Annual Report

2020/2021

NHS
Nottingham University Hospitals
NHS Trust

We Listen
We Care

NHS
Nottingham
University Hospitals
NHS Trust

We are

TRUST | EMPOWER | AMBITIOUS

MINDFUL | NURTURING | UNITED | HONEST

#WeAreTeamNUH

Contents

Welcome from the Chairman and Chief Executive

We are delighted to present our annual report and accounts for 2020/21.

This year has been like no other in the history of the NHS, and one that has reinforced our pride in our incredible staff, who have achieved phenomenal amounts despite the challenges they have faced, and continue to face.

As we write this we are nearing the end of the third wave of Covid-19, and so the highlights from our introduction this year, like the year itself, are likely to be different to any other. You will see later in the report the detail of how our performance faired as our teams rapidly altered our services to ensure we were able to support the needs of our communities.

At the beginning of the pandemic we all pulled together and made adaptations quickly. This was difficult with the ever-changing guidance as we all learnt more about Covid-19 and the things we needed to do to stop the spread, particularly around the increase of infection prevention measures, a rigorous testing programme, the use of PPE and social distancing. In the first wave we also ceased all non-urgent planned operations, which allowed our staff to help in areas of the greatest need. In subsequent waves we continued to enhance our online capabilities meaning, among other things, that patients could have their outpatient appointments via a phone or computer as many areas offered digital appointments, something we are likely to continue.

Undoubtedly whilst we have cared for large numbers of Covid-19 patients, those waiting for their planned operation or treatment may have had to wait longer than we would have liked. Balancing the care of Covid-19 and non-Covid-19 patients relies on difficult decisions being made by our staff every day and we do not underestimate how difficult these decisions have been and how hard it is for the patients and families waiting for their treatment. We were briefly able to restore many of our clinical services in the summer of 2020. However, we have ended the financial year with around 4,000 patients awaiting elective treatment. Our aim, as we look forward into 2021/22, is that we will be able to treat these patients as quickly as we can, to return to our previous position of having nobody waiting more than 52 weeks for treatment, acknowledging that this will take some time. We need to manage this carefully, because we remain committed to the wellbeing of our staff and are aware of the importance of not overloading colleagues who are physically and emotionally tired as we begin to carry out planned operations.

We continued cancer and urgent operations throughout the pandemic by working in partnership with the Independent Sector. The incredible efforts of staff have helped to ensure that we carried out as many operations as possible, keeping patients free from Covid-19 infection.

One of the incredible achievements of the year was the roll-out of our vaccination hubs, which made history on 8 December 2020 when they vaccinated the first person in Nottinghamshire from Covid-19. By the end of March 2021 the part our staff played in the largest vaccination programme in NHS history was clear as they registered dose number 45,195. As we write this the Midlands has become the first region to reach 10 million vaccinations given to its population. When modelling suggests that for every 160 vaccines provided a life is saved it shows the incredible thanks we owe our vaccination teams, not just in our organisation but across our system – we are truly proud.

This year research has come to the fore as the whole world looked to science to help defeat Covid-19, and our teams did not shy away from this challenge. They contributed to trials to identify life-saving treatments to the disease, as well as those involving vaccines.

Another priority throughout the year has been the wellbeing of our staff. This has always been important, but over the year we have been able to increase this offer and access funds to support staff in multiple ways.

You will see in this report how we've delivered some important projects, and how our wellbeing team has taken a leading role in ensuring staff get the support they need to help them through this most challenging year. We have also continued to make strides in the fields of equality and diversity, which included the relaunch of the BAME, Staffability and LGBTQIA+ networks.

One of the real challenges, away from Covid-19, this year has been in our Maternity services. In October 2020 the Care Quality Commission (CQC) made an unannounced inspection of our maternity services at QMC, City and in the community, which resulted in a re-rating from requires improvement to inadequate and two warning notices for our service. As the CQC noted in their October inspection, our staff are passionate about their roles within Maternity, and we are committed to working with them and supporting them to ensure that we improve our services to our communities, offering every family safe, high quality, compassionate care. We are sorry we haven't always got this right. We want to reassure you that we have invested significantly in improving our service and will continue to do so, but we know this will take time; you can read more on page 55.

During 2020 we delivered the largest capital programme we have ever delivered, spending more than £90m – around £40m more than the previous year - to deal with some of our critical infrastructure issues. We spent £17.4m mitigating our critical infrastructure backlog, although significant issues remain. We have also invested £7m directly responding to Covid-19 and the impact on our ways of working including; our gases infrastructure and £12.9m to support remote and mobile working. We have spent £6m on minor medical equipment and £1.9m on a replacement MRI as well as being able to complete projects such as the robotic surgery (£3.7m), adult intensive care expansion (£8.3m), LINAC (£3.5m), Endoscopy (£2.5m). We have also made some huge strides towards our goals in sustainability, and the teams are planning much more next year as they deliver the City Energy Project, which you can read more about on page 59.

One of the highlights of the year was Magnet® recognition for Nottingham City Hospital, making it the only hospital in the UK to currently have the accreditation. It means that City Hospital is now globally recognised for providing world-class nursing care and leadership.

Alongside the Magnet® accreditation our children's hospital became the first in Europe to be Pathway to Excellence accredited; meaning it is internationally recognised as an excellent place for nurses to work, with high job satisfaction, professional opportunity and retention, which enables our staff to deliver outstanding patient care. We are very proud of both of these achievements, and hugely grateful to Nottingham Hospitals Charity who funded these programmes.

In November 2020 we launched our new Team NUH Awards, which are aligned with our values – Trust, Empower, Ambitious, Mindful, Nurturing, United, and Honest (Team NUH). This new awards programme, which recognises staff every quarter, replaces our annual NUH Honours. We've already presented 32 staff and teams with awards since the launch, and will present 16 more in June, and they really are well deserved. You can read more about the first award winners later in the document, and we are very much looking forward to the main award presentation in September 2021.

Despite the challenges that Covid-19 has brought us during the year, the team have continued to work on our plans for Tomorrow's NUH. Clinical teams have worked with partners across the system to start to set out a clinical model for the future of our hospitals. You can read more about how the plans are shaping up on page 101.

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 and our staff.

Whilst we have cared for our community, you have cared for us. The countless gifts and donations we have received, not just from local people but from further afield, have been eye-watering. Nottingham Hospitals Charity has raised over £300,000 and combined with grants from NHS Charities Together so far they have funded; over 80 staff rest areas across the hospitals, four sleep pods, two wellbeing centres, multiple garden and outside areas, a significant bicycle compound based at City Hospital, chocolates, thank you cards and pin badges and refreshments for teams. They also continue to work on bids that have been submitted to make improvements to many areas across our hospitals with the money that you have raised. I would like to thank them, and local people, for their continued support for Team NUH.

To our volunteers, who despite challenges from Covid-19 continue to give their time freely to help our patients, visitors and staff. Many couldn't come in to support during the pandemic but supported from afar and a special thank you to those who did continue to come in and help, it was incredibly valuable.

To our Patient Partnership Group which has been very active during the year and supported us across a number of pieces of work and have helped our thinking through some difficult decisions.

To our partners and colleagues at Nottinghamshire Healthcare NHS Trust, CityCare and Sherwood Forest NHS Foundation Trust, our Independent Sector partners at the Spire, BMI Park Hospitals and Ramsey Woodthorpe Hospital, Healthwatch, the Clinical Commissioning Groups, local authority partners, and primary care for their continued help and support. We have never worked more closely than we have over the past year and it strengthens our relationships for the work we need to do over the coming years.

Lastly, but by no means least, our unreserved thanks, on behalf of the whole Trust Board, must go to our staff. This past year has seen the most incredible challenges and pressures and yet we still hear of colleagues selflessly going above and beyond for our patients. We really appreciate everything you are doing to support our organisation and our patients. Thank you - each and every one of you is amazing, and 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 just over 17,000 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 of around £1.3 billion, 98 wards and around 1,700 beds. We are based in the heart of Nottingham and provide services to more than 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.

COVID-19 Achievements in Numbers

5,541 patients discharged following a stay with **Covid-19***

53,000+ visits to the Covid-19 support and information section on our public website (www.nuh.nhs.uk) in the last year

1,400 staff supported to work from home

168,096 Covid-19 tests processed by our Microbiology department*

2.4 Million meetings held via MSTeams

14,915 members of staff have had a COVID risk assessment

700+ people have used our Messages to Loved Ones service

17,000 additional cleans of our hospitals since March

1,600 Posters put up to remind people to social distance and wear face masks

15,704 NUH staff members vaccinated*

40+ Million individual PPE items given out since March 2020

2,000 additional laptops and PC's and 446 iPads provided to staff to support working from home

10,000 patients recruited to Covid-19 vaccine trials

18,000 Lateral Flow Test boxes given out to staff during the second phase of testing

304,066 virtual and remote appointments

200 iPhones repurposed to help patients keep in touch with families

40,535 people vaccinated at NUH*

100+ COVID-19 email briefings sent out to keep staff up to date

£850,000 in donations received from the community to support NUH

7,377 births between March 2020 and the end of January 2021

Help Your Hospital appeal raised more than **£300,000**

3,337 cancer surgeries from 18 March to 29 December (only slightly down on the same period last year)

*As of 23 February 2021

We Listen We Care

The Accountability Report

Corporate Governance Report

This section of the Annual Report focuses on our governance, providing information about the legal status of our organisation, the processes and structures by which we maintain our commitment to good governance.

Directors' Report

As an NHS Trust, we are governed by the NHS Act 2006, the Health and Social Care Act 2012 and by secondary legislation made under these Acts. The statutory functions of the organisation are set out in the NHS Act 2006, and in the Establishment Order as amended by Amendment Order 2019 No 1016.

The Role of the Board

The Board leads in the development and delivery of our strategy and vision while ensuring it achieves value for money and acts in the best interests of patients and public. To carry out this role effectively, the Board carefully monitors its strategic risks as well as engaging with stakeholders to keep them informed on progress while seeking their input and feedback in relation to service delivery. In order to achieve its purpose, the Board has delegated some of its powers to its Board Committees and the Executive Directors.

The Board is held to account for stewardship of public money and delivery of services by NHS England and Improvement (NHSE/I) and for quality of services by the Care Quality Commission (CQC).

The Secretary of State for Health has delegated responsibility to the healthcare regulator NHS England and NHS Improvement (NHSE/I) to appoint to the role of Chair and Non-Executive Director, as well as responsibility for the removal and ongoing appraisal, support and mentoring of all Non-Executive Directors.

Their main responsibilities include:

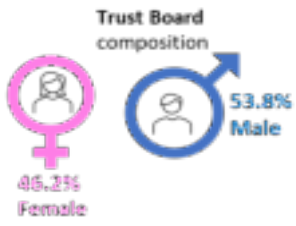
- holding the Executive to account on matters of operational, financial and strategic delivery;
- helping to plan for the future growth and success of the organisation;
- ensuring effective governance arrangements are in place and being adhered to; and
- ensuring the Board operates in the best interest of patients and the public.

Our Board

Our Board comprises the Chair, seven voting Non-Executive Directors, two non-voting Associate Non-Executive Directors, five voting Executive Directors and four non-voting Directors. Non-Executive Directors are not employees of the organisation. The five Executive Directors with voting rights are the Chief Executive, Chief Financial Officer, Medical Director, Chief Nurse and the Chief Operating Officer. The four non-voting Directors are the Director of Corporate Governance, Director of Strategy and Transformation, Director of Communications and Engagement and the Chief People Officer.

The Chief Executive and the Executive Directors are responsible for the day-to-day management and running of the organisation.

Together, the Non-Executive Directors and Executive Directors bring a wide range of skills and experience to the organisation, such that the Board achieves balance and completeness.



The Trust Board's composition as at 31 March 2021 was 46.2 per cent Female (six voting board members) and 53.8 per cent Male (seven voting board members).

Voting Board members - Non-Executive Directors

Mr Eric Morton

Appointed Trust Chairman on 1 May 2017

Chair

Eric joined the organisation as Chairman on 1 May 2017. He is an Accountant by background and began his career in local authority settings before he joined the NHS in 1987 as Senior Assistant Regional Treasurer at Trent Regional Health Authority. Eric held Finance Director, Chief Executive and Advisor to the Board posts for several years in several NHS Trusts

Membership of committees

- Remuneration and Terms of Service Committee (Chair)
- Appointment of CEO (Chair)
- Appointment of other Executive Directors (Chair)

Declaration of Interests

- Ice Hockey UK – Non-Executive Board Member

Mr Stephen Thomas

Joined the Trust Board in April 2017

Non Executive Director/Vice Chair

Steve joined NUH in April 2014 and is currently Managing Director of Strategic Development at Experian Plc. He is a member of its UK board, responsible for strategy, marketing, innovation and proposition development.
Before joining Experian in 2007 he was at IBM, where he was a member of the UK, Ireland and Southern Africa Board responsible for a $1.8bn business.
As well as a strong leadership background, Steve has advisory board experience and is currently a member of the National Data Steering Group advising Ministers. Before this he was a member of the Data Strategy Board and the Public Sector Transparency Board. He is also a member of the Nottingham University Business School Advisory Board, and reviews MBA presentations and projects.

Membership of committees

- Finance and Performance Committee (Chair)
- Remuneration and Terms of Service Committee

Declaration of Interests

- Experian PLC - Managing Director, Strategic Development
- National Data Steering Group - Member
- Digital Catapult - Non-Executive Director

Prof. John Atherton

Joined the Trust Board on 1 April 2019

Non Executive Director

John is Pro Vice-Chancellor and Dean of the Faculty of Medicine and Health Sciences in the University of Nottingham. He oversees medical, allied health, veterinary and biological science education and research in the University. John is a practising Consultant Gastroenterologist and Professor of Gastroenterology with personal research and education interests in upper gastrointestinal disease.
John serves on the executive of the UK Medical Schools Council and works closely with other Midlands universities.

Membership of committees

- Quality Assurance Committee (Chair)
- Remuneration and Terms of Service Committee

Declaration of Interests

- Pro Vice Chancellor for the Faculty of Medicine and Health Sciences in the University of Nottingham
- Chairperson of Medical Schools Council UK
- Member of Midlands Health Innovation which represents the interests of research-intensive Universities in the Midlands
- University of Nottingham is the joint lead university for education and research at the National Rehabilitation Centre at Stamford Hall
- Wife is Deputy Medical Director at NUH

Mrs Anita Day

Joined the Trust Board on 15 April 2019

Non Executive Director

Anita has significant experience as a Chartered Accountant, executive leader and business coach and Board-level experience spanning the private, public and third sectors.
Anita was the European Culture Transformation Leader for IBM Global Business Services 2015-2018. Prior to this, she was Leader of L&K Learning Consultants for GBS Europe Responsibilities, and Global Learning and Channel Enablement Leader, also for IBM Global Services. Anita's earlier experience includes practising as a qualified Chartered Accountant with Hays Allan, a partner in Hill Day Chartered Accountants and Founder and CEO of Adlibs Professional Courses Ltd.
Anita has a track record and expertise of driving transformation across large, complex organisations, as well as delivering improvements in culture transformation, change leadership, inclusion and workforce strategy, cross-system engagement and NHS Trust Strategy and Governance.

Membership of committees

- People and Culture Committee (Chair)
- Audit Committee
- Remuneration and Terms of Service Committee

Declaration of Interests

- Non-Executive Director - Worcestershire Acute Hospitals Trust
- Principle - Anita Day Consulting
- Associate - Steps Drama Learning Development
- Good Governance Institute – Well Led Reviews

Mrs Clare Urmston

Joined the Trust Board on 1 January 2020

Non Executive Director

Clare is currently the Chief Financial Officer of Anemoi Marine Technologies Limited and sits on the ICAEW Business Committee. Clare's former roles include Chief Finance Officer of Mamas and Papas Limited and Symingtons Limited, Interim Chief Finance Officer of Wilko Retail Limited and Finance Director of W'Innovate Limited. Clare qualified with KPMG in 2002 and was awarded an ICAEW Finance Director Excellence award in 2013.

Membership of committees

- Finance and Performance Committee (Deputy Chair)
- Audit Committee (Deputy Chair)

Declaration of Interests

- Chief Financial Officer - Anemoi Marine Technologies Limited
- Business Committee Member - ICAEW

Mr Craig Wilcockson

Joined the Trust Board on 1 January 2020

Non Executive Director

Craig has over 15 years of experience in employee engagement, business and cultural change, talent management and organisational development gained in a variety of large national and international businesses. He is currently Group People Director for the Orbit Group, which he started in April 2017.

Membership of committees

- Finance and Performance Committee
- People and Culture Committee (Deputy Chair)

Declaration of Interests

- Executive Director - Orbit Group Limited

Mr Mark Chivers

Joined the Trust Board on 1 February 2020
(previously an Associate Non-Executive Director)

Non Executive Director

Mark is the Senior Independent Director and has 17 years' experience at Board level in both the private and public sector, including as Director of Estates at Boots UK, Director of the Nottingham Enterprise Zone for Walgreens Boots Alliance and Director of Shared Services for Alliance Boots.

Membership of committees

- Audit Committee (Chair)
- Remuneration and Terms of Service Committee
- Quality Assurance Committee

Declaration of Interests

- 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.

Professor Maggie Boyd

Joined the Trust Board on 1 April 2020

Non Executive Director

Maggie Boyd joined our Board on 1 April 2020. Maggie has over 40 years of NHS experience in clinical and leadership roles. Clinical experience as a nurse, midwife and health visitor coupled with her Executive Director roles in provider and commissioning organisations, she brings a wealth of experience to complement the board skills and expertise. Latterly she has worked as a Regional Director in NHS Improvement with regulatory experience and particularly oversight of quality governance and leadership in NHS providers across Midlands and East. She has a track record in driving improvements for patients and has led and developed quality governance systems supporting staff to have ownership for improving standards of care for patients and communities. Maggie is very committed to improving staff experience and developing leaders to face complex challenges across health and social care.
Of her appointment, Maggie said: "I am delighted to be joining the board and committed to driving improvements for staff and patients at a key point for Nottingham University Hospitals and the local community. I look forward to meeting and working with you all over the coming years.

Membership of committees

- People and Culture Committee
- Quality Assurance Committee (Deputy Chair)

Declaration of Interests

- Maggie Boyd Consulting Ltd - Executive coaching and Board development
- Effective Leadership Solutions hosted by Arden and GEM Commissioning Support Unit – leadership support/ consulting
- Honorary Professor, De Montford University
- An Associate for Value Circle
- Sister is Fran Steele at NHS Improvement

Voting Board members - Executive Directors

Mrs Tracy Taylor
Chief Executive

Tracy joined NUH as Chief Executive on 30 October 2017. She trained as a nurse in Birmingham and held a number of community nursing posts around the city before progressing into managerial roles within the NHS and is a registered general nurse, health visitor and school nurse. Before joining NUH, Tracy held Chief Executive roles at Birmingham Community Healthcare NHS Foundation Trust and Black Country Partnership NHS Foundation Trust.

Membership of committees
- Committee to Appoint Executive Directors
- Finance and Performance Committee
- People and Culture Committee
- Quality Assurance Committee

Declaration of Interests
- NHS Providers Board - Member

Mr Rupert Egginton
Chief Financial Officer/
Deputy Chief Executive

Rupert is Chief Financial Officer and Deputy Chief Executive. He qualified as an accountant in 1992 and has held roles as Finance Director of Northampton General Hospital and of East Kent Hospitals University NHS Foundation Trust. He took up his current post on 1 January 2011.

Membership of committees
- Finance and Performance Committee

Declaration of Interests
- J.T. Egginton Ltd - Director
- Hospital Pharmacy Services (Nottingham) Ltd - Director

Dr Keith Girling
Medical Director

Keith is a consultant in critical care medicine. He provides medical professional advice to the Board and has lead responsibility for the professional standards of the hospital's medical staff, teaching and research, and quality governance.

Membership of committees
- Quality Assurance Committee
- Finance and Performance Committee

Declaration of Interests
- Pharmacy Director for Hospital Pharmacy Services (Nottingham) Ltd, effective 1 February 2019

Ms Sarah Moppett
commenced in this role on 1 January 2021
Interim Chief Nurse

Sarah was appointed as Interim Chief Nurse in January 2021. She has been Deputy Chief Nurse at NUH since 2018. Her clinical background is predominantly in surgery and gastroenterology, including posts as a ward sister and clinical nurse specialist, followed by over 15 years of senior nursing leadership experience.

Membership of committees
- Quality Assurance Committee
- People and Culture Committee

Declaration of Interests
- Husband is Iain Moppett, Professor of Anaesthesia and Perioperative Medicine at University of Nottingham

Ms Lisa Kelly
commenced in this role on 1 August 2019
Chief Operating Officer

Lisa was previously Chief Operating Officer at University Hospitals of Coventry and Warwickshire NHS Trust and has previously worked in senior Operations and General Management roles at a number of Trusts. She has also worked as an Operational Manager at University Teaching Hospital in Zambia.

Membership of committees
- Finance and performance Committee
- People and Culture Committee
- Quality Assurance Committee

Delaration of Interests
- None

Ms Mandie Sunderland
Chief Nurse

Membership of committees
(until December 2020)
- People and Culture Committee
- Quality Assurance Committee

Non-voting Board members - Associate Non-Executive Directors

Ms Sardip Sandhu

Joined the Trust Board on 1 January 2020

Associate Non-Executive Director (non-voting)

Sardip brings with her over 20 years general management and commercial experience, latterly in organisational strategy and transformation roles, focusing on operational capability and change, at global Health and Beauty company Walgreens Boots Alliance. She has public sector experience and is currently Vice-Chair of the Corporation board at West Nottinghamshire FE College.

Membership of committees

- Finance and Performance Committee
- Quality Assurance Committee

Declaration of Interests

- Non-Executive Director - West Nottinghamshire College
- Director - Vidiya Consulting Services Ltd
- Non-Executive Director, University Hospitals of Derby and Burton NHS Foundation Trust

Mrs Serbjit Kaur

Joined the Trust Board on 2 November 2020

Associate Non-Executive Director (non-voting)

Serbjit Kaur has over 35 years expertise within the public healthcare sector, both as a clinician and in provided professional and clinical leadership to dental profession in England. Clinical experience as a dentist, along with Executive roles in both the Department of Health and NHS England, she brings a broad range of experience and expertise. Serbjit is committed to improving quality and the experience of all patients and staff. Serbjit currently sits on the Statutory Assurance Panel for the General Dental Council and is a partner in two dental practices. On her appointment Serbjit said: "It is a privilege to be joining the Trust Board at Nottingham University Hospitals and I look forward to collaborating with the team to bring about improvements for local people and staff."

Membership of committees

- Audit Committee
- People and Culture Committee

Declaration of Interests

- Parkview Dental Practice - Partner
- Glen Parva Dental Practice - Partner
- General Dental Council - Statutory Assurance Panel Member
- Academy of Sikh Studies - Volunteer
- Leicester University - Faith Advisor

Ms Natalie Sigona

Left this role on 26 September 2020

Associate Non-Executive Director

Membership of committees

(until September 2020)

- Audit Committee
- People and Culture Committee

Non-voting Board members - Executive Directors

Ms Michelle Rogan
Director of Corporate Governance

Michelle brings to the Trust almost 30 years' experience as a nurse and manager, and a track record of delivery across a number of areas including governance, risk management, compliance and regulation and performance and operations. She held several roles at Birmingham Community Healthcare NHS Foundation Trust, including Corporate Governance Director, Associate Director of Compliance and Assurance and Associate Director of Risk and performance.

Membership of committees
- Quality Assurance Committee

Declaration of Interests
- None

Ms Alison Wynne
Director of Strategy and Transformation

Alison has significant experience in commissioning, planning, partnerships, transformation and strategy. She was previously an Executive Director of Strategy and Partnerships at Burton Hospitals NHS Foundation Trust for four years where she led on the merger of Derby and Burton Hospitals which took effect on 1 July 2018.

Membership of committees
- Finance and Performance Committee

Declaration of Interests
- Partner is Executive Medical Director at University Hospitals of Derby and Burton NHS Foundation Trust

Ms Tiffany Jones
Director of Communications

Tiffany was previously Deputy Director of Communications and Engagement at the University Hospitals of Leicester NHS Trust. Her NHS career spans 20 years, with 15 of those in a leadership role. Tiffany joined the NHS in 1999 gaining experience in commissioning organisations in Hampshire, before moving to Hampshire Ambulance Service in 2003.

Membership of committees
- People and Culture Committee

Declaration of Interests
- None

Dr Neil Pease
Chief People Officer

Neil has worked in the NHS for over 25 years. He was Director of Organisational Development and Workforce at Northern Lincolnshire and Goole Foundation Trust, with his more recent role was as Executive Director of Workforce and Organisational Development at the University Hospitals of Derby and Burton NHS Foundation Trust.

Membership of committees
- People and Culture Committee

Declaration of Interests
- Provides consultancy advice to Clinician Connected (subsidiary company of the University Hospital of Derby and Burton NHS Foundation Trust) – this is unpaid
- Provides consultancy service to Globis Mediation Group

Committees of the Board

The Board can delegate and make arrangements to exercise any of its functions through a committee, sub-committee or other group, such as a task and finish group.

During 2020/21, there were eight committees of the Board:

- Advisory Appointments Committee
- Audit Committee
- Finance and Performance Committee (formerly Finance & Investment Committee)
- People and Culture Committee (formerly People Committee)
- Quality Assurance Committee
- Remuneration and Terms of Service Committee
- Appointment of CEO Committee
- Appointment of other Executive Directors Committee

The latter two committees are set up solely for the appointment of the CEO and other Executive Directors.

The Board approves the terms of reference which detail the remit and delegated authority of each committee. Committees routinely provide a report to the Trust Board showing how they are fulfilling their duties as required by the Board and highlighting any key issues and achievements. The role of each committee is outlined in the Annual Governance Statement section of the Annual Report.

Committee Structure

Board Meetings

The Board routinely meets seven times a year in public and in private, as well as holding three additional Board development sessions. The Board met on twelve occasions during 2020/21. The agenda, minutes and papers for the public Board meetings are available on our website: www.nuh.nhs.uk.

The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation of powers details what types of decisions can be delegated to Board committees and sub-groups.

Annual Public Meeting

Our annual public meeting for the year ending 31 March 2020 was held on 30 July 2020 via MS Teams, due to the restrictions in place as a result of the Covid-19 pandemic.

We shared some of our achievements during the year in relation to our finances, quality and safety and performance. Our Chief Executive shared our focus for 2020/21 and future objectives.

Attendance

The table below summarises Board Members' attendance at Board Meetings together with Committee Members' attendance at their respective Committees for 2020/21.

Members		Trust Board and Committees					
		Trust Board	Audit Committee	Quality Assurance Committee	Finance and Performance Committee	People and Culture Committee	Remuneration and Terms of Service Committee
		(Possible/ Actual)					
Mr Eric Morton	Chair	12/12	X	X	X	X	2/2
Mr Steve Thomas	Non-Executive Director/ Deputy Chair	10/12	X	X	11/12	X	2/2
Professor John Atherton	Non-Executive Director	12/12	X	12/12	X	X	2/2
Mrs Anita Day	Non-Executive Director	11/12	3/6	X	X	10/10	2/2
Ms Clare Urmston	Non-Executive Director	12/12	6/6	X	12/12	X	x
Mr Craig Wilcockson	Non-Executive Director	12/12	X	X	10/12	9/10	x
Mr Mark Chivers	Non-Executive Director	11/12	6/6	12/12	X	X	2/2
Ms Maggie Boyd	Non-Executive Director	12/12	X	12/12	X	9/10	x
Ms Sardip Sandhu	Associate Non-Executive Director	12/12	X	12/12	12/12	X	x
Mrs Serbjit Kaur	Associate Non-Executive Director	3/3	3/3	X	X	4/4	x
Ms Tracy Taylor	Chief Executive	12/12	X	11/11	9/9	6/6	x
Mr Rupert Egginton	Chief Financial Officer and Deputy Chief Executive	11/12	X	X	12/12	X	x
Dr Keith Girling	Medical Director	12/12	X	12/12	10/12	X	x
Ms Sarah Moppett	Chief Nurse (Interim)	2/2	X	3/3	X	1/2	x
Ms Lisa Kelly	Chief Operating Officer	11/12	X	9/12	8/12	7/10	x
Ms Michelle Rogan	Director of Corporate Governance	12/12	X	12/12	X	X	x
Ms Alison Wynne	Director of Strategy and Transformation	10/12	X	X	10/12	X	x
Ms Tiffany Jones	Director of Communications and Engagement	12/12	X	X	X	9/10	x
Dr Neil Pease	Chief People Officer	12/12	X	X	X	8/10	x
Ms Mandie Sunderland 1	Chief Nursing Officer	7/8	X	7/9	X	5/7	x
Ms Natalie Sigona 2	Associate Non-Executive Director	6/7	3/3	X	X	5/5	x

1 Retired on 31 December 2020
2 Left on 26 September 2020

Register of interests

We are required to hold and maintain a register setting out details of any company directorships and/or significant interests held by Board members, which may conflict with their responsibilities as Trust Directors. At each meeting of the Board and its committees, a standing item requires all executive and non-executive directors to make known any interests in relation to the agenda and any changes to their declared interests. The register is held by the Director of Corporate Governance and is available for public inspection via our website at https://www.nuh.nhs.uk or by contacting:

Director of Corporate Governance

Nottingham University Hospitals NHS Trust

Trust Headquarters, 3rd Floor

City Hospital Campus

Hucknall Road

Nottingham NG5 1PB

Openness and Accountability

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

NHSE/I 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.

Anti-fraud and corruption statement

One of the fundamental objectives of public sector organisations is the appropriate use of public funds. The vast majority of people who work in the NHS are honest and professional; they believe that fraud and bribery are wholly unacceptable. Besides the impact on professional morale, bribery and fraud ultimately leads to a reduction in the resources available for patient care.

NHS Counter Fraud Authority (NHSCFA) and Nottingham University Hospitals NHS Trust are committed to taking all necessary steps to prevent fraud, bribery and corruption or, failing that principal objective, detect it early to minimise the consequences.

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
- To support key individuals and departments involved in the development and implementation of our bribery prevention procedures.

Modern Slavery Act 2015

Nottingham University Hospitals NHS Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015 and we expect our staff and suppliers to comply with the legislation.

We have relevant policies in place and ensured that training about slavery and human trafficking is available to staff through the safeguarding team. You can read our latest progress statement, republished in March 2021, on our website here: https://www.nuh.nhs.uk/modern-slavery-act.

Fit and Proper Person Test

All Board members have been assessed against the requirements of the Fit and Proper Person Test in 2020/21.

Directors' disclosure

Each Director knows of no information which would be relevant to the auditors for the purposes of their audit report and of which the auditors are not aware and has taken all the steps that he/she ought to have taken to make himself/herself aware of any such information and to establish that the auditors are aware of it.

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 organisation. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

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

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed
Tracy Taylor
Chief Executive
Date: 10 June 2021

Annual Governance Statement 2020/21

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*.

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 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The organisation has a Risk Management Strategy and Policy in place. We continue to ensure that its risk management arrangements receive the appropriate level of leadership and management. At the strategic level, our Board Assurance Framework (BAF) provides a current view around the principal risks to achieving our strategic objectives. It enables us to assess and evaluate whether we have the appropriate controls and assurances in place, to be able to identify any gaps in controls and assurances and identify planned actions to address these.

Each of our BAF risks are assigned to executive directors and to a Board Committee. During the year, the BAF was regularly updated and reviewed by the Board, as well as the Audit Committee.

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 we operate our activities in compliance with all relevant statutory requirements. The Director of Corporate Governance has responsibility for the implementation of the Risk Management Strategy and for ensuring we have effective processes in place for the management of risk. Risk appetite is determined by the Board which is clearly documented within the Trust Risk Management Strategy.

At the outset of the Covid-19 pandemic, we recognised the need to ensure that its governance structure would enable a prompt response to the significant change in circumstances. The risks associated with this have been closely monitored and added to the risk register. Several measures were either introduced or adapted from existing governance mechanisms to achieve this;

- The Trust Board approved changes to its delegated authority powers in the Standing Orders to ensure that decisions could be made appropriately for rapid deployment of resources.
- The Trust adopted an approach to continue to hold its Board Meetings with a focussed agenda and virtually. The approach to Board Committee meetings was also to continue to hold these with streamlined agendas. This approach was mirrored across all governance and risk committees in order to provide a sharper focus on the management of risk whilst reducing the burden around routine reporting.
- In addition to standing up its Critical and Major Incident Plans and associated command and control structures; we also established a Covid-19 Strategic Oversight Group chaired by the Chief Executive in order to steer the Covid-19 response with direct inputs and reporting from the

tactical response. The Strategic Oversight Group continues to manage and oversee the Covid-19 Significant Risk Register and associated actions and assurance. Covid-19 risks scoring 20 or above have also been added to the Trust Significant Risk Register to ensure transparency of reporting and subsequent organisational management and oversight.

- Regular telephone briefing was held between the Chief Executive, the Chair and the Non-Executive Directors to enable the Non-Executive team to be kept up to date with the changing position on Covid-19 and to enable the Non-Executive Directors to ask questions of the Chief Executive in relation to the impact of Covid-19 on the organisation.

The approaches described above enabled the organisation to maintain control over its decision making and governance during the financial year as the impact of the Covid-19 pandemic was felt.

Risk management training is provided to staff in order to equip them to manage risk in a way proportionate to their authority and duties. In addition, a range of risk management resources are accessible via our intranet along with the contact details for the specialist advisors within the organisation who can support managers and staff with specific risk management issues.

Our Local Counter Fraud service ensures that the annual counter fraud work programme minimises the risk of fraud within our organisation and is compliant with the NHS Counter Fraud Authority Standards.

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 Risk Management Strategy clearly sets out the accountability, roles and responsibilities, committee structures and arrangements for the identification, management , control and reporting on risk.

The Risk Management Strategy also set out the Risk Appetite decided by the Trust Board, which is applied to risks and challenged as part of the ongoing confirm and challenge through the Trust's designated risk committees.

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.

In order to aid prioritisation we assess risks using a standardised 5 x 5 Consequence and Likelihood scoring tool giving a range of risk scores from 1 to 25.

All risks are recorded in our Risk Management System Datix and banded into the following risk categories

1-3 Very low scoring risks
4-9 Low scoring risks
10-12 Moderate Risks
15-16 High Risks
20-25 Significant Risks

Throughout the financial year, we continued our work to embed risk management in the organisation in the following ways:

- For all approved 20 and 25 significant risks; the associated risk assessments (including any controls) are recorded in the Significant Risk Register (SRR) and are 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 are monitored via the relevant risk committee (high risks) or through divisional governance forums (moderate, low and very low risks).
- Executive Directors regularly review the BAF to ensure that appropriate action is being taken against key risks to our strategic objectives and the Board formally reviews the BAF at its meetings in public. The BAF supports the process for monitoring ongoing compliance with the requirements for registration set by the Care Quality Commission.
- During the year, the Board Committee Chairs reported to the Board and escalated issues as appropriate. Individual committee reports are a standing Board agenda item. The practice of having a standing item for the escalation of issues to the Board on committee agendas has helped ensure systematic consideration by all committees about emerging key risks the Board needs to consider.
- 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 our staff, services and premises. All of our policies require an equality impact assessment and these are integral to the policy documents.

We are committed to continuous improvement and learning from incidents and complaints, outcomes from audits and the experiences of patients and staff.

We had put together a Covid-19 restoration and recovery plan which has been supported by Management Board, based on establishing a 'new norm'. Our goals for restoration and recovery throughout 2020/21 are to safely provide sufficient capacity/services to manage Covid-19 and non-Covid-19 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.

We acknowledge that in order to achieve its objectives some risk is acceptable whereas in other scenarios it must be rigorously avoided. We use the risk appetite classification below in considering its decision making and assurance process for classification of risk.

Appetite	Descriptor	Risk Appetite	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 this area to realise the potential rewards	**15-25**	
Moderate	Willing 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**	People Potential Partners
Cautious	Preference 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 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**	

Strategic Risks

The strategic risks have been developed to take account of the deliverables in the Annual Plan for 2020/21 with consideration to the impact the coronavirus pandemic has had in the 2020/21 financial year. Each individual strategic risk has actions associated with it which support the delivery of our Strategic Objectives - Patients, People, Places, Performance, Partners and Potential, to bring the risk to the target level. These form the BAF which is regularly monitored at Board and relevant Board Committees.

Objective 1: Patients **We will ensure our patients receive consistently high quality, safe care with outstanding outcomes and experience**	
Strategic risks	**How they are mitigated (summary)**
Risk 9223: If we do not take account of the impact of the coronavirus pandemic and broader health issues in the provision of services then patients may suffer harm.	There are a number of strong controls in place to support mitigation of this risk in relation to current factors that are known to potentially cause harm.
Risk 9224: If we do not adequately adapt our ways of working to reduce the risk of Covid-19 infection, then we may cause harm to patients who access our services.	The Trust has effective Infection Prevention and Control policies and controls in place and receives strong assurance from NHSE/I and Public Health England (PHE) on the steps that it is taking to prevent, manage and control infection.
Risk 9225: If we do not identify learning and make sustainable improvement from incidents, complaints, claims and inquests we may cause undue or preventable harm.	The Learning Strategy is under review. Its Implementation will reduce the strategic risk to the agreed tolerance level.
Risk 9204: If we do not effectively engage with patients and the public to agree how their needs will be best met then we may not benefit from transformed services and deliver timely care and treatment.	A co-produced Patient Involvement Strategy is in development that will bring this risk score into agreed tolerance levels.
Risk 9248: If we do not implement a positive leadership and safety culture across Maternity Services then we may not deliver a consistently safe and effective service resulting in poor patient experience and continued regulatory activity.	A number of immediate safety actions are in place. A maternity transformation programme will ensure sustainability of the maternity improvement plan.
Objective 2: People **We will build on our position as an employer of choice; with an engaged, developed and empowered team that puts patient care at the heart of everything it does**	
Strategic risks	**How they are mitigated (summary)**
Risk 9207: If we do not address staff wellbeing, both in the long term and from pressure of the Covid-19 pandemic, then we may have insufficient staff to deliver services and a poor reputation as an employer which may impact on recruitment.	The existing comprehensive staff wellbeing offer continues to be provided along with more recent developments linked to supporting staff through the pandemic such as psychological first aid training.
Risk 9208: If we do not address the challenges the pandemic has presented within regards to training and development, including changes to how we are able to educate staff and how to cope with additional training demands, then staff may not have the requisite skills to deliver essential services.	There has been a concentrated effort to transfer as much training as possible to an on-line offer, some permanent and some temporary. Over 300 laptops have been issued to support access to on-line learning. Where required, face to face training is being delivered.
Risk 9209: If we do not overcome the ongoing challenges with regards to the recruitment of staff, including the immediate issues the pandemic has presented, we may not have adequate staffing with appropriate skills, and may not be able to deliver our operational performance or deliver safe, high quality and effective care to our patients.	There are a number of initiatives in place including the recruitment of international nurses and nursing pipeline roles. Divisions have been given recruitment targets for apprenticeships and we continue our widening participation work.
Risk 9476: If we fail to sustain the positive changes in organisational culture and minimise the causes/triggers of a negative Trust culture, then we may fail to engage, attract and retain sufficiently qualified, skilled and	Chief People Officer is incorporating the Culture and Leadership Plan into the People Plan. This is due to go to Trust Board in November 2021 for sign off. Culture and leadership action plan has now been divided into six key work streams to support and

experienced staff to sustain the delivery of safe, effective high quality compassionate treatment and care.	enable delivery. Following feedback these will be signed off at Culture and Leadership Committee in July 2021 and implementation will begin.

Objective 3: Places **We will invest in our estate, equipment and digital infrastructure to support the delivery of high quality patient care**	
Strategic risks	**How they are mitigated (summary)**
Risk 9210: If we do not invest in our estate, we may not have safe premises that are fit for the delivery of high quality care we may cause harm to patients and staff.	The March 2018 Estate Strategy set out a 10-year plan to manage our premises and invest in them.
Risk 9211: If we do not mobilise capacity in an agile way then we may not deliver against capital investments and benefit from the improvements that will deliver improvement in the quality of care.	The Estate strategy and Tomorrow's NUH are aligned in process as one iteratively feeds the other. As we develop our annual capital plans we consider our procurement and contracting options according to performance, scale and capacity.
Risk 9212: If we do not optimise our technological infrastructure we may not realise opportunities to deliver efficient and productive health care.	We have secured a share in £5.5m to replace our biggest divisional system risk. We have secured £1.2m external funding to support the ongoing inpatient digitisation programme.
Risk 9251: If we do not have the right people, at the right time with the right technological knowledge and information we may not maximise the benefits from new ways of working.	We have been exploiting the technologies we have available to improve reporting. We will work through the development of a sustainable support infrastructure for the technologies we now offer and ensure the training and user solutions are in place to effectively exploit the technology.
Objective 4: Performance **We will consistently achieve our performance standards and make the best use of resources to contribute to an affordable healthcare system**	
Strategic risks	**How they are mitigated (summary)**
Risk 9213: If we do not implement a clear and consistent performance management and accountability framework we may not improve and meet our statutory and regulatory standards.	Progress has been made on the performance framework review and the Financial and Investment Committee has reassessed its terms of reference and altered its remit to become the Finance and Performance Committee.
Risk 9214: If we do not have access to accurate, timely data and do not have the ability to interpret correctly then we may not make informed decisions.	The new Director of Performance and Information will reassess this risk and the plans to mitigate it.
Risk 9226: If we do not embrace and embed new ways of working developed during the pandemic then we may not sustain the improvements made to our performance standards.	A number of new ways of working were established at pace during the initial phase of the pandemic. System partners continue to work tirelessly together to expedite discharge and we remain committed to ensure that there is a shared understanding of delays so plans can be agreed.
Risk 9215: If we do not implement robust systems for financial management then we may not deliver against our statutory financial targets.	The Trust met its statutory duty to break even for the first six months of this financial year, alongside all Trusts, due to the financial regime implemented by NHSI during the pandemic. Weekly meetings are ongoing with the regional NHSI/E Team to identify ways to materially reduce the system deficit.
Risk 9216: If we do not identify and eliminate waste across our services, we will fail to make best use of our resources and limit the choices we have over improvements to, and investments in, patient care and associated supporting technologies.	Improvement in the score between quarter 2 and quarter 3 has been achieved through the work being undertaken by the Improvement and Transformation Team across three priority areas.

Objective 5: Partners 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	
Strategic risks	**How they are mitigated (summary)**
Risk 9217: If we do not continue to strengthen our system partnership and leadership within the ICS we may not effectively implement the integrated system-wide arrangements needed to meet the needs of the population alongside the existence of Covid-19.	The Trust is proactively investing in ICS, ICP and bi-lateral partnerships to continue to progress priority areas that will positively impact achievement of the Trust's strategic objectives and the priorities agreed for the ICS.
Risk 9218: If we do not identify and develop the right partnerships then we may fail to fully benefit from collaborative working and transformation opportunities and subsequent benefits.	We have strengthened our collaborative arrangements with a number of key partners and given the national and regional focus on specialised services.
Objective 6: Potential **We will deliver world-class research and education and transform health through innovation**	
Strategic risks	**How they are mitigated (summary)**
Risk 9205: If we do not develop our quality improvement methodology sufficiently and support our staff through building the necessary capacity, capability and culture for improvement then we may limit improvement.	Significant progress has been made in addressing part of the risk with a well establish governance process, programmes of improvement work and aligned structured training programmes all framed within defined strategic plans that align.
Risk 9220: If we are unable to recruit to clinical trials then we may reduce the opportunities for patients to benefit from innovative treatments.	We have strengthened our collaborative arrangements with a number of key partners and given the national and regional focus on specialised services.
Risk 9219: If we do not identify the limitations of virtual educational programmes and develop ways to address then we may not produce fit for practise clinical staff.	This risk was fully mitigated in Quarter 3.

The Board and its committees

The role of the Trust Board, Board and Committee membership and attendance record are detailed under the Directors' Report.

The Board is the accountable body for risk and is responsible for ensuring the organisation has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems throughout the organisation.

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

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 Committee considered diverse range of subject matter this year. Commensurate with its terms of reference, it has received and reviewed an extensive number of assurances and, subject to the further actions which it has requested during meetings, has been satisfied by the evidence that it has received.

The Chairs of the Finance and Performance, People and Culture and Quality Assurance Committees presented their annual reports, which included providing an overview of the topics that each committee had considered throughout the year, discussions around the Board Assurance Framework and highlighting any issues of concern.

Finance and Performance Committee

The remit of the Finance and Performance Committee (FPC) (formerly Finance and Investment Committee) was expanded to oversee performance management across all domains, although the Board will retain corporate responsibility for overall performance. The remit of the Board Committees for Quality and People and Culture have also been strengthened to support FPC with each having responsibility for gaining assurance on relevant aspects of performance. Additional key performance indicators have been developed to support oversight.

The Committee on behalf of the Board, monitors the achievement of the organsation's statutory financial duties, seeks assurance on the progress of the Financial Efficiency Programme, monitors the organisation's monthly financial performance, oversees the performance indicators of all Board Committees and supports the development of the annual plan and receives and considers business cases prior to approval to the Board. On a monthly basis the Committee also receives finance updates regarding the Integrated Care System.
The Committee met nine times during 2020/21.

The Committee received finance updates at each meeting for the previous month's financial priorities. This year these updates were primarily dominated by the impacts of Covid-19, including the financial regime implemented for the first half of the year, and the acceptance of claims raised against Covid-19 monies. It also received periodic updates in regard to the Performance and Places risks outlined within the BAF. Ongoing focus was placed on the progression of the Annual Plan in relation to the financial aspects, where progress was monitored at each meeting and assurance and actions progressed as needed.

People Committee

The remit of the People and Culture Committee is to provide assurance to the Board on the effectiveness of our arrangements for the leadership, engagement, recruitment, training, development and education of staff at Nottingham University Hospitals.
The Committee meets monthly, consistent with the requirements of its remit. It met nine times during 2020/21.

The Committee received assurance through:

- People Strategy and delivery plan
- Quarterly Mapping of the Annual HR Plan, People and Milestones
- People Metrics
- Equality, Diversity and Inclusion
- Safe staffing levels and agency spend
- Staff engagement
- Staff stories
- Deep dives
- Periodic updates in regard to the People risks outlined within the BAF
- Horizon scanning
- Leadership and culture programme.

Quality Assurance Committee

The Committee reviews and provides assurance to the Board on the effectiveness of the organisation's arrangements for quality, ensuring that there is a consistent approach throughout the Trust.

The Committee, on behalf of the Board, receives and challenges assurances provided relating to the adequacy, compliance and robustness of our governance and risk management activity and processes.

The Committee meets monthly, consistent with the requirements of its remit. It met twelve times during 2020/21.

The Committee received reports concerning all the principal areas within its annual programme of work and sought additional information where further assurances were felt to be required or where there were areas of concern.

In particular, the management and impact of Covid-19 and maternity services were frequently and rigorously debated.

The Committee was also observed by the Good Governance Institute during the year and feedback received had been positive.

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.

Register of Interests and Gifts and Hospitality

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

Quality governance arrangements

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

We have 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 organisation'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.

Our 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 we describe our quality priorities in its quality account. Achievement of the quality priorities is monitored through our performance management arrangements, annual plan reports to the Board, and the Board assurance framework.

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

Clinical governance

Our Management Board reports to the Trust Board through the Chief Executive on the operational delivery and effectiveness of the organisation'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, we have 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.

CQC registration

We have had a peer review system in place for a number of years. This is used to assess compliance with the CQC's standards of quality and safety within all specialties across the organisation on a regular basis. Reports from these peer reviews are reported to the Board Quality Assurance Committee.

There is a plan to review this process in 2021/22 in order to ensure it remains fit for purpose in providing a robust self-assessment of our compliance with the standards.

In October 2020 our maternity services were inspected by the CQC, resulting in the imposition of conditions on our registration under sections 29a and 31 of the Health and Social Care Act due to concerns about risk of harm to women and babies.

The CQC identified significant concerns, particularly in relation to systems and processes to ensure suitably qualified and competent medical and midwifery staffing and governance of services to ensure the safety of women and babies.

We have developed a comprehensive Maternity Improvement Plan and an executive led oversight structure to ensure delivery of the required improvements.

Well-led assessment

We were assessed for the quality of its leadership by the CQC in January 2019 and rated as 'Good' in the well-led domain.

NHS Trusts are required to undertake an external Well-led development review every 3 years as part of the NHS Improvement well led framework requirements. A review was undertaken in this year with good assurance provided on many aspects of the well-led key lines of enquiry. The Trust Board is developing as action plan in response to the recommendations.

Pensions

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Sustainable Development

We have undertaken risk assessments and have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). We ensure that its obligations under the Climate Change Act and Adaptation Reporting requirements are complied with.

Equality, diversity, and human rights

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. We have an established process to ensure that equality and diversity and human rights is embedded in its policy development process. All new, and reviewed, policies have an equality impact assessment completed, which is considered by the approving committee and Trust Board (where applicable).

We regularly engage with staff for feedback on their experience at the organisation 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 our annual report.

Workforce strategies and staffing systems

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

The Chief People Officer attends the Nottinghamshire People and Culture Board on behalf of the organisation, to oversee achievement of the Integrated Care System (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. Additionally we have key senior representation on other ICS subgroups and delivery groups to include Nursing and Midwifery Cabinet, Allied Health Professional Cabinet, Medical, Pharmacists and Medical Scientists Cabinet, Learning and Development Partnership and Clinical Reference groups.

We have 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 our organisation and to support Divisions in the development of their plans.
Given the operational pressures linked to the pandemic PIPG has met less frequently and the annual planning process (which includes a people planning element that the PIPG would contribute to) was put on hold. However, PIPG have supported:

- Creation of a recovery plan linked to NHSE/I 'phase 3 recovery planning
- Oversight of progress against the above plan
- A review of the workforce implications of the Tomorrows NUH project.

PIPG provide a quarterly update to the People and Culture Committee (a sub-committee of the Trust Board).

As part of annual planning an initial workforce submission for 2020/21 was made in Quarter 1 to the ICS to support a system workforce return to NHSE/I. The submission ensured 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.
Submissions were refreshed at both local and ICS level to NHSE/I, throughout the year to reflect Trust plans around restoration, recovery and supporting future Covid-19 peaks with additional templates completed as required to remodel workforce need.
Progress against our workforce plan is measured through the People Management Committee with Board oversight.

Our Board Assurance Framework includes four strategic risks in relation to people. Each risk is mitigated by a detailed action plan. Progress against these plans is discussed regularly at the People Management Committee.
Our Risk Management Committee oversees the management of our 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 four 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 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 and Culture Committee. A comprehensive report is provided every six months.
In terms of compliance with Developing Workforce Safeguards the following can be highlighted:

- For in-patient wards there is a well-established process of reviewing Nursing and Midwifery establishments every six months using the evidence based methodology for safe staffing as recommended by NHSE/I. The Chief Nurse signs off each review and is presented to Management Board for formal sign off. The latest Establishment review is due to be presented to Management Board in March 2021. Prior to Covid- 19 we were in the early stages of completing a Clinical Nurse Specialist review and had planned to review non-ward areas. We continue to report daily staffing safety via the Staffing App. However we are now in the roll out phases of SafeCare. SafeCare is additional software which links rosters, patient acuity and safety. The surgical division went live with the system from 15 February 2021. Medicine will be complete by mid-April 2021. SafeCare also supports efficient and effective staff deployment to ensure safety of all areas.
- 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 organisation 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.

  We have 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 and Culture Committee on a quarterly basis and the Board on an annual basis.

  We use Model Hospital workforce data to compare services with peer Trusts in terms of staffing and costs. Whilst there are issues with data quality in some areas, current data does not suggest that our headcount/staffing costs for nursing and midwifery, medical and AHP are significantly lower than our peers.

  We use 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).

Review of Economy, Efficiency and Effectiveness of the use of resources

The key processes that have been applied to ensure that resources are used economically, efficiently and effectively across the organisation involve a hierarchy of scrutiny of the use of resources throughout the organisation.

Accountability for economy, efficiency and effectiveness to the Board is delivered through its committee structure, most notably through the Audit Committee and Finance and Performance Committee.

The Audit Committee has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of our strategic objectives. The Committee receives and considers reports on all aspects of the organisation's systems of internal control, including reports from internal audit, reviews the

organisation's accounting policies and statutory accounts for submission to the Board. This is supported by the work of 360 Assurance (internal audit) to ensure that delivery of services takes place within a sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently.

The Audit Committee carries out an annual self-assessment of its performance and reports this formally to the Trust Board. The Committee reports to the Board and the Board seeks assurance from the Committee that it is satisfied that we are using resources in an efficient and effective manner.

The Finance and Performance Committee provide overall value for money assurance, including approving and performance monitoring of the organisation'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.

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 over the last year. We delivered a £16.5m reported surplus for 2020/21 before adjustment for: the impacts of impairment reversals £0.1m, the removal of capital donations and grants £7.3m, and the net impacted of PPE consumables donated by Department of Health £2.4m. This gave an adjusted financial performance total of £6.7m surplus, and enabled us to contribute towards the Nottingham and Nottinghamshire ICS also achieving a financial surplus.

The financial regime that has been in operation during 2020/21 has led to the suspension of normal activity based contract arrangements between providers and commissioners for the entire year. These have been replaced by system financial envelopes with block contracts based on actual spend from 2019/20 with additional incremental Covid-19 costs also reimbursed.

For the first six months of 2020/21 the financial framework included top up expenditure to enable providers to break even. This amended financial regime came with clear expectations that while finances should not be a barrier to managing the response to the pandemic, normal financial management and governance requirements should remain in place throughout, and that all claims for additional funding could be subject to external audit. The organisation amended its standing financial instructions to ensure it had a proportionate and timely response to review and authorise appropriate Covid-19 expenditure. It also amended its financial record keeping ensuring that a complete and transparent record of Covid-19 expenditure was available, with updates provided to the Finance and Performance Committee each month.

For the second half of 2020/21, the financial regime was changed to reflect policy expectations that the NHS would begin to recover from Covid-19 and to incentivise restoration and recovery of normal activity. While system envelopes and block arrangements remained, there was no longer a reimbursement of all reasonable costs to break even; systems were expected to operate within a financial envelope including most Covid-19 costs. The Trust's initial view of its likely second half deficit was £20m but through internal financial discipline and collaborative working with ICS and NHSEI colleagues, this has been improved to a second half surplus of £6.7m. Delivery of an overall surplus for the year has been possible due to additional funding being made available in relation to non-NHS income shortfalls arising from the pandemic.

Despite the ongoing impact of the pandemic, we have maintained robust financial management and investment governance procedures throughout the financial year. As the staged transition towards

business as usual began, we have also been able to deliver Quality Improvement and Waste Reduction efficiencies of £3.2m, in line with its plan.

We invested £95m in its capital infrastructure in 2020/21 in order to: improve the clinical environment, invest in its digital infrastructure, replace and enhance medical equipment whilst addressing specific needs arising from the Covid-19 pandemic. This was the largest annual capital programme since the inception of the Trust.

The normal NHS Finance regime was also changed from a cash perspective during 2020/21. To support the rapid response to the pandemic and ensure prompt payments, we have been receiving its block and core top up payments one month in advance, for the majority of the year. This has resulted in higher average cash balances and a concomitant reduction in PDC dividend. During the year, the policy decision to convert existing financial support from DHSC into a public dividend capital was enacted eliminating historical loan debt as of 31 March 2020.

A combination of the working capital movements along with some cash payments linked to the capital program taking place after the end of the financial year led to a year end cash balance of £126m.

Prior to the pandemic, NHS Improvement (NHSI) measures use of resources as part of the Single Oversight Framework (SOF). Due to the impact of the national funding measures, this basis would not have been representative of underlying performance in 2020/21, and so has not been applied.

The organisation maintained its reference cost of 99 in 2019/20, demonstrating that its costs are in line with national average costs. The Trust uses the reference cost benchmarking tool alongside the model hospital, Getting It Right First Time' (GIRFT) and other operational information, to highlight areas where there may be financial efficiency opportunities. Rapid improvement (Wave) events are used to design and implement change to both improve clinical and financial performance.

We use costing data and service line reporting across its service lines. This information is used to generate financial reports to support speciality and divisional financial management. Costing data is also used to drive more efficient practices across services.

The CQC inspection of our maternity service in October 2019 resulted in an inadequate rating. We subsequently approved investments within its maternity services to support the consequent improvement program and some service enhancements recommended within the Ockenden report; this included bringing its midwifery staffing levels in line with the new Birthrate Plus staffing model.

In accordance with section 5.1 of the Trust Standing Orders, the Trust Chair, Chief Executive and Chair and Deputy Chair of the Finance and Performance Committee (then the Finance and Investment Committee) approved an amendment to the Scheme of Delegation in response to the need to ensure both agile decision making and strong governance through our response to the Covid-19 pandemic. The urgent approval was that for an interim six month period or until the emergency period ends (whichever comes earlier), all expenditure orders or contract approvals exceeding £50,000 relating to Covid-19, whether capital or revenue in nature, can be signed off by members of the Covid-19 Executive Group or the Critical Incident Gold Command up to a limit of £1m. Any orders exceeding £1m would require Chief Executive sign-off, in line with the current Scheme of Delegation.

This decision was noted by the Board at its meeting on 30 April 2020.

Expenditure and income support for Covid-19 has been reported to the Finance and Performance Committee each month.

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 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 Performance 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

Information governance and data security

Information Governance

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

Data Security and Protection Toolkit

Data Security and Protection Toolkit (DSPT) requires NHS organisations to self-assess their compliance with current legislation and national guidance.

In 2020/21 we have continued to work on delivering the actions that were agreed as part of an action plan last year. Due to Covid-19 the final submission date for 2020/21 has been postponed again until end June 2021.

	2016/17	2017/18	2018/19*	2019/20	2020/21
Overall assessment	Satisfactory	Satisfactory	Standards not fully met (improvement plan agreed)	Standards not fully met (improvement plan agreed)	Submission delayed nationally due to Covid-19

In 2020 we were also subject to a consensual audit by the Information Commissioner's Office and achieved 'Reasonable' assurance on those scope areas reviewed. This provides a level of assurance that we have positive practices in place to protect personal data.

ICO Reported Incidents

Six IG incidents were reported to the Information Commissioner's Office and/or Department of Health and Social Care in 2020/21.

Category	2020/21	Action Taken
Unauthorised Access/Disclosure	6	No formal ICO action in any case.
Total	**6**	

All reported IG incidents/ breaches are assessed for severity in line to national guidance. Where data breaches meet the criteria to be reported to the Information Commissioner's Office, they are escalated to senior staff as appropriate. The IG Department ensure appropriate immediate action is taken, external reporting happens as appropriate, and that thorough investigations/ root cause take place and lessons learnt and implemented as identified.

Data Security

We have appointed a Cyber Security Manager who will lead strategy and response to new and emerging Cyber threats and attacks. Funding has also been approved for a specialised Cyber Security team to be created.

We have carried out an annual on-site assessment which was provided by Dionach /NHS Digital, which included a penetrations test and a Cyber Essentials Plus assessment. The two main areas for us to focus on are:

- Unsupported Systems – Applications
- Unsupported Systems – Operating Systems

We have formulated a strategic plan with our partners, suppliers, and colleagues, to address any legacy applications or systems and will be working to remediate throughout the next 12 months.

We have made significant investment in endpoints such as PCs, laptops, and mobile devices in the last 12 months partly due to the Covid-19 pandemic and partly to ensure that we migrate desktops to Windows 10. Over 91 per cent of our desktops now run Windows 10, and we have seen an increase of 30 per cent in the number of endpoints.

We have also undertaken a Backup review, a Cyber Security Culture review, and a policy review, in collaboration with NHS Digital and partners.

We continue to maximise the full value of investments already made including our ongoing network upgrade, our backup platform, and anti-malware suite of products; and make strategic procurements to improve our cyber posture.

Data quality and governance

It is recognised good data quality is required to enable us to accurately monitor performance. A Data Quality and Reporting Assurance Group, reporting to the Information Governance and Health 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

We use 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 51,000 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 (our 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. We use 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.

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.

Our 2021/22 Quality Account will be published by 30 June 2021. Prior to publication we will take a number of steps to assure itself of the accuracy of the account, including quality checks of the robustness of the data through our information governance processes; scrutiny of the report by the Trust Board, Joint Health

Scrutiny Committee, Nottingham and Nottinghamshire CCG and ICS, all of whom have been invited to comment on the account.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust that 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, Audit Committee and Quality Assurance Committee; and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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.

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: Audit Committee; Finance and Performance Committee; People and Culture Committee; Quality Assurance Committee; Quality and Safety Committee; Risk Management Committee; Information Governance and Records Committee; and The Trust Health and Safety Committee.

The internal auditors reported on 23 internal audit assignments during the financial year. Six completed during the year have been given a limited assurance opinion. Management actions have been agreed in response to these reviews, the implementation of which will be overseen by the relevant Directors and progress will be regularly reported to the Audit Committee. The Committee requests the attendance of senior management to its meetings to address issues in relation to internal audit outcomes and progress.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance and on the controls reviewed as part of the work that Internal Audit has undertaken.

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.

In providing this opinion the Head of Internal Audit considered three main areas:

- Board Assurance Framework and strategic risk management
- Internal audit plan out-turn
- Follow-up of internal audit actions.

At total of 23 Internal Audit reviews were reported to the Audit Committee during the year, six of which were provided with limited assurance. These related to the Data Security and Protection Toolkit; Medicines Prescribing; Mental Health Act; Duty of Candour; Clinical Coding; Overseas Visitors; Consultant Job Planning; Recruitment and Divisional Risk Management. One report was provided with a split assurance and this related to the Review of Compliance with NHS Employment Check Standards. The lead Directors for all of these reviews were requested to attend the Audit Committee meeting to provide assurance around actions being taken to address the recommendations made. Progress will be regularly reported to the Audit Committee.

Significant control issues

Covid-19

The Covid-19 pandemic has placed significant pressure on all services throughout 2020/21.

2020/21 has also seen a number of Covid-19 related risks emerging which have been documented and accounted for in our BAF and Significant Risk Register. Oversight of these risks remains a key priority with recognition that some risks will carry forward to the 2021/22 BAF.

Although we remain below the national standard for 62 day referral to treatment cancer care, we have maintained cancer activity levels throughout the pandemic, and have worked closely with local Independent Sector providers to secure additional capacity.

Controls required to minimise cross-infection throughout the pandemic, such as the need to segregate inpatients, socially distance ambulatory patients and avoid overcrowding in the Emergency Department, have placed further pressure on our resources. This has at times led to longer waits on our emergency pathway. Services and pathways have been reconfigured and redesigned to accommodate these requirements. Improvement plans for urgent and emergency care are in place and improving timely emergency access remains a top priority for us and our partners in 2021/22.

As a consequence of the pandemic, we have seen waiting lists and backlogs grow significantly across elective, diagnostic and cancer pathways which have been reflected in our risk management process. A recovery structure is in place which has supported the restoration of activity since the first wave of the pandemic and is focussed on maximising recovery of outpatient, diagnostic, elective and cancer activity throughout the pandemic.

Maternity

As described above (CQC Registration), in October 2020 our maternity services were inspected by the CQC, resulting in the imposition of conditions on our registration due to concerns about risk of harm to women and babies.

The CQC identified significant concerns, particularly in relation to systems and processes to ensure suitably qualified and competent medical and midwifery staffing and governance of services to ensure the safety of women and babies.

We have developed a comprehensive improvement plan and an executive led oversight structure to ensure delivery of the required improvements.

Conclusion

In conclusion I can confirm that there are two significant control issues which have been identified in my Annual Governance Statement above, both 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.

Signed

Tracy Taylor
Chief Executive

Date: 10 June 2021

Remuneration Report

The remuneration and staff report sets out our 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.

All disclosures in the remuneration report are consistent with identifiable information for 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 our Executive and Non-Executive Directors.

The 2020/21 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 2020/21. There were no payments to past directors or payments for loss of office.

Salary and Pension Entitlements of Senior Managers Remuneration

Name and Title	2020/21					2019/20					Notes
	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	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	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	All pension-related benefits * (bands of £2,500) £000	TOTAL (bands of £5,000) £000	
Executives											
Mrs T Taylor, Chief Executive	255-260	0	0	27.5-30	285-290	235-240	0	0	12.5-15	250-255	**
Mr R Egginton, Chief Financial Officer	235-240	0	0	0	235-240	190-195	0	0	0	190-195	1 **
Dr K Girling, Medical Director	205-210	0	0	82.5-85	290-295	195-200	0	0	25-27.5	220-225	
Ms L Kelly, Chief Operating Officer	155-160	0	0	12.5-15	170-175	95-100	0	0	75-77.5	175-180	2
Ms R Eddie, Acting Chief Operating Officer	0	0	0	0	0	40-45	0	0	0	40-45	3
Ms M Sunderland, Chief Nurse	115-120	0	0	0	115-120	155-160	0	0	0	155-160	4
Ms S Moppett, Interim Chief Nurse	30-35	0	0	20-22.5	50-55	0	0	0	0	0	5
Non-Executives											
Mr E Morton (Chair)	35-40	10	0	0	40-45	35-40	23	0	0	40-45	
Ms A Day	10-15	4	0	0	10-15	5-10	12	0	0	5-10	6
Ms C Urmston	10-15	0	0	0	10-15	0-5	2	0	0	0-5	7
Mr C Wilcockson	10-15	1	0	0	10-15	0-5	0	0	0	0-5	8
Mr M Chivers	10-15	0	0	0	10-15	0-5	0	0	0	0-5	9
Mr S Thomas	10-15	0	0	0	10-15	5-10	0	0	0	5-10	
Professor J Atherton	10-15	0	0	0	10-15	5-10	0	0	0	5-10	10
Ms M Boyd	10-15	0	0	0	10-15	0	0	0	0	0	11
Mrs J Pomeroy	0	0	0	0	0	5-10	0	0	0	5-10	12
Mr D Cartwright	0	0	0	0	0	5-10	0	0	0	5-10	13

Notes:

1. Rupert Egginton was appointed Deputy Chief Executive Officer on 14 January 2019
2. Lisa Kelly was appointed Chief Operating Officer on 1 August 2019
3. Rachel Eddie was appointed Acting Chief Operating Officer on 14 January 2019 until 31 July 2019
4. Mandie Sunderland retired as Chief Nurse on 31 December 2020
5. Sarah Moppett was appointed Interim Chief Nurse on 1 January 2021
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. Professor John Atherton joined the Trust Board on 1 April 2019
11. Maggie Boyd term of office as Non-Executive Director commenced on 1 April 2020
12. Julie Pomeroy's term of office ended on 31 January 2020
13. David Cartwright's term of office ended on 31 March 2020

There are no performance pay, long term performance pay or bonuses for the Directors in 2020/21

* 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.

** We 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.

Salary and pension entitlements of senior managers pension benefits 2020/21

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 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2020 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real Increase in Cash Equivalent Transfer Value £000	Notes
Mrs T Taylor, Chief Executive	0-2.5	2.5-5	95-100	295-300	2,027	2,140	78	
Mr R Egginton, Chief Financial Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1
Dr K Girling, Medical Director	5-7.5	2.5-5	90-95	225-230	1,791	1,955	103	
Ms L Kelly, Chief Operating Officer	0-2.5	0	20-25	0	172	196	0	
Ms M Sunderland, Chief Nurse	0	0-2.5	65-70	200-205	1,525	0	0	
Ms S Moppett, Interim Chief Nurse	0-2.5	0-2.5	30-35	70-75	497	592	18	

Notes:
We have no employer contributions for Partnership pension accounts
1. No pension disclosure is required for 2020/21 as the member is not pensionable in this current year.

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

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 in Nottingham University Hospitals NHS Trust in the financial year 2020/21 was £255,000 - £260,000 (2019/20 £235,000 - £240,000). This was 8.4 times (2019/20 7.9 times) the median remuneration of the workforce, which was £30,732 (2019/20 £29,817).
In 2020/21, four employees (2019/20 two) received remuneration in excess of the highest paid Director. Remuneration ranged from £6,023 to £388,935 (2019/20 £6,003 to £340,272)

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
In 2020/21, four (2019/20, four) employees received remuneration in excess of the highest-paid Director / member. Remuneration ranged from £290,000 to £390,000 (2019/20 £235,000 to £340,000).

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 organisation, 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 2021, 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 2020 and 31 March 2021, 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 2020 and 31 March 2021.

Summary of Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2021, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2021	82
The number that have existed for less than 1 year at the time of reporting	60
The number that have existed for between 1 and 2 years at the time of reporting	6
The number that have existed for between 2 and 3 years at the time of reporting	4
The number that have existed for between 3 and 4 years at the time of reporting	0
The number that have existed for 4 or more years at the time of reporting	12

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

For all off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day

	Number
Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	59
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	43
Number subject to off-payroll legislation and determined as out of scope of IR35	16
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll board member / senior official engagements

For any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number 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.	17

Severance and Exit Packages

Actual redundancy and other departure payments in the year were £17,000.
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 organisation has agreed early retirements, the additional costs are met by the organisation and not by the NHS pension's scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included here.

Reporting of compensation schemes - exit packages 2020/21	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	**1**
£10,000 - £25,000	-	1	**1**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**2**	**2**
Total cost (£)	£0	£17,000	**£17,000**

Reporting of compensation schemes - exit packages 2019/20	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	**1**
£10,000 - £25,000	-	1	**1**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**3**	**3**
Total resource cost (£)	£0	£45,000	**£45,000**

Exit packages: other (non-compulsory) departure payments	2020/21		2019/20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	17	3	45
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**2**	**17**	**3**	**45**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Staff Report

The tables below show the number of staff employed by our organisation as at the end of March 2021, both in terms of headcount and full time equivalence. We also show the split by gender across staff groups. Our head count has continued to grow this year, and now stands at just over 17,000. Around 75 per cent of our workforce is female, which is fairly typical for a healthcare organisation. Nursing and Midwifery is our largest staff group with over 5,000 members. However, we know that each and every person is integral to the delivery of safe and high quality care for our patients.

	2020/21	2019/20	2018/19	2017/18				
Main Staff Group	**FTE**	**Headcount**	**FTE**	**Headcount**	**FTE**	**Headcount**	**FTE**	**Headcount**
Add Prof Scientific and Technical	737.87	822	670.08	750	649.34	728	621.52	694
Additional Clinical Services	2,566.23	2,967	2,407.75	2,775	2,293.80	2,628	2,118.47	2,436
Administrative and Clerical	2,970.43	3,356	2,836.77	3,224	2,606.21	2,959	2,601.26	2,946
Allied Health Professionals	871	767.44	717.73	824	702.86	802	670.38	769
Estates and Ancillary	1,240.57	1,463	1,243.89	1,487	1,184.30	1,420	1,055.37	1,263
Healthcare Scientists	540.51	590	525.78	572	521.10	564	494.50	536
Medical and Dental	2,035.05	2,149	1,871.61	1,977	1,735.58	1,827	1,644.11	1,730
Nursing and Midwifery Registered	4,556.91	5,176	4,280.06	4,878	4,138.46	4,698	4,027.96	4,568
Other			0.43	1	0.50	0		
Grand Total	**15,415.00**	**17,394**	**14,554.09**	**16,488**	**13,832.15**	**15,626.00**	**13,233.56**	**14,942.00**

	2020/21				2019/20				2018/19				2017/18			
Gender	**FTE**	**Headcount**	**FTE %**	**Headcount %**	**FTE**	**Headcount**	**FTE %**	**Headcount %**	**FTE**	**Headcount**	**FTE %**	**Headcount %**	**FTE**	**Headcount**	**FTE %**	**Headcount %**
Female	11,460.03	13,247	74.34%	76.16 %	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 %
Male	3,954.97	4,147	25.66%	23.84 %	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 %
Grand Total	**15,415.00**	**17,394**	**100.00%**	**100.00%**	**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%**

Average number of staff (WTE basis)

Main Staff Group	Total 2020/21	Permanent	Other	Total 2019/20	Permanent	Other
Add Prof Scientific and Technic	775	755	20	726	712	14
Additional Clinical Services	3,273	3,027	246	2,877	2,842	35
Administrative and Clerical	2,610	2,275	335	2,392	2,217	175
Allied Health Professionals	811	755	55	741	723	18
Estates and Ancillary	1,287	1,221	66	1,259	1,229	30
Healthcare Scientists	579	577	1	571	558	13

Medical and Dental	2,207	1,977	231	2,273	1,927	346
Nursing and Midwifery Registered	4,699	4,371	328	4,839	4,232	607
Other	2	2	0	0	0	0
Grand Total	**16,243**	**14,960**	**1,282**	**15,678**	**14,440**	**1,238**

Numbers of staff (per cent of workforce)

Headcount - per cent workforce					
Main Staff Group	**2021 / 2020**	**2019 / 2020**	**2018 / 2019**	**2017 / 2018**	**2016 / 2017**
Add Prof Scientific and Technic	4.73%	4.57%	4.71%	4.70%	5.12%
Additional Clinical Services	17.06%	16.69%	16.41%	16.04%	16.85%
Administrative and Clerical	19.29%	19.56%	18.88%	19.44%	21.25%
Allied Health Professionals	5.01%	5.01%	5.20%	5.21%	5.65%
Estates and Ancillary	8.41%	9.05%	9.20%	8.57%	0.83%
Healthcare Scientists	3.39%	3.49%	3.66%	3.64%	4.04%
Medical and Dental	12.35%	12.02%	11.84%	11.74%	13.05%
Nursing and Midwifery Registered	29.76%	29.60%	30.10%	30.67%	33.19%
Other			0.00%		0.02%
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Policy in Relation to Disabled Employees

We value the unique contributions, background, lived experience, skills and knowledge that all our people bring to the organisation. We are committed and proactive in supporting our employees and prospective employees who may define as disabled or differently abled.

Under the Equality Act 2010 if you have a physical or mental impairment that has a substantial and long-term effect on your ability to do normal daily activities you are classed as disabled. However, when it comes to reflecting disability within our staff group it is not always straightforward. Some staff, who may fall under the definition of having a disability may not self-define as such, which can impact on equal opportunities monitoring.

We aim to hold open conversations in the workplace about disability, and separately neurodiversity and mental health, to help staff understand that the disability declaration is there to confidentially assess and address equality of opportunity, rather than be used negatively. With around 57 per cent of our workforce unspecified with regards to having a disability, we have a substantial challenge to reduce this figure annually. This work on inclusion will be part of the Culture and Leadership Programme.

DFN Project SEARCH is a transition to work programme for students with learning disabilities and autism spectrum conditions, aimed at those motivated to achieve competitive employment. We will relaunch this in September 2021.

We have renewed our Disability Confident accreditation status and Mindful Employer Charter; these schemes support better inclusion – including the commitment 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

Our overall sickness absence rate is 4.25 per cent, which is above our target of 3.6 per cent. However, against the backdrop of a national pandemic the higher rate is to be expected.

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 a 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, menopause, cycle to work, smoking cessation, resilience and managing stress.

We have a comprehensive staff wellbeing programme in place. This has continued to be strengthened this year in response to the pandemic with particular emphasis on increasing staff rest spaces and support for mental health, as well as specific initiatives for those who have been shielding.

While training has been scaled back this year, as a result of the pandemic, we will soon be relaunching our proactive training for managers on supporting health, attendance and wellbeing. 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. This policy is current being updated and will be relaunched during 2021.

The HR team monitor sickness absence levels on a monthly basis, sharing details of concerns with their divisional leadership teams, and local managers. Interventions always aim to be supportive and help staff either return to work or stay at work, making reasonable adjustments where necessary.

Sickness Absence					
Staff group	**% sickness 2020/21**	% sickness 2019/20	% sickness 2018/19	% sickness 2017/18	% sickness 2016/17
Add Prof Scientific and Technical	**3.10%**	4.09%	3.71%	3.27%	3.16%
Additional Clinical Services	**6.89%**	6.60%	5.99%	5.70%	5.91%
Administrative and Clerical	**3.62%**	4.13%	3.78%	3.67%	3.50%
Allied Health Professionals	**3.06%**	2.93%	2.49%	2.50%	2.22%
Estates and Ancillary	**6.32%**	6.50%	5.49%	5.67%	4.93%
Healthcare Scientists	**2.54%**	2.74%	2.27%	2.24%	2.53%
Medical and Dental	**1.09%**	1.20%	1.15%	1.37%	1.30%
Nursing and Midwifery Registered	**4.62%**	4.50%	4.34%	4.01%	4.01%
Total	**4.25%**	**4.36%**	**3.99%**	**3.82%**	**3.65%**

Our sickness performance is summarised in the table below:

Sickness data 2020/21		
Absence FTE (01/04/2020 - 31/03/2021)	**FTE (as at 31/03/2021)**	**Avg working days lost per FTE**
228,702.94	15,415.00	14.84

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

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. 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. The consultant workforce has an active job plan held electronically - we continue to align job plans to service requirements. There is also ongoing progress in developing partnership with other NHS trusts within some of the hard to recruit services. Other clinical services including some therapy services use e-rostering and our estates and facilities service also use a rostering system.

Staff Retention

Our overall retention rate improved slightly over the last twelve months and now stands at 85 per cent. We continue to focus on improving staff retention through various initiatives including; analysis of staff survey results and associated action planning, Magnet accreditation, and targeted training and career development opportunities for the non-qualified nursing workforce. We also employ doctors directly to our local NHS trust grade programme, which has helps to reduce gaps in our 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 provides an overview of our operational performance in 2020/21 against core standards and our progress against the priorities we set ourselves. Operational performance was heavily influenced by the Covid-19 pandemic so this section also provides an overview of the three waves of the pandemic during this financial year.

Overview

Coronavirus pandemic

The coronavirus (Covid-19) pandemic resulted in the fastest and most far-reaching repurposing of NHS service, staffing and capacity in the NHS' history. It radically affected the provision of our business as usual services, significantly impacted patient demand, and in turn impacted a number of our performance metrics.

Throughout the pandemic, our priority has been consistent - to provide safe access to services for patients to the best of our ability, prioritising our resources to urgent and time critical services.

During 2020/21 our hospitals experienced three main Covid-19 waves:

1. **Wave one** commenced mid-March 2020 and peaked in mid to late April 2020 with the pressure easing into the summer months.
2. **Wave two** commenced early October 2020 and peaked late October (at double the size of the first wave) before starting to ease marginally late November to early December 2020. Wave two pressures did not ease significantly.
3. **Wave three** commenced early to mid-December 2020, peaked late January 2021 (at three times the size of the first wave) and gradually eased during February into March 2021. By mid-March 2021, the number of Covid-19 positive patients in our hospitals was broadly equivalent to the first wave peak. The pressures on our Critical Care facilities in the third wave were exceptional, with our units surging to around 200 per cent of their usual capacity. To enable this, a concerted effort was required from across the whole organisation.

The uncertainty throughout the year made planning exceptionally challenging, as there was limited understanding about how the virus would spread and how the local and national restrictions would impact demand on NHS services (both Covid-19 and non-Covid-19). The national request by NHS England and Improvement in mid-March 2020 to cease all routine elective work, including routine diagnostic tests, to create capacity for Covid-19 patients soon created large backlogs of patients waiting for outpatient appointments, routine diagnostic tests and routine surgery. These backlogs resulted in a sharp downturn in our elective performance measures.

During the first wave, we also experienced significant reductions in the number of patients being referred to or presenting at our services; this included non-elective attendances and routine, urgent and cancer referrals. Fortunately, cancer referrals quickly returned to pre-pandemic levels, as there was concern that patients were not seeking the time-critical medical advice that they needed. Non-elective attendances mainly reduced in the 'minors' (low acuity) patient cohort. Aside from the first wave of the pandemic, non-elective demand remained strong which, coupled with the pandemic peaks, made it exceptionally challenging operationally.

We rapidly put strict social distancing and infection control measures in place to prevent the spread of the virus, including segregating pathways for patients being admitted to our hospitals. These measures reduced throughput and productivity, making it challenging to recover activity levels to pre-pandemic levels without increasing capacity.

Despite the challenges, we kept as many services in place as possible, and have delivered care as quickly as we can to those patients with the highest clinical need. During the summer of 2020, we managed to safely restore many of our clinical services and successfully increased activity levels until the second wave pressures developed. We are immensely proud of and grateful to our staff for their continued commitment, hard work and dedication; they have worked under immense pressure to adapt our services, see patients safely and maintain the quality of care that our patients expect.

Urgent and emergency patient care

As mentioned above, non-elective demand reduced at the start of the pandemic. This eased some of the pressure on our hospitals, leading to improvements in both patient flow and the provision of timely access to emergency services – something that we have at times struggled to deliver previously. As a Trust, we continue to report against the 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 and 2020/21 for those organisations involved in the pilot to avoid contaminating the study design. During the field testing period, a memorandum of understanding is in place that precludes us from publically reporting performance against the new metrics that are being tested.

We needed to make significant changes to the way people accessed urgent and emergency care at the start of the pandemic to create separate pathways for Covid-19 and non-Covid-19 patients. Whilst, for the majority of the year, flow has remained much better than previous years with improved timeliness of care, we have had periods of exceptional pressure where patients have experienced delays in admission beyond the level that we would wish. The third wave of the pandemic was particularly challenging, as we were also managing increased seasonal demand and the recurrence of some of the limitations around timely flow out of hospital into health and care services. Generally, thanks to the support of our health and social care partners, patients, who needed to be transferred to health and care services, were able to leave our hospitals much faster. However, there remains further work to do to realise our system ambition in this area. We are committed to eliminating discharge delays and building on the successes achieved during the first wave of the pandemic.

Another area of great success during the pandemic has been the increase in the use of Same Day Emergency Care. This has been an area of focus and is fundamental to our system long term plan.

Performance and improvement plans for urgent and emergency care continue to be overseen by the A&E Delivery Board, which is attended by leaders from across health and social care in Nottingham and Nottinghamshire. Consistently improving timely access to emergency care remains one of our top priorities for 2021/22, ensuring that there is sufficient system capacity to enable our emergency pathway to function alongside the recovery of elective care.

Cancer care

Our cancer services are amongst the largest in the UK. During the pandemic, we worked hard to maintain access to surgery, chemotherapy and radiotherapy for cancer patients. From the start of the pandemic a clinically-led group carefully prioritised our limited theatre and critical care capacity to ensure access for our most clinically urgent patients. We embraced the national contract agreed between the NHS and the Independent Sector, working closely and constructively with our local providers to transfer activity to their facilities, supported by our theatre and anaesthetic staff. The strong local relationships have enabled continued treatment of cancer patients in the sector during the whole of 2020/21, despite changes to the

national contract. We also provided mutual aid to other organisations to ensure time critical patients elsewhere in the region were not disadvantaged.

During the first wave, we saw an increase in the number of long waiting patients; this was driven by delays in diagnostics - largely associated with the infection prevention and control measures required for endoscopy. By autumn we had reduced backlogs to pre-pandemic levels. However, the number of long-wait cancer patients increased slightly in the third wave as surgical access became increasingly challenging due to the exceptionally high Covid-19 demand on our critical care and base ward beds.

Whilst a number of our cancer waiting times standards saw a reduction during the first wave of the pandemic, we have recovered a number of these. The limiting factor preventing further recovery in our cancer standards at present is reducing surgical waits. As access to critical care and theatres improves with easing pressures following the third wave, we will allocate capacity; although this allocation will be based on clinical priority rather than length of wait.

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 that have been compounded by the pandemic. We will continue to work to protect, where possible, cancer treatment during the coronavirus pandemic.

Elective care

The sharp downturn in performance in spring/summer 2020 was driven by the NHS England mandate to cease routine elective services due to the pandemic. The level of Covid-19 demand since October 2020 has resulted in a need to re-purpose elective capacity in order to manage non-elective (including Covid-19) demand, and this continues to have an adverse impact on a number of our operational performance constitutional standards; including 18-week referral to treatment and 52-week wait. The number of long wait elective patients has grown from zero when the pandemic first occurred to almost 4,000 at the end of March. As soon as we have the right blend of critical care, theatre and base ward beds available, together with sufficient staff across the aforementioned areas, we will start to begin the recovery process, and increase elective operations.

In 2020/21 we started a Post-Anaesthetic Care Unit (PACU) trial at QMC in order to help reduce the pressure on our critical care units by providing an area with enhanced supervision for elective patients post-surgery. The early indications are very positive, and we hope to build on this model in 2021/22.

Access to the Independent Sector has been crucial in mitigating the loss of elective capacity. Due to further national contract changes at the end of March, we will have reduced theatre access in this sector which means that the case-mix will change. We have plans in place to make best use of the available capacity. Access to critical care beds and theatres at our hospitals for elective operating is also slowly improving, with a roadmap in place to increase capacity, assuming Covid-19 pressures continue to ease.

Outpatient activity levels have generally remained strong compared to other Trusts in the region. At the start of the pandemic, we rapidly accelerated work to make a significant shift to non face-to-face outpatient appointments. We seek to maintain these appointments going forwards in areas where it is clinically appropriate to do so.

Many of our diagnostic services developed backlogs during the national pause in routine tests. Social distancing and infection control measures mean that throughput is constrained. We are now in a position where backlogs have either flattened, or are in the process of being cleared. Some services require further capacity to reduce the number of routine patients waiting in their backlogs.

Some of our screening programmes were paused during the initial phase of the pandemic. All screening programmes restarted and are operating compliant with Public Health England guidance, with plans in place to reduce backlogs of patients where they exist.

As the third wave pressures ease and our hospitals are able to de-escalate, we are focusing heavily on the restoration and recovery of our clinical services, which in turn will support the recovery of our underperforming operational performance standards. We will ensure that we build in time for staff recovery and wellbeing and have agreed to focus on patient treatment by clinical priority.

Maternity

The CQC conducted an unannounced inspection of our maternity services at City, QMC and in the community in October 2020 after concerns were raised by the coroner following the inquest into the death of a baby, who was in our care in September 2019.

Following the inspection our services were re-rated from requiring improvement to inadequate. The inspectors also issued two warning notices (29a and 31) meaning urgent action was required to maintain the safety of our services.

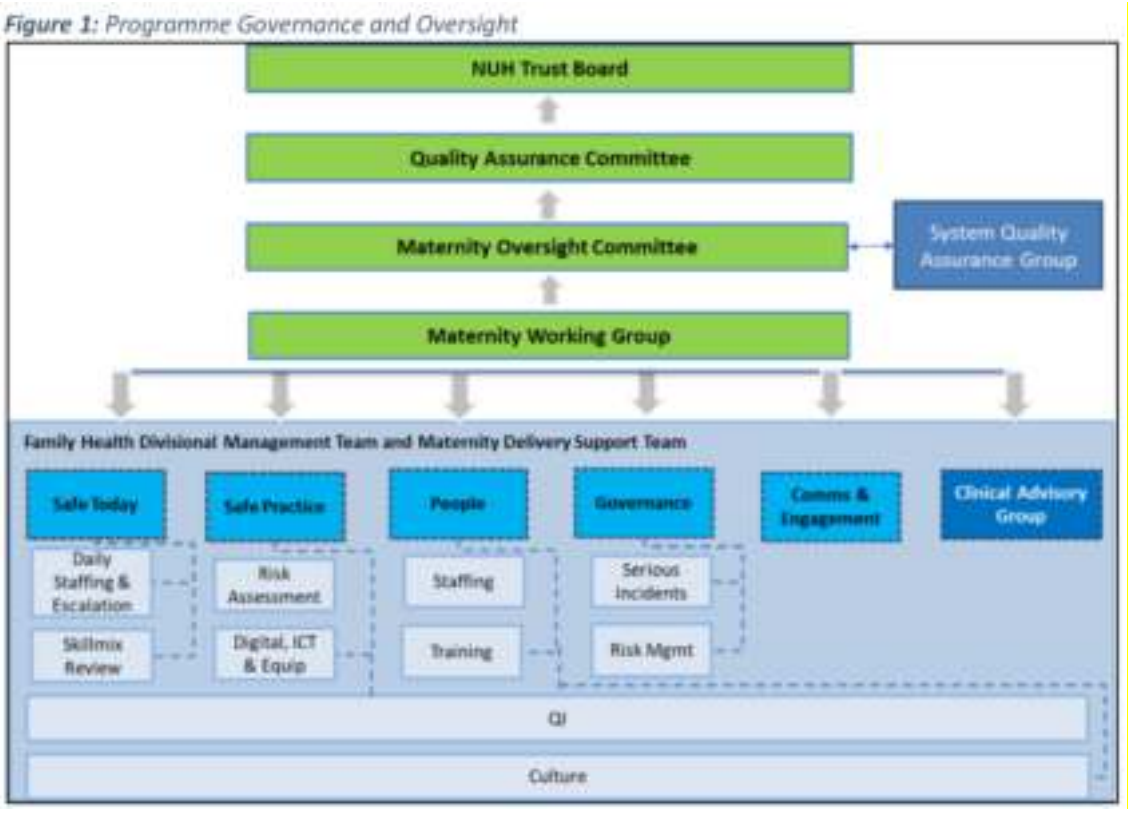
We took immediate action, which included; launching a plan to recruit more staff, introducing senior midwifery management support 24 hours a day, implementing additional training and changing our methods of triaging service users.

This added to and reshaped the improvement work we had already started earlier in 2020 when we received the results of a commissioned Birthrate Plus report, a workforce planning review system, which for the first time looked at our staffing levels in line with the needs of our service users.

We therefore reviewed our actions and launched our Maternity Improvement Programme, which is overseen by a new Maternity Oversight Committee.

There are five main work-streams within the programme, as shown below.

Figure 1: Programme Governance and Oversight



Each is led by an Executive Director and underpinned by culture and quality improvement. The improvement work is reported monthly to the Maternity Oversight Committee, Quality Assurance Group and CQC to ensure the appropriate improvements are made.

The CQC noted our staff are passionate about their roles within maternity, and we are committed to working with them and supporting them to ensure that we improve our services to our communities, offering every mother and baby safe, high quality, compassionate care.

Performance against our National Standards

Quality measure (per cent unless shown)	Target 2020/21	18/19	19/20	20/21	Trend
Eligible patients having Venous Thromboembolism (VTE) risk assessment	≥95%	94	94	93	↓
Never Events	0	2	2	2	–
Patient safety alerts not completed by deadline	0	0	0	0	–
Clostridium difficile (NUH acquired)	≤142	68	152	119	↑
Clostridium difficile per 100k occupied bed days (rolling 12 months)	≤25	14	30.2	30.1	↓
MRSA bacteraemia (NUH acquired)	0	2	2	2	–
Safe staffing levels (overall fill rate)	≥80%	95	93	100	↑
Number of wards below 80 per cent fill rate	0	71	73	36	↑
Cleaning audit score	≥92	-	95.6	97.99	↑
Same sex accommodation standards breaches	0	1	0	0	–
Per cent complaints responded to within the national standard of six months from receipt of the complaint.	100%	99	99	97	↓
Per cent eligible patients who have dementia case finding applied	≥90	97	97	96	↓
12 hour trolley waits	0	7	277	44	↑
Ambulance handovers completed within 15 minutes	100%	55	73	69	↓
Occupied beds for adult patients staying in hospital >=21 days	209	233	249	166	↑
18 weeks referral to treatment time - incomplete pathways	≥92%	93	87	66	↓
Number of cases exceeding 52 weeks referral to treatment	0	3	5	3990	↓
Diagnostic waiters, 6 weeks and over-DM01	≥99%	99	97	49.5	↓
Breaches of the 28 day readmission guarantee	0	33	67	93	↓

Urgent operations cancelled more than once		0		0		0		0	–
2 week GP referral to 1st outpatient appointment		≥93%		95.4		93.7		92.9	↓
14 days referral for breast symptoms to assessment		≥93%		98		98.4		95.7	↓
31 day diagnosis to treatment		≥96%		95.2		92.7		92.3	↓
31 day second or subsequent treatment (drug)		≥98%		99.2		99.5		99.2	↓
31 day second or subsequent treatment (surgery)		≥94%		88.1		83.2		77	↓
31 day second or subsequent treatment (radiotherapy)		≥94%		98.6		99		95.2	↓
62 days urgent referral to treatment (adjusted)		≥85%		81.9		77.2		74.4	↓
62 day referral to treatment from screening		≥90%		93.7		85.2		70.7	↓
Statutory planned preventative maintenance		100%		74		75		74	↓

Sustainability Report

Commitment to Sustainable Development

During 2020/2021, we continued implementing our sustainability strategy, which was approved by the Trust Board in November 2018. This was a challenging year as a result of the Covid-19 pandemic, and a number of sustainable initiatives were affected. However, by adapting to the circumstances and embracing opportunities we also achieved certain improvements; from reducing travel requirements for patients and staff to achieving major milestones in decarbonising the heating infrastructure at City Hospital.

Carbon and Energy

We have reduced our carbon footprint by 47,002 tCO_2, a four per cent reduction on the previous year; another record year in terms of achieving our carbon footprint reduction goal. This is on account of the continued cessation of the burning of coal at the City Hospital, and the ongoing decarbonisation of the national electricity grid. Of course, the reduction also resulted from decreased activity, in terms of use of carbon, during the pandemic.

This year's major achievement was the approval of the City Energy Project initiative in January 2021 which will see great improvements to the heating infrastructure at the City Hospital. Not only will the campus definitively cease burning coal, but it will also generate electricity to supply 80 per cent of the campus demand. Additionally, the project will replace 6,000 low efficiency lamps with LED equivalents and install 300 kW photovoltaic panels as well as heat pumps to provide heating to three decentralised buildings. The project will also commence the 'de-steaming' of the campus operations by creating a low temperature hot water distribution which can be expanded as we develop our site and disconnect facilities from the steam network. The construction and commissioning of this work will be delivered during the financial year 2021/2022.

Sustainable Food

In 2021/21 we continued our successful sustainable food programme, focused on the delivery of meals to our patients, visitors and staff from low carbon and sustainable sources. The scheme ensures that around 65 per cent food used on our Memory Menu is local/British and continues to increase efficiencies by reducing wastage. In addition to our previous accolades, in 2020 we were a finalist for the prestigious Catey Award, and our work has led to us becoming one of eight exemplar hospital catering sites chosen to work with NHS England/NHS Improvement.

Sustainable commuting

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

The Covid-19 pandemic affected the way we promoted access to our hospital sites. Due to the requirements for social distancing, we suspended the promotion of car sharing to our staff. The popularity of public transport as a means to commute was also impacted. However, one of the gains from the pandemic has been the embracing of smarter working. We responded by swiftly rolling out a teleconferencing platform which allowed around 1,600 staff to work from home, thereby reducing the need for travel between campuses to attend meetings. This reduced carbon miles related to commuting.

During December 2020 we ran a staff travel survey in order to better understand our staff's transport needs and the effect of the Covid-19 pandemic. The survey was completed by 2,588 respondents.

In the past year, our Travel to Work scheme decreased by 25 per cent, largely as a result of Covid-19 and more staff working from home. Despite this, 1,529 new passes were issued.

The Medilink service finished its roll out of a new larger all-electric fleet during this reporting period. With the exception of the double decker duplicates (and vehicle breakdown), all of the vehicles used on Medilink are now fully electric.

We promoted active travel via a number of initiatives including Dr Bike, the cycle to work scheme, bike maintenance classes and cycle safety competitions - aiming to promote health, wellbeing and active travel.

Our October 'Brighten Up!' cycle safety campaign saw over 200 staff members sign a pledge to use bike lights and reflective pedals/gear during the winter months.

Our Cycle2Work scheme allows staff to obtain a discounted bicycle for their commute to work, with 106 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 395 staff subscribed to this initiative during 2020/21.

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 like the Covid-19 pandemic, which saw many of our staff taking up active travel as opposed to using public transport.

We have been in discussions with these stakeholders over the future provision of additional Park and Ride sites that would benefit our staff, as well as setting up a new cycle route between City campus and the QMC.

Air Quality

The shift from coal to gas as the primary fuel for heating the City Hospital, and the expansion of the electric bus fleet to larger buses were both completed this year, added to this the expansion of the additional travel concession choices will help in delivering improvements to the local area air quality. Covid-19 has led to a reduction in energy use, through changes to our service delivery, smarter working by some of our teams and different travel choices. In addition to this, we installed innovative technology as part of a new emergency substation at Queen's 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 have, where feasible, continued to work in partnership with Nottingham City Council on a shared vision of health via the County Council's Health and Wellbeing Board, and through our integrated care partnerships with the Carbon Neutral Board and the NHS Greener Programme. We are also actively working with our other stakeholders; Nottingham Trent University, Nottingham University and NHS Trusts within the Trent Network, to maximise the opportunities for shared knowledge and resources to help us all reach our net zero targets.

2020/2021 had a tremendous impact on local businesses, but through our long established sustainable food sourcing methods, it has been shown that every £1 we invest in local food sourcing benefits the local economy by £3.

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

We continue managing our medicine recovery procedure on our wards, which is successfully preventing the disposal of pharmaceuticals that have been issued and can be reused.

Our 'Paperless Hospital' project has also helped us reduce the use of around 5 million sheets of paper this year.

We have successfully implemented our prescription dispensing service, which allows patients to receive their prescriptions at home, reducing their need to commute to our hospitals and thereby reducing the number of vehicles on the roads and the associated carbon emissions, helping improve the air quality of the city.

Recognition

We have been recognised nationally on the sustainability front as a finalist for the Health Service Journal's Environment and Sustainability Award, and by being asked to support the NHS Food Review Programme as one of eight exemplar sites across the country.

We also recruited a designated sustainability officer this year, with responsibility for driving forward the sustainable travel agenda.

This table details our full sustainability report:

AREA	2018-19	2019-20	2020-21
GREEN HOUSE GASES REPORT			
Total Energy Consumption (GJ)	**986,122**	**1,000,237**	**976,295**
Coal (GJ)	105,677	-	-
Natural Gas (GJ)	670,763	778,504	740,637
Electricity (Imported) (GJ)	105,656	117,830	114,229
Electricity (Produced) (GJ))	100,096	94,336	102,360
Gasoil (GJ)	3,930	9,566	19,069
Energy expenditure (£)	**12,419,169**	**10,618,482**	**9,045,253**
Total Business Travel (miles)	**1,237,951**	**1,189,176**	**568,165**
Car	863,143	970,514	495,742
Train	346,504	167,641	8,767
Airplane (domestic)	28,304	51,021	63,656
Carbon Emissions (TCO2eq)	**53,124**	**49,221**	**47,002**
Scope 1			
Coal	9,850	-	-
Natural Gas	34,276	39,758	38,022
Gasoil (GJ)	318	719	1,433
Scope 2			
Electricity Imported	8,308	8,366	7,398
Scope 3			
Business Travel Miles	373	378	149
WASTE MINIMISATION & MANAGEMENT			
Total Waste Produced (tonnes)	**5,166**	**5,123**	**3,972**
Waste recycled/reused	1,212	768	510
Waste to energy	1,148	715	555

Waste to recovery treatment*	2,121	2,451	1,628
Waste for alternative treatment	251	297	802
Waste to Landfill	434	893	476
Total Waste disposal expenditure (£)	**£1,397,569**	**£1,331,525**	**£1,346,121**
FINITE RESOURCE CONSUMPTION			
Total Water consumed (m3)	**653,072**	**673,318**	**552,933**
Water Imported (m3)	148,899	156,981	97,605
Waster Abstracted (m3)	504,173	516,337	455,328
Total Water Expenditure (£)	**1,059,556**	**1,108,882**	**1,065,899**

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 our staff, leaders and Board members.

2020/21 key strategic objectives

This is a summary of how we did against our annual aims for 2020/21.

Aims	Actions	Achievement
Patients		
1.1 Improve patient safety, including safer care to minimise the risks associated with Covid-19	• Reduce the incidence of failure to rescue, ensuring we escalate and respond to deteriorating patients in a timely manner. • Implement a Covid-19 testing infrastructure to minimise the risks of cross infection to staff and patients and reduce nosocomial spread. • Develop and comply with Covid-19 and PPE guidance. • Maintain effective social distancing in all areas of the organisation, including identifying and maintaining green, yellow and blue areas. • Develop and implement a 20/21 flu vaccination programme. • Develop and implement 20/21 divisional prevention priorities as per our Clinical Services Strategy - building upon ICS partnership work. • Develop and implement a clinical prioritisation model to ensure	**Partially Achieved:** • CQC published report on our maternity services, concluding with a re-rating of our maternity service from requires improvement to inadequate along with two Warning Notices (29a/30). A Maternity Oversight Committee has been set up to support the acceleration of our journey to excellence. • Maternity Improvement Programme is being embedded with associated sub groups (reporting to Trust Board), the focus remains on developing a safety culture to support positive change for continuous improvement in key areas of maternity and neonatal services.

Aims	Actions	Achievement
	services are restored and operated safely to meet the needs of our population. • Continuous development of a safety culture - embedding evidence based practice and creating conditions for continuous improvement in key areas of focus such maternity and neonatal services. • Build on the implementation of seven day service provision, in line with NHS improvement standards.	
1.2 Continue to improve patient engagement and experience	• Involve patients in Trust-wide Tier 1 quality improvement programmes covering improving inpatient stays, outpatients, and diagnostic imaging. • Programmes will include patient and staff evidence based co-design to ensure successful and sustainable delivery - evidenced through bespoke patient reported outcomes and impact measures. • Design and implement activities to support patient experience during times of reduced visiting times and other impacts of Covid-19. • Maintain focus on achieving agreed patient experience metrics.	**Achieved** • Successfully achieved objectives set out within year 1 of the Complaints Quality Improvement Plan. • Design and development of Going Home Shared Learning Workshop completed, with further plans to develop Discharge Experience Improvement Plan. • Outpatient's vision successfully presented to the Patients Partnership Group, obtaining patient feedback to further enhance design of future state outpatient models.
1.3 Achievement of goals set within the clinical outcomes programme and deliver outstanding outcomes	• Achieve national and international recognition in delivering outstanding outcomes and experience through Magnet Accreditation and ANCC Pathway to Excellence Accreditation. • Continue implementation of the Clinical Outcome Improvement Programme. • Implement CQC action plan. • Implementation of year two of the Dementia strategy.	**Partially Achieved** • Achieved outstanding caring rating from the CQC, however, overall rating of remains good for our organisation, and requires improvement for safety • Achieved Magnet nursing accreditation – internationally recognised • Suspension of some elements of the Dementia Strategy due to the pandemic. However, significant progress has been made including the achievement of 70 per cent compliance mandatory training target in October, environmental improvements in health care of older people.
People		
2.1 Enhance our health and wellbeing offer to our staff, specifically addressing the health and wellbeing impacts arising from the Covid-19 pandemic	• Developing advice, guidance, training and interventions to support staff mental wellbeing. • Completion and implementation of relevant wellbeing policies - Wellbeing and Attendance, Staff Hydration, Menopause. • Ensure staff have a Covid-19 risk assessment and are supported accordingly • Completing the renovation of the agreed rest area, changing and cycling facilities • Completion and opening of the welfare area at QMC.	**Achieved** • Staff psychologist started in post developing existing materials of psychological first aid training • Guides, toolkits and videos published to support staff mental wellbeing. • Welfare hub opened – November 2020. • A redeployment hub has successfully redeployed staff across the organisation in response to Covid-19.

Aims	Actions	Achievement
	• Develop robust redeployment infrastructure to manage staff rotas/work cover during Covid-19.	
2.2 Ensuring Equality, Diversity and Inclusion is embedded within the organisation, in particular issues which impact on ethnic minority staff	• Engagement with ethnic minority colleagues to identify and progress three priorities for action in 20/21 • Review membership of key committees to ensure equality, diversity and inclusion (EDI) issues are considered within key decisions. • Development and launch of an EDI strategy.	**Partially Achieved** • Priorities superseded by approval of a BAME Staff Network Strategy, with implementation of priority areas within the strategy to be scheduled over 12 month period. • Key committees have ethnic minority representation and will be considered as one of the eight key areas for action within the BAME strategy.
2.3 Improve our HR processes and focus on recruitment and retention to respond to Covid-19 need and medium-term workforce plan ambitions.	• Develop mandatory training to an online offer as far as possible and further refinement of induction for new starters. • Embed fast track and virtual recruitment processes where supported by continued flexibility in legislation. • Complete international and other recruitment campaigns to reduce current number of vacancies. • Implement rapid recruitment processes to bolster workforce during Covid-19 outbreak. • Implement digital solutions to support virtual recruitment, appraisal and, training and development programmes. • Sustain ways of working initiative.	**Achieved** • Successfully completed international recruitment campaigns and fast-tracked virtual recruitment processes to reduce vacancies, with the development of additional campaigns planned for 2021/22. • Developed and implemented digital solutions to enable virtual recruitment, appraisals, training and development programmes, aligned to smart working guidance to enable many staff to continue working flexibly.
Places		
3.1 Complete Tomorrow's NUH Programme Business Case	• Establish revised programme governance, including a Clinical Advisory Group, and develop detailed programme plan to deliver the Programme Business Case and Pre-Consultation Business Case requirements (by end of June). • Develop a revised clinical operating model for Nottingham University Hospitals in line with the Clinical Service Strategy (by end of August). • Undertake a full options appraisal process to identify the long list, short list and preferred way forward for the site configuration options (by end of December). • Complete the relevant cases and complete the national assurance processes to enable commencement of public consultation by the end of 20/21 (by end of March). • Implementation of the third year of our Estates Strategy to improve building and infrastructure resilience and reduce critical infrastructure risk.	**Achieved** • Tomorrow's NUH Programme Board established, chaired by our CEO with senior membership from within the organisation, CCG and other system partners. • Successfully presented Clinical Operating Model to the Clinical Senate • Drafting of the Tomorrow's NUH Programme Business Case and Pre-Consultation Business Case chapters has progressed, with final sign-off of the PBC scheduled for Q1 2021/22. • A review of non-clinical evidence against the shortlisted options appraisal was completed, with agreement for a preferred way forward by the Programme Board.

Aims	Actions	Achievement
3.2 Reconfigure our estate to respond safely to Covid-19 to protect patients and staff	• Establish Blue Yellow and Green areas of the estate that comply with IPC requirements, maximise capacity and minimise cancellations. • Develop plans to promptly flex estate usage as Covid-19 demand dictates to maximise bed capacity, Emergency Department and other infrastructure capacity. • Expansion of critical care capacity in line with regional Executive Group and endoscopy capacity • Implementation of the third year of our Estates Strategy to improve.	**Achieved** • The Endoscopy expansion for the City site is programmed for final delivery by the second week in April 2021. • There was unprecedented capital programme of £96.4m in 20/21, with £14.9m capital funding allocated estates to support critical infrastructure risks across ageing estates, with work being undertaken on a planned basis. • Estates and Facilities Management continue to attend daily Covid-19 outbreak meetings, with all requests for ward changes or cleaning actioned on the day.
3.3 Ensure required medical equipment is in place to support our Covid-19 and non-Covid-19 activity.	• Balance the needs of our capital equipment replacement programme with the Covid-19-related resources, planning for future peaks and the restoration and recovery requirements. • Establish and embed local hospital-based HTA Unit as a resource for medical equipment procurement. • Imaging equipment replacements including iMRI project, Treatment Centre MRI and CT, complete MRI (1) and commence MRI (2) replacements and two X-ray rooms. • Complete the installation of Linac (LA3) by FYE - for clinical use in 2021/22. • Complete the implementation of the Bed Project. • Progress plans to procure a replacement for the Pathology Laboratory Information System.	**Partially Achieved** • Successful purchase and deployment of devices • The Treatment Centre MRI and CT scanners have been replaced and installation of X-rooms are complete • iMRI installation completed December 2020 • Building works completed and installation of the Lianc Pathology Laboratory Information System is being progressed, however project completion is not anticipated until August 2021.
3.4 Robust digital infrastructure within Nottingham University Hospitals to support our new ways of working.	• Establish basic digital infrastructure within the organisation, including fast and reliable Wi-Fi, agile access to laptops, and remote working. • Evaluate software and licensing needs and procure as appropriate to support new working arrangements. • Implementation of ESR Manager Self Service (shared across all departments) - this will include the work on Employee Self Service, OLM and improving Data Quality and will be dependent on securing additional resource via a business case. • 80 per cent of all clinicians will have a mobile device, working towards equipping all clinicians with a mobile device by the end of 2021/22 (in line with the Digital Strategy). • Evaluate and progress opportunities to work formally with key	**Achieved** • ICT infrastructure improvements to enable over 1,200 remote workers connected at any time via VPN from home (a 10-fold increase in pre-Covid-19 remote working) • ICT infrastructure improvements, including the deployment of voice and video call system (Jabber) to support remote working • Revised project plan for Network refresh with clear target dates for deadline • Successfully achieved funding and procurement process completed for Electronic Prescribing and Medicines Administration system. • A licencing software replacement project has been approved by the Trust, with funding from NHSE/I for a joint procurement with SFH.

Aims	Actions	Achievement
	partners to leads the way in exploiting AI and machine learning, including smart appointments. • Achieve funding for Electronic Prescribing and Medicines Administration, procuring a development partner and commence implementation.	
Performance		
4.1 Address internal inefficiencies and work with system (ICS) partners to reduce hospital demand and expedite discharges.	• Support system partners to ensure only appropriate patients attend the Emergency Department following curtailment in demand during the coronavirus pandemic (i.e. attendance demand does not return to pre-pandemic levels). • Reduce hospital length of stay by: Increase appropriate use of Same Day Emergency Care pathways. Maintain the number of supported patients in hospital for greater than 24 hours post medically safe at 37 or less in alignment with the system-agreed target (following significant backlog reduction during the Covid-19 pandemic).	**Achieved** • Emergency Department (ED) improvement programme of work in place and ongoing to enable optimised processing time in ED • System wide A&E Delivery Board, capacity and discharge cells in place to facilitate system hospital discharge performance. • Targeted internal Improving Inpatient Stays programme established and focussed on core flow improvement initiatives to ensure timely discharge planning.
4.2 Adapt to new national performance standards/framework following the coronavirus pandemic	• Safely restore and recover elective and diagnostic services following curtailments during the coronavirus pandemic embedding successful new ways of working. • Re-base plans and trajectories to support safe patient care during restoration and recovery; to include bed and capacity modelling. • Maximise opportunity to use independent sector to support safe restoration of services and reduce backlogs/waiting lists to ensure timely access for patients. • Ensure elective, cancer and diagnostic services have capacity to operate safely whilst living with coronavirus. • Reduced elective, cancer and diagnostic backlogs/waiting lists to ensure timely access for patients.	**Not Achieved** • We demonstrated agility within the first and second phase of the pandemic to ensure that we maximised opportunities for recovery, whilst managing winter demand and the ongoing varied levels of Covid-19 demand • Strong progress was made in the restoration and recovery of our clinical services. However, recovery efforts were impeded in response to Covid-19 waves.
4.3 Achieve financial performance standards in line with national requirements	• Re-engineer our resources to focus on priority areas whilst living within our means under revised block contract financial framework for 20/21. • Assess and prepare for potential new funding models beyond 20/21. • Maximise Treatment Centre facilities through delivering and agreed future operating model, including improving theatre session utilisation and appropriate speciality usage. • Re-establish and agree the 20/21 Quality Improvement and Waste Reduction programme of work (Tier 1), including quantum of	**Achieved** • Our financial performance is in line with the agreed revised trajectory with NHSE/I

Aims	Actions	Achievement
	opportunities lost to us as a result Covid-19 and, during recovery phase, embedding beneficial changes arising from rapid Covid-19 response	
Partners		
5.1 In the context of the Covid-19 pandemic, work in partnership with the ICS to support incident management, restoration and recovery, and establish new governance arrangements	• Effectively engage in the system incident management structure (through the LRF and CCG led cells) • Actively participate in ICS restoration and recovery work, building upon rapid transformation (outpatients, discharge) where appropriate and taking the opportunity to re-base and reframe the ICS five year plan. • Continue to support work develop the ICS Clinical Services Strategy and deliver our components of outputs to date e.g. stroke. • Continue to develop the City and South Notts ICPs and our role within. • Continue to develop the interface between secondary and primary care clinicians. • Support organisational and system leaders to set up any new or different ICS leadership arrangements. • Consider options and develop our collective approaches to commissioning and delivering specialised services, to ensure sustainable services across the system.	**Achieved** • Successful roll-out of the Covid-19 vaccination programme. The current Covid-19 response has had significant system and partner input and has demonstrated the value of working together. The current NHS funding regime and Covid-19 vaccination programme is pushing the pace of system integration and partnership working. • We had a lead role in co-ordinating the system response through the recovery and capacity cells. • Work with Community Trusts to ensure the maximisation of ICS partners capacity following impact of social distancing measures
5.2 Work in partnership with our university consortium and the MoD to deliver the National Rehabilitation Centre (NRC).	• Pre-Consultation Business Case taken to governing body by June 2020. • Public consultation plan prepared and public consultation undertaken June/July 2020. • Architect selection process developed and architect appointed by June 2020. • Development of NRC work streams (clinical, academic, digital and commercial) and plans to inform capital requirements and DMBC. • DMBC authored and submitted by Oct 2020. • OBC authored and submitted January 2021 externally.	**Achieved** • Outline Business Case for National Rehabilitation Centre successfully signed-off by Trust Board and submitted to NHSE/I for approval in January 2021. • Key NRC work streams and plans developed and implemented for the DMBC stage.

Aims	Actions	Achievement
5.3 Work in Partnership with Sherwood Forest Hospitals NHS Trust (SFH)and Community Trusts in order to secure acute services and maximise estates across our system	• Agree partnership arrangements with SFH including fragile services such as Pathology. • Works with Community Trusts to ensure we are maximise our estates capacity across the ICS, particularly given the impact of social distancing measures on our capacity.	**Partially Achieved** • We have agreed a renewed partnership agreement, outlining how they will work together and key principles for effective joint working. However, given the pandemic and subsequent organisational pressures, we are not progressing all our strategic partnership discussions at pace. • Commenced NHC and Nottingham University Hospitals executive level partnerships meeting, areas include liaison psychiatry and mental health input into our Emergency Department and acute wards; broader psychological services support; support to our urgent and emergency care pathway (with emphasis on discharge to assess). • We are exploring potential future areas of collaboration around: emergency psych liaison service, Nottinghamshire wide MSK service, joint work on nursing training and development; ACP development and strategy and strategic development of 'Lings Bar'.
Potential		
6.1 Progress existing clinical research programmes whilst picking up new Covid-19 research opportunities	• Re-establish the biobank • Identify and progress opportunities to participate in Covid-19 related research. • Embed the joint research office with the University of Nottingham; including appropriate data sharing agreements. • Re-gain Human Tissue Authority licence that will support clinical research. • Continue offering every Covid-19 patient the opportunity to participate in Urgent public health research while restoring recruitment activity to 50 per cent of our non Covid-19 portfolio by end of March. • Increase our partnerships with industry to ensure that we provide new treatments and better evidence to improve the health of our local communities. • Increase the number of members of our team who are research active through our Research Futures School.	**Partially Achieved** • Over 3,800 Covid-19 patients recruited to urgent public health studies to date. • 5,169 Covid-19 patients recruited to urgent public health research studies. 86 per cent of all non-Covid-19 studies have been restarted • 45 new commercial studies opened • We have achieved 12,000 recruitment target, placing us among top five NHS Trusts in England for recruitment in Covid-19 research. However, we are awaiting approval and timelines for development of QMC inpatient research facility
6.2 Develop our Learning, Education and Training offer to support people plan ambitions and Covid-19 needs	• Strengthen our partnerships with the University of Nottingham and Nottingham Trent University to develop new training delivery methods, increase number of students accessing training and diversify programs to reflect new and emergent roles.	**Partially Achieved** • Online learning via Moodle platform in currently in development to enhance blended learning opportunities learning management systems and software remains a constraint, with upgrades required

Aims	Actions	Achievement
	• Delivery of effective and improved education initiatives based on feedback from staff and students. • Effectively redesign and restart learning, education and training of all areas, embedding the new normal. Ensure adequate capacity of educators and trainers and clinical training facilities. • Develop workforce surge planning for upskilling and re-skilling • Invest in digital technology platforms with adequate equipment • Build on existing relationships with HEI and HEE to ensure delivery of required taught programmes and enable innovation for new courses.	to meet the changing models in training delivery. • Training laptops delivered enabling more training to occur socially distanced and in smaller groups, however estate capacity remains a constraint to delivering required face to face sessions.
6.3 Improve services throughout restoration and recovery by utilising our quality improvement approach, key learning from Covid-19 and culture and leadership approach	• Launch our Quality Improvement Strategy to include key Covid-19 learning insight. • Evidenced improvement delivery across priority quality improvement programmes demonstrating efficiency and productivity impact across key quality, performance and financial indicators. • Roll-out our culture and leadership programme in line with our quality improvement approach.	**Partially Achieved** • QSIR virtual training – around 300 members of staff accessed training which is behind the plan (target – 900). • Development of a revised QI approach, linked with annual planning to enable further engagement sessions to socialise QI model approach. • A number of component parts of the Culture and Leadership Programme have commenced, however further review and refinement of the strategy being undertaken before wider programme roll-out.

Our Patients

We are committed to providing services that value people and act in their best interests. All patients, families and carers can expect to be treated with dignity, respect, compassion and understanding when accessing any of our services. We are committed to delivering continuous improvement in patient, family and carer experiences of care, and have robust systems and processes in place for measuring and monitoring feedback about our services. These include:

- Compliments, complaints, concerns and comments – 4Cs Feedback
- National patient surveys
- Local patient surveys based on a selection of questions from the national inpatient survey focussing on the quality of our care and responsiveness to patient, family and carer personal needs
- Friends and Family Test Survey
- Online and social media feedback
- Engagement with patient and service user groups

Patient Advice and Liaison Service (PALS)

PALS is the first stop for patients, families and carers with enquiries and concerns, and offers impartial advice and support. The service is confidential, and by working in partnership with services it aims to respond and resolve those enquiries and concerns as quickly as possible. During 2020/21, we dealt with 6,471 contacts, of which 6,072 were enquiries or requests, and 399 were concerns that were de-escalated preventing the need for further formal investigation.

The majority of the contacts with PALS related to requests for information about hospital services and involved putting people in touch with the correct service, department or individual to help them.

PALS collates all comments, concerns and suggestions made, and shares this feedback directly with services and departments, as well as through the patient experience feedback mechanisms available throughout the hospital.

4Cs (compliments, complaints, concerns and comments)

2020/2021 is the eleventh year that we have been using the complaints, concerns, compliments and comments approach to capturing feedback from patients, carers and families. Quarterly patient experience reports on complaint themes with examples of learning are received by the Quality Safety Committee.

During the year, we received a total of 549 new complaints for investigation. We closed and responded to a further 484 complaints. We identified a total of 429 learning actions in direct response to complaint investigations. Learning outcomes included; feedback to staff and teams to raise awareness of good practice and challenges identified; developing and implementing new systems and processes; and supporting further staff learning and development. 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 2017/18 to 2020/21.

Number of local complaints and PHSO referrals

	17/18	18/19	19/20	20/21
Complaints	637	683	735	549
Complaints Upheld	87 fully 129 partially	104 fully 199 partially	80 fully 198 partially	56 fully 176 partially
PHSO Contacts	75	70	79	60
Investigations taken up by the PHSO	15	6	7	4
Upheld PHSO Referrals (In year)	0 fully 3 partly	0 fully 5 partly	0 fully 2 partly	1 fully 2 partly

Most frequent complaint themes

	2017/18	2018/19	2019/20	2020/21
1	Standards of care (treatment)	Standards of care (diagnosis)	Standards of care (treatment)	Standards of care (treatment)
2	Standards of care (assessment)	Standards of care (treatment)	Standards of care (diagnosis)	Standards of care (diagnosis)
3	Standards of care (diagnosis)	Verbal communication	Complications during/after surgery	Standards of care (assessment)
4	Complications during/after surgery	Complications during/after surgery	Standards of care (assessment)	Complications during/after surgery
5	Verbal communication	Lack of communications regarding discharge	Verbal communication	Verbal communication

Total Compliments

2017/18	2018/19	2019/20	2020/21
6,415	5,703	5,463	2,780

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	91	140	162	156
Reopened	10	18	16	19
per cent resolved at first response	90%	87%	90%	88%

Complainant Demographics

The demographic data of patients accessing the NHS complaints procedure are collected in terms of age group, ethnicity and declared disabilities. Similar to previous years, the dominant age range of patients in 2020/21 was 20-59 years (42.5 per cent), followed by the 60-79 years age group (28.5 per cent).

In relation to the ethnicity of patients who were the subject of a complaint, the White British group is the main ethnicity of patients (54 per cent); this has remained unchanged over the last three years.

In terms of the declared disability of the patient, there has been a decrease in the number of complaints in which a disability has been declared (two per cent of total complaints). The predominant groups relate to patients with mobility issues – lower body.

Our patients have been supported with complaints through independent complaint advocacy provided by the advocacy service 'People of Hertfordshire want Equal Rights' who supported twenty three

complainants to make their complaint (four per cent of our total complaints).

Examples of learning from complaints taken from most frequent complaint themes

Reason for Complaint	Quality Priority	Action taken
Standards of care (treatment)	Improve clinical effectiveness	• Leaflet developed to explain procedure and aftercare advice for patients having an appendectomy. • Discussions held with ward doctors, who have been reminded of best practice and to ensure that all communication with carers and family members is documented. • Further education provided to staff around diabetes and blood sugar monitoring to be delivered at the next ward education day. • Local audit put in place to routinely check that 'About Me' forms are completed. • A podcast regarding taking care of patients' skin has been developed which is available to all staff.
Standards of care (diagnosis)	Improve clinical effectiveness	• Medical Admin Standard Operating Procedure updated to record if patients are aware of two week wait referral. Standard email template also created to ensure that this (is patient aware yes/no) is not missed off. • Case highlighted during MDT meeting and governance meeting. • Reflective discussion between Head of Service and named clinician. • Identifying ligament damage has been added to weekly teaching sessions for fellows and junior doctors. • Standard operating procedure written to detail who takes responsibility for contacting patients with their results and documenting any conversations which will then be clearly documented within a patient's medical records.
Standards of care (assessment)	Improve clinical effectiveness	• Complaint shared at Specialty Governance meeting. • Process reviewed with radiology to ensure teams have alternative contact details for urgent matters within working hours. The team have also established a radiology newsletter which is circulated to GP practices via the ICS/CCG communications officer.
Verbal communication	Improve patient experience	• Complaint discussed with staff members involved and shared with wider team for learning and reflection. • All health care of older people wards now have a call log sheet on the reception desk where the call is logged on receipt. The log is further updated when staff members make outgoing calls to relatives. The frequency of calls is agreed and recorded to ensure personalised communication with families and carers. • A customer care workshop is being accessed for reception and nursing staff in order to develop further understanding of the importance of good, effective and timely communication. • Concerns shared in patient safety huddles. • An orientation checklist has been developed and implemented at Linden Lodge. • Switchboard operators have been reminded through toolbox talks that any faults reported through switchboard must be reported to the telecoms engineer. • Teaching sessions are being delivered on delivering discharge information to parents of young patients.
Complications during/after surgery	Improve clinical effectiveness	• Team to perform a three month audit to determine how many times the ward teams are asked to move patients throughout the night and to document the reason for this. The data will be reviewed to determine the frequency and reasons for transfer in the hope of preventing unnecessary transfers throughout the night. • Re-education of staff on wound care provided. • Service manager has shared the complaint with the administration team and discuss with staff on an individual basis for learning and reflection.

Improving how we investigate and respond to complaints

In 2020/21:

- We have continued to participate in the Complaint Case Peer Review process on a bi-monthly basis, reviewing 25 complaint files in the past year. Due to the pandemic, these reviews have been completed remotely and provided opportunities for shared learning from complaints handling.
- The Complaints and Patient Experience Team has maintained caseload management and kept the PALS accessible, offering a patient-centred approach and providing prompt resolution of concerns where possible.
- Patient stories taken from complaints which have demonstrated learning within the organisation are presented throughout the year to Trust Board. A patient attended the Trust Board in March 2021 to personally share their story.
- A comprehensive complaints handling training offer has been rolled out across the organisation over the past year. In addition to bespoke training sessions, the Complaints and Patient Experience Team has delivered Letter Writing Workshops, Habitual and Vexatious Policy Workshops and Investigating and Responding to Complaints with Compassion Workshops. This training offer will continue throughout 2021/22 with the addition of a Complaints and PALS Workshop focussing on learning from feedback and the importance of prompt resolution of enquiries and concerns at the first point of contact.
- The Complaints Team continues to participate in the weekly Incident Review Meetings with patient safety and corporate colleagues to ensure triangulation of complaint investigations where there is an associated incident or claim.
- As a result of increased feedback, two deep dive reviews have been completed in the year 2020/21 including loss of property and standards of care (treatment). These reviews looked at all feedback and provided insight into local service actions for continuous improvement. All deep dive reviews were reported to and discussed by the Quality Safety Committee.
- The Complaints Quality Improvement Plan 2020/21 focused on improving the quality of complaint investigations and responses. Following a successful pilot and consultation period, the Complaints and Patient Experience Team have launched a new co-produced Complaint Investigation Report document which is supported by a suite of guidance and top tips documents that complaint investigators can refer to during the course of their investigation.
- The Covid-19 global pandemic impacted our ability to respond to complaints within our internal thresholds and many trusts experienced similar challenges. A decision was made at a national-level to pause the NHS Complaints Procedure between May and July 2020. We are working to the national timescale for response which allows a maximum of six months to reply from initial receipt of the complaint. In the majority of complaints we will be able to respond sooner, however, in more complex cases we will use additional time to ensure our local investigation is undertaken comprehensively and therefore in some cases the timescale for response may be longer than initially expected.

National Patient Surveys

During 2020, the results of the National Adult Inpatient Survey 2019 were published, and the National Maternity Survey was cancelled by the Care Quality Commission (CQC). Although the National Maternity Survey was cancelled, we participated in a variation of the survey with 12 other trusts to understand new mothers' experiences of care. A summary of our results is given below.

Adult Inpatient Survey 2019, published by the CQC in July 2020

We had a total of 549 responses, a 46 per cent response rate to the survey. Historical comparison showed that we did significantly better in two questions, which relate to involving patients in their care and ensuring they have confidence in decisions made about their care.

We have achieved a number of improvements since the last survey in 2018 and areas to celebrate include:

- staff working well together
- expertise in a wide range of specialities
- reported increase in involving patients in the decision making process
- patients know which nurse is in charge of their care
- widespread patient involvement
- patients have confidence in staff
- patients report feeling treated with dignity and respect
- overall high quality or care

In response to the survey findings, a shared learning workshop was held in July 2020. This was during the peak of the Covid-19 pandemic, and at a time where our priority was ensuring clinical teams were focussing on delivering critical patient care. We therefore opted to ask services to commit to sharing what their pledges for improvement would be locally instead of developing an action plan for improvement. Examples of the pledges made are given below:

- The Pain Team will support all ward teams to improve satisfaction scores in response to managing patient pain.
- Nutritional Excellence Leads pledged to maximise the use of available food and drink options to offer the best and most appropriate choice for patients.
- Ward managers pledged to ensure best practice in hospital to home communication and to ensure patients and their carers are fully informed about all aspects of their care.
- Discharge coordinators pledged to work towards the timely discharge of patients, with a minimum amount of delays, whilst keeping the patient and their family and carers fully informed.
- The Ambulatory Care Division pledged to empower staff to improve patient experiences of care by embedding shared governance.

The New Mothers' Experiences of Care Survey

In December 2020 we held a Maternity Experiences of Care Shared Learning Workshop to reflect on the latest survey results and all other feedback to gain further insight into the experiences of women, their partners or significant others at all stages of their maternity journey. The New Mothers' Experiences of Care Survey was voluntary due to the national survey being cancelled as a result of Covid-19. The same survey methodology was used so the results are comparable to the national survey results. A total of 12 acute trusts participated in the survey, which was co-ordinated by Picker. A total of 214 women responded to the survey, a 32 per cent response rate. Maternity Services demonstrated strengths in the following areas:

- Providing support and advice about breastfeeding during evenings, nights or weekends
- Partners being able to stay with women as long as they wanted
- Being offered a choice of where to have baby
- Not leaving women alone when they are worried
- 98 per cent of women felt treated with respect and dignity
- 99 per cent of women had confidence and trust in staff (during labour and birth)
- 98 per cent of women felt involved enough in decisions about their care (during labour and birth)

There is much good about the feedback that our maternity services receive including examples of excellent feedback about individualised patient care and evidence that findings from surveys and complaints have been acted upon, including the establishment of 24 hour visiting for partners (pre-Covid-19) and improved postnatal feeding support for new mothers. However, there are also areas for

improvement to ensure that women feel listened to, their concerns taken seriously and to improve communication. The feedback from service users is a key part to the improvements being made within the Maternity Improvement Programme. We are also working in close partnership with the Maternity Voices Partnership to support the co-design and development of improved services for women, including those from seldom heard communities.

Urgent and Emergency Care 2020 Survey

We are participating in this survey and the publication of the national results by the CQC are expected in September 2021.

Children and Young People's 2020 Survey

We are participating in this survey and the publication of the national results by the CQC are expected in November 2021.

Adult Inpatient 2020 Survey

We are participating in this survey and the publication of the national results by the CQC are expected in November 2021.

Friends and Family Test and Local Surveys

Revised Friends and Family Test (FFT) survey guidance was published in September 2019 for implementation from 1 April 2020, replacing all FFT implementation guidance previously published. Due to the Covid-19 pandemic, FFT data submission was suspended from March 2020 and data submission resumed from December 2020 for acute providers.

The FFT is a continuous feedback stream. It enables patients and people who use NHS services to provide anonymous feedback quickly and easily, when they want to. People can give feedback on their experiences at any point during the care and treatment.

The survey is offered across all main hospital settings including inpatients, day case, outpatients, accident and emergency, children and young people's services and maternity. The new standard questions asks patients and people who use our services to think about their overall experience and to rate this on a scale of very good to very poor.

The national pause in the FFT survey during Covid-19 significantly impacted our total number of responses, comments and suggestions for improvement. In 2019/20 we had a total of 126, 175 FFT responses compared to 17, 406 responses in 2020/21, which is an overall 86 per cent reduction in responses. During Covid-19 we also experienced a reduction in responses to our local surveys, gathering a total of 7,468 survey responses in 2020/21 compared to 21,295 responses last year, a reduction of 65 per cent.

There is an important shift in the new revised version of the FFT that encourages organisations to focus on quality rather than quantity of responses. There is therefore no longer a requirement to achieve response rate targets in each setting. Instead, the FFT is used as a feedback quality improvement tool to help services gather insight into service user experiences and to demonstrate how they are learning and continuously improved in direct response to this feedback.

During Covid-19 we continued to offer the FFT on electronic devices in all inpatient and day case settings, this enabled us to gather 12, 936 responses and patients gave our services a combined very good/ good rating of 97 per cent. FFT paper-card collection was suspended until December 2020 and since then we have resumed paper-card collection in over half of all of our services. We are introducing a new online feedback system in 2021/22 to enable people to give their feedback through digital solutions given the Covid-19 impact on paper-card collection methods.

FFT Survey 2020/21	Total Responses	per cent Combined Very Good/ Good Rating
Emergency Department **FFT suspended due to Covid-19 and the service is introducing alternative feedback collection in 2021/22**	0	0
Inpatient and day case	12,936	97.10%
Community	26	84.62%
Outpatients	3,874	97.11%
Maternity (Antenatal)	87	100%
Maternity (Labour Ward/ Birthing Unit)	46	97.83%
Maternity (Postnatal Ward)	382	96.86%
Maternity (Postnatal Community Service)	52	98.08%
Total	**17,403**	**97.10%**

The top five themed suggestions for improvement from FFT comments are:

2019/20	2020/21
Wait (542 comments)	Food & Drink (198 comments)
Communication (439 comments)	Communication (196 comments)
Food & Drink (387)	Wait (181 comments)
Facilities (329)	Noise (140 comments)
Noise (304)	Facilities (135 comments)

FFT Responder Demographics

The demographic data of people responding to the FFