2018/19: <£13.5> million).

Note 16 Discontinued operations (Group)

The Group has no discontinued operations.

Note 17 Intangible assets - 2019/20

Group and Trust	Software licences	Development expenditure	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019	**17,475**	**25,146**	**42,621**
Additions	-	-	**-**
Valuation / gross cost at 31 March 2020	**17,475**	**25,146**	**42,621**
Amortisation at 1 April 2019	**12,207**	**15,823**	**28,030**
Provided during the year (see note 7)	2,031	3,814	**5,845**
Amortisation at 31 March 2020	**14,238**	**19,637**	**33,875**
Net book value at 31 March 2020	**3,237**	**5,509**	**8,746**
Net book value at 1 April 2019	**5,268**	**9,323**	**14,591**

Note 18 Intangible assets - 2018/19

Group and Trust	Software licences	Development expenditure	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018	**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	**10,690**	**10,731**	**21,421**
Provided during the year (see note 7)	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 19 Property, plant and equipment - 2019/20

Group and Trust	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**27,059**	**414,139**	**30,615**	**126,496**	**1,296**	**49,294**	**3,270**	**652,169**
Additions	-	9,305	25,107	14,494	-	559	-	**49,465**
Impairments (see note 24)	(2,951)	(5,388)	-	-	-	-	-	**(8,339)**
Reversals of impairments (see note 24)	79	500	-	-	-	-	-	**579**
Revaluations (see note 24)	351	(13,740)	-	-	-	-	-	**(13,389)**
Reclassifications	-	11,038	(13,961)	(1,149)	-	4,072	-	**-**
Disposals (see note 14)	-	-	-	(3,177)	(5)	-	(3)	**(3,185)**
Valuation / gross cost at 31 March 2020	**24,538**	**415,854**	**41,761**	**136,664**	**1,291**	**53,925**	**3,267**	**677,300**
Accumulated depreciation at 1 April 2019	**-**	**-**	**-**	**85,677**	**1,178**	**31,473**	**2,270**	**120,598**
Provided during the year (see note 7)	-	14,863	-	7,755	40	6,663	184	**29,505**
Revaluations	-	(14,863)	-	-	-	-	-	**(14,863)**
Disposals (see note 14)	-	-	-	(3,101)	-	-	-	**(3,101)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**90,331**	**1,218**	**38,136**	**2,454**	**132,139**
Net book value at 31 March 2020	**24,538**	**415,854**	**41,761**	**46,333**	**73**	**15,789**	**813**	**545,161**
Net book value at 1 April 2019	**27,059**	**414,139**	**30,615**	**40,819**	**118**	**17,821**	**1,000**	**531,571**
Land & Buildings NBV at 31 March 2020		**440,392**						
Land & Buildings NBV at 31 March 2019		**441,198**						

The **freehold** property known as **Nottingham University Hospitals NHS Trust** was valued as at **31 March 2020** by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuations were prepared in accordance with the requirements of the RICS Valuation – Global Standards (January 2020 edition), the International Valuation Standards and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM). The valuations of specialised properties were derived using the **Depreciated Replacement Cost (DRC)** method, with other in-use properties reported on an Existing Use Value basis.

Note 20 Property, plant and equipment - 2018/19

Group and Trust	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018	**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 (see note 14)	-	-	-	(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	**-**	**-**	**-**	**88,697**	**1,101**	**28,142**	**2,065**	**120,005**
Provided during the year (see note 7)	-	13,238	-	5,840	98	5,665	205	**25,046**
Revaluations	-	(13,238)	-	-	-	-	-	**(13,238)**
Disposals (see note 14)	-	-	-	(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**

The **freehold** property known as **Nottingham University Hospitals NHS Trust** was valued as at **31 March 2019** by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuations were prepared in accordance with the requirements of the RICS Valuation – Global Standards (July 2017 edition), the International Valuation Standards and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM). The valuations of specialised properties were derived using the **Depreciated Replacement Cost (DRC)** method, with other in-use properties reported on an Existing Use Value basis.

Note 21 Property, plant and equipment financing - 2019/20

Group and Trust	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	24,538	380,946	41,761	44,417	70	10,381	534	**502,647**
Finance leased	-	-	-	-	-	5,408	-	**5,408**
On-SoFP PFI contracts and other service concession arrangements	-	12,532	-	-	-	-	-	**12,532**
Owned - donated	-	22,376	-	1,916	3	-	279	**24,574**
NBV total at 31 March 2020	**24,538**	**415,854**	**41,761**	**46,333**	**73**	**15,789**	**813**	**545,161**

Note 22 Property, plant and equipment financing - 2018/19

Group and Trust	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 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 23 Donations of property, plant and equipment

The Trust received £386k of donations of property, plant and equipment during the year, all from NUH Charity.

Note 24 Revaluations of property, plant and equipment

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 2019/20 interim valuation (a Full Valuation was conducted in 18/19) and assess the continuing changes in property values of the NUH Estate. The 2019/20 valuation resulted in an impairment on some Trust properties and upward revaluations on other buildings, with an overall net decrease of £6.3m in the value of the Trust asset base (including in year 2019/20 capital additions). It is appropriate to make adjustments in recognition of the economic downturn precipitated by the current pandemic situation. In particular, the Valuers have taken into account the most recent published set of BCIS cost data, published on 27th March 2020, which shows their provisional all-in TPI for Q1 2020 reducing from 335 to 330 and Location Factors for Nottingham and Gedling reducing from 1.05 to 1.04 and from 1.01 to 1.00 respectively. In addition, the Valuer has applied a -10% reduction to land value to reflect their assessment of the likely effects of the COVID19 shutdown on development land pricing.
In making these judgements, the Trust is aware that the Royal Institute of Chartered Surveyors (RICS) has issued a valuation practice notice which gives guidance to valuers where a valuer declares a materiality uncertainty attached to a valuation in light of the impact of COVID-19 on markets. As explained above, the Trust has not obtained a valuation report for 2019/20 but it should be noted that there may now be greater uncertainty in markets on which the valuation obtained in [date] and reflected in these financial statements is based. Given the judgements explained above in preparing these 2019/20 financial statements, the Trust has not deviated from its existing accounting policy by obtaining an additional valuation to which a materiality uncertainty might be attached. 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 below:

	£'000	£'000
Upward Valuation to Revaluation Reserve	1,474	
Upward Valuation Reversal of Previous Impairments	579	2,053
Downward Valuation / Impairment transferred to Revaluation Reserve	(4,750)	
Downward Valuation / Impairment transferred to SoCI	(3,589)	(8,339)
Total Impact of Valuation		**(6,286)**

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 Nottingham University Hospitals NHS Trust. The trust has no interests in any other enities.

Note 28 Inventories

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Drugs	10,106	8,172	8,073	6,281
Consumables	15,191	13,782	15,191	13,782
Energy	117	112	117	112
Total inventories	**25,414**	**22,066**	**23,381**	**20,175**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £257,011k (2018/19: £218,271k). Write-down of inventories recognised as expenses for the year were £371k (2018/19: £361k).

Note 29 Receivables

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Current				
Contract receivables	86,888	64,275	93,262	66,685
Capital receivables	71	71	71	71
Allowance for impaired contract receivables / assets	(6,192)	(4,704)	(6,192)	(4,704)
Prepayments (non-PFI)	5,491	4,849	5,491	4,849
PFI lifecycle prepayments	559	544	559	544
Finance lease receivables	511	643	511	643
PDC dividend receivable	1,473	751	1,473	751
VAT receivable	420	331	1	-
Other receivables	107	-	107	-
Total current receivables	**89,328**	**66,760**	**95,283**	**68,839**
Non-current				
Contract receivables	4,896	4,859	4,896	4,859
Prepayments (non-PFI)	195	455	195	455
Finance lease receivables	978	358	978	358
Other receivables	2,629	-	2,629	-
Total non-current receivables	**8,698**	**5,672**	**8,698**	**5,672**
Total Receivables	**98,026**	**72,432**	**103,981**	**74,511**
of which receivable from NHS and DHSC group bodies:				
Current	66,367	46,380	66,367	46,380
Non-current	2,824	455	2,824	455

Note 29.1 Allowances for credit losses - 2019/20

	Group and Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2019 - brought forward	**4,704**	**-**
New allowances arising	820	-
Changes in existing allowances	930	-
Utilisation of allowances (write offs)	(262)	-
Allowances as at 31 Mar 2020	**6,192**	**-**

Note 28.2 Allowances for credit losses - 2018/19

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

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

	Group		Trust	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
At 1 April	**25,127**	**13,360**	**23,952**	**13,238**
Net change in year	863	11,767	166	10,714
At 31 March	**25,990**	**25,127**	**24,118**	**23,952**
Broken down into:				
Cash at commercial banks and in hand	1,899	1,201	27	26
Cash with the Government Banking Service	24,091	23,926	24,091	23,926
Deposits with the National Loan Fund	-	-	-	-
Total cash and cash equivalents as in SoFP	**25,990**	**25,127**	**24,118**	**23,952**
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**25,990**	**25,127**	**24,118**	**23,952**

Note 32.2 Third party assets held by the trust

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

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Bank balances	-	-
Monies on deposit	8	-
Total third party assets	**8**	**-**

Note 33 Trade and other payables

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Current				
Trade payables	37,486	34,170	43,603	34,170
Capital payables	20,347	12,612	20,347	12,612
Accruals	84,309	64,132	84,309	66,299
Receipts in advance and payments on account	208	209	208	209
Social security costs	13,599	12,695	13,562	12,695
VAT payables	215	603	215	603
Other taxes payable (corporation tax)	213	29	37	(26)
Other payables	771	706	771	706
Total current trade and other payables	**157,148**	**125,156**	**163,052**	**127,268**
Non-current				
Total non-current trade and other payables	**-**	**-**	**-**	**-**
Total Trade and Other payables	**157,148**	**125,156**	**163,052**	**127,268**
of which payables from NHS and DHSC group bodies:				
Current	17,824	9,812	17,824	9,812
Non-current	-	-	-	-

Note 33.1 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2020	31 March 2020	31 March 2019	31 March 2019
	£000	Number	£000	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 2020	31 March 2019
	£000	£000
Current		
Deferred income: contract liabilities	16,579	15,859
Total other current liabilities	**16,579**	**15,859**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 35 Borrowings

	Group	
	31 March 2020	31 March 2019
	£000	£000
Current		
Loans from DHSC	92,366	28,725
Obligations under finance leases	1,801	1,748
Obligations under PFI and other service concession contracts (excl. lifecycle)	472	554
Total current borrowings	**94,639**	**31,027**
Non-current		
Loans from DHSC	9,213	72,256
Obligations under finance leases	3,767	5,568
Obligations under PFI and other service concession contracts	10,909	11,410
Total non-current borrowings	**23,889**	**89,234**
Total borrowings	**118,528**	**120,261**
Loans from DHSC	101,579	100,981
Obligations under finance leases	5,568	7,316
Obligations under PFI and other service concession contracts	11,381	11,964
Total borrowings	**118,528**	**120,261**

Note 35.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2019/20 and Trust	Loans from DHSC	Finance leases	PFI schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**100,981**	**7,316**	**11,964**	**120,261**
Cash movements:				
Financing cash flows - payments and receipts of principal	520	(1,748)	(583)	**(1,811)**
Financing cash flows - payments of interest	(1,917)	(200)	(960)	**(3,077)**
Non-cash movements:				
Application of effective interest rate	1,995	200	960	**3,155**
Carrying value at 31 March 2020	**101,579**	**5,568**	**11,381**	**118,528**

Group and Trust - 2018/19	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 Nottingham University Hospitals NHS Trust 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 2020	31 March 2019
	£000	£000
Gross lease receivables	**1,489**	**1,001**
of which those receivable:		
- not later than one year;	511	643
- later than one year and not later than five years;	978	358
Net lease receivables	**1,489**	**1,001**
of which those receivable:		
- not later than one year;	511	643
- later than one year and not later than five years;	978	358
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

Note 37.2 Nottingham University Hospitals NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group	
	31 March 2020	31 March 2019
	£000	£000
Gross lease liabilities	**5,843**	**7,791**
of which liabilities are due:		
- not later than one year;	1,948	1,948
- later than one year and not later than five years;	3,895	5,843
Finance charges allocated to future periods	(275)	(475)
Net lease liabilities	**5,568**	**7,316**
of which payable:		
- not later than one year;	1,801	1,748
- later than one year and not later than five years;	3,767	5,568
Total of future minimum sublease payments to be received at the reporting date	**5,568**	**7,316**
Contingent rent recognised as expense in the period	-	-

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

- Existing lease for hospital beds, which entered its secondary lease term of seven years in 2012/13 and terminated 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	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2019	**949**	**1,810**	**351**	**1,486**	**4,596**
Change in the discount rate	**36**	**184**	**-**	**-**	**220**
Arising during the year	**-**	**108**	**101**	**3,946**	**4,155**
Utilised during the year	(72)	(86)	(168)	(530)	**(856)**
Reversed unused	**(56)**	**-**	**-**	**(227)**	**(283)**
Unwinding of discount	**2**	**5**	**-**	**-**	**7**
At 31 March 2020	**859**	**2,021**	**284**	**4,675**	**7,839**
Expected timing of cash flows:					
- not later than one year;	72	86	284	**2,038**	**2,480**
- later than one year and not later than five years;	292	348	-	**127**	**767**
- later than five years.	495	1,587	-	**2,510**	**4,592**
Total	**859**	**2,021**	**284**	**4,675**	**7,839**

Note 38.1 Clinical negligence liabilities

At 31 March 2020, £606,795k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Nottingham University Hospitals NHS Trust (31 March 2019: £587,914k).

Note 39 Contingent assets and liabilities

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Value of contingent liabilities		
Employment tribunal and other employee related litigation	3,000	-
Gross value of contingent liabilities	**3,000**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**3,000**	**-**
Net value of contingent assets	**-**	**-**

Leave to appeal to the Supreme Court has been granted in Flowers v East Of England Ambulance Service and therefore on the basis of accounting convention the outcome of this case is not yet probable and remains a contingent liability

Note 40 Contractual capital commitments

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	10,970	2,880
Intangible assets	-	-
Total	**10,970**	**2,880**

£4.2m of the increase in capital commitments was due to COVID-19

Note 41 Other financial commitments

The Group and Trust have no other financial commitments

Note 42 Defined benefit pension schemes

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

Note 43 On-SoFP PFI and other service concession arrangements

The ENT / Ophthalmology Scheme provides ENT and ophthalmology facilities at the Queens Medical Centre 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 2005 for a term of 15 years.

The Trust has no LIFT arrangements.

Note 43.1 On-SoFP PFI or other service concession arrangement obligations

The following obligations in respect of the PFI and other service concession arrangements are recognised in the statement of financial position:

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Gross PFI or other service concession liabilities	**20,483**	**22,024**
of which liabilities are due		
- not later than one year;	1,391	1,511
- later than one year and not later than five years;	5,184	5,258
- later than five years.	13,908	15,255
Finance charges allocated to future periods	(9,102)	(10,060)
Net PFI and other service concession arrangement obligation	**11,381**	**11,964**
- not later than one year;	472	554
- later than one year and not later than five years;	1,810	1,749
- later than five years.	9,099	9,661

Note 43.2 Total on-SoFP PFI and other service concession arrangement commitments

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

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Total future payments committed in respect of the PFI and other service concession arrangements	**70,936**	**77,583**
of which payments are due:		
- not later than one year;	6,067	6,657
- later than one year and not later than five years;	15,237	17,253
- later than five years.	49,632	53,672

Note 43.3 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	
	2019/20	2018/19
	£000	£000
Unitary payment payable to service concession operator	**7,010**	**6,712**
Consisting of:		
- Interest charge	960	994
- Repayment of balance sheet obligation	553	518
- Service element and other charges to operating expenditure	4,608	4,359
- Contingent rent	889	841
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	454	565
Total amount paid to service concession operator	**7,464**	**7,277**

Note 44 Off-SoFP PFI and other service concession arrangements

Nottingham University Hospitals NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI arrangements:

The Combined Heat and Power (CHP) scheme provides CHP plant at the Queens Medical Centre 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 2020	31 March 2019
	£000	£000
Charge in respect of the off SoFP PFI and other service concession arrangement for the period	**4,230**	**4,701**
Commitments in respect of off-SoFP PFI and other service concession arrangements:		
- not later than one year;	4,230	4,701
- later than one year and not later than five years;	16,920	18,804
- later than five years.	15,863	23,199
Total	**37,013**	**46,704**

Note 45 Financial instruments

Note 45.1 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

Nottingham University Hospitals NHS Trust 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

Nottingham University Hospitals NHS Trust 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

Nottingham University Hospitals NHS Trust's 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, exposed to significant liquidity risks.

Note 45.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	84,675	-	-	**84,675**
Other investments / financial assets	1,489	-	-	**1,489**
Cash and cash equivalents	25,990	-	-	**25,990**
Total at 31 March 2020	**112,154**	**-**	**-**	**112,154**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	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**

Note 45.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	90,779			**90,779**
Other investments / financial assets	1,489			**1,489**
Cash and cash equivalents	24,118			**24,118**
Total at 31 March 2020	**116,386**	**-**	**-**	**116,386**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	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**

Note 45.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	101,579	-	**101,579**
Obligations under finance leases	5,568	-	**5,568**
Obligations under PFI and other service concessions	11,381	-	**11,381**
Trade and other payables excluding non financial liabilities	140,612	-	**140,612**
Provisions under contract	7,831	-	**7,831**
Total at 31 March 2020	**266,971**	**-**	**266,971**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	100,981	-	**100,981**
Obligations under finance leases	7,316	-	**7,316**
Obligations under PFI and other service concessions	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**

Note 45.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	100,981		**100,981**
Obligations under finance leases	7,316		**7,316**
Obligations under PFI and other service concessions	11,964		**11,964**
Trade and other payables excluding non financial liabilities	148,506		**148,506**
Provisions under contract	7,831		**7,831**
Total at 31 March 2020	**276,598**	**-**	**276,598**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	100,981		**100,981**
Obligations under finance leases	7,316		**7,316**
Obligations under PFI and other service concessions	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**

Note 45.6 Fair values of financial assets and liabilities

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

Note 45.7 Maturity of financial liabilities

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
In one year or less	240,360	141,279	249987	141,279
In more than one year but not more than two years	2,145	9,704	2,145	9,704
In more than two years but not more than five years	9,689	38,540	9,689	38,540
In more than five years	14,777	40,990	14,777	40,990
Total	**266,971**	**230,513**	**276,598**	**230,513**

Note 46 Losses and special payments

	2019/20		2018/19	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Bad debts and claims abandoned	244	246	189	115
Stores losses and damage to property (inventories written down - see note 7)	3,333	371	4,293	361
Total losses	**3,577**	**617**	**4,482**	**476**
Special payments				
Ex-gratia payments	120	203	102	178
Total special payments	**120**	**203**	**102**	**178**
Total losses and special payments	**3,697**	**820**	**4,584**	**654**
Memo: Losses, ex gratia & special payments (see note 7)		449		293

Note 47 Gifts

The Trust has made no gifts during the year.

Note 48 Related parties

parties related to them, have undertaken any material transactions with Nottingham University Hospitals NHS Trust.

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

Name of Counter Party	Current Year 2019-20				Prior Year 2018-19			
NHS Commissioned Patient Care Activity								
Nottinghamshire Commissioning Consortia, comprised of:	£000	£000	£000	£000	£000	£000	£000	£000
	Income	Expenditure	Debtors	Creditors	Income	Expenditure	Debtors	Creditors
NHS Commissioning Board (Specialised)	371,310	0	1,266	0	363,902	0	19,513	0
NHS Commissioning Board - N&D at (Dental / Public Health)	10,207	0	171	0	17,870	0	1,483	0
NHS England (Military)	273	0	12	0	28	0	23	0
Nottingham City CCG	215,125	189	3,038	2,357	186,149	(57)	3,156	1,910
Nottingham North & East CCG	87,280	1,028	4,199	649	84,941	33	8	623
Rushcliffe CCG	73,027	881	489	517	61,018	(2)	18	447
Nottingham West CCG	65,091	2	228	5,088	50,263	22	0	410
Derby and Derbyshire CCG *	42,897	1	667	0	0	0	0	0
Erewash CCG *	0	0	0	0	24,499	0	496	0
Newark & Sherwood CCG	17,504	15	117	0	15,166	14	232	0
Mansfield & Ashfield CCG	15,598	(2)	85	0	13,517	7	380	14
Southern Derbyshire CCG *	0	0	0	0	9,529	0	321	0
South West Lincolnshire CCG	9,448	0	0	58	7,543	0	169	0
Lincolnshire West CCG	5,505	0	0	10	4,930	0	17	1
Lincolnshire East CCG	4,193	0	68	0	3,873	0	66	0
West Leicestershire CCG	6,954	0	866	0	4,639	15	173	0
East Leicestershire & Rutland CCG	6,086	0	307	0	4,671	0	53	0
Hardwick CCG *	0	0	0	0	2,095	2	224	1
South Lincolnshire CCG	759	1	0	5	736	2	0	95
North Derbyshire CCG *	0	0	0	0	660	0	14	0
Bassetlaw CCG	666	0	29	0	683	0	57	0
East Staffordshire CCG	898	0	154	0	626	0	54	0
Leicester City CCG	860	0	117	0	951	0	153	0
Nene CCG	644	0	60	0	527	0	48	0
Sheffield CCG	176	0	22	0	160	0	0	42
Doncaster CCG	182	0	0	0	106	0	1	0
South East Staffordshire & Seisdon CCG	0	0	0	0	400	0	45	0
Nottingham City Council	3,389	0	0	0	3,389	0	282	0
Nottinghamshire County Council	1,600	0	0	0	1,600	0	133	0
Cambridge University Hospitals NHS Foundation Trust	6,767	126	1,791	130	772	93	213	70

* Derby and Derbyshire CCG was formed on 1 April 2019 by merging Erewash CCG, Southern Derbyshire CCG, Hardwick CCG and North Derbyshire CCG.

Note 48 Related parties (continued)

Non Patient Care activity	£000	£000	£000	£000	£000	£000	£000	£000
	Income	Expenditure	Debtors	Creditors	Income	Expenditure	Debtors	Creditors
NHS England	81,131	116	38,904	450	24,638	210	9,606	300
Health Education England	43,668	1	189	3	44,665	10	175	1
Department of Health and Social Care	10,965	0	891	0	19,543	0	232	0
Her Majesty's Revenue and Customs	0	52,354	420	14,027	0	48,245	331	13,327
NHS Pensions	0	91,461	0	8,972	0	59,477	0	8,332
Sherwood Forest Hospitals NHS Foundation Trust	2,979	3,733	1,872	2,367	1,664	5,131	1,664	1,823
Nottinghamshire Healthcare NHS Foundation Trust	2,662	2,464	1,279	573	695	2,881	695	796
University Hospital of Derby and Burton NHS Foundation Trust	2,188	3,644	998	3,245	2,292	1,537	1,524	982
University Hospitals of Leicester NHS Trust	7,041	1,596	3,592	1,984	3,006	1,655	3,006	970
United Lincolnshire Hospitals NHS Trust	1,072	3,195	361	1,051	812	1,246	266	1,144
NHS Resolution (formerly NHS Litigation Authority)	0	29,419	0	69	0	31,140	0	34
NHS Blood and Transplant Authority	312	5,236	40	86	303	4,905	20	12
University of Nottingham	3,539	11,317	2,190	15	3,190	13,410	1,082	870
Nottingham City Council	20	917	0	0	343	5,317	0	0
Nottinghamshire County Council	50	30	0	0	197	0	0	0

NUH also received income (£0.3m) from Nottingham Hospitals Charity during 2019/20 (£1.2m in 2018-19).

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

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

In 2019/20, Mr Rupert Egginton and Dr Keith Girling served as Executive Directors of both NUH and Trust Pharmacy for all of the financial year.

Note 49 Transfers by absorption

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

Note 50 Prior period adjustments

There are no prior period adjustments.

Note 51 Events after the reporting date

Impact of the Reforms to the NHS Cash Regime effective from 1 April 2020

DHSC announced that all interim revenue and capital loans would be extinguished on 1 April 2020 and replaced by Public Dividend Capital. Therefore there is no longer a requirement to repay outstanding loan balances at 31 March 2020, creating an adjusting event after the reporting period.

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

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

Note 53 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	200,601	631,775	184,131	528,950
Total non-NHS trade invoices paid within target	172,754	555,023	149,379	448,210
Percentage of non-NHS trade invoices paid within target	86.1%	87.9%	81.1%	84.7%
NHS Payables				
Total NHS trade invoices paid in the year	4,912	169,654	4,496	182,808
Total NHS trade invoices paid within target	1,845	153,258	2,500	164,585
Percentage of NHS trade invoices paid within target	37.6%	90.3%	55.6%	90.0%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 54 External financing

The trust is given an external financing limit against which it is permitted to underspend

	2019/20 £000	2018/19 £000
Cash flow financing	6,908	13,202
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**6,908**	**13,202**
External financing limit (EFL)	38,995	36,316
Under spend against EFL	**32,087**	**23,114**

Note 55 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	49,465	44,936
Less: Disposals	(84)	(62)
Less: Donated and granted capital additions	(307)	(1,235)
Charge against Capital Resource Limit	**49,074**	**43,639**
Capital Resource Limit	49,188	43,735
Under spend against CRL	**114**	**96**

Note 56 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	48
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2018/19 post-accounts PSF reallocation	835
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**883**

Note 57 Breakeven duty rolling assessment

	2005/06 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		7,256	5,010	4,764	9,133	701
Breakeven duty cumulative position	26,288	33,544	38,554	43,318	52,451	53,152
Operating income		722,169	742,215	784,605	812,969	847,938
Cumulative breakeven position as a percentage of operating income		4.6%	5.2%	5.5%	6.5%	6.3%

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	750	(47,154)	(20,108)	(2,168)	(31,771)	883
Breakeven duty cumulative position	53,902	6,748	(13,360)	(15,528)	(47,299)	(46,416)
Operating income	874,090	870,621	934,771	987,499	1,021,952	1,177,845
Cumulative breakeven position as a percentage of operating income	6.2%	0.8%	(1.4%)	(1.6%)	(4.6%)	(3.9%)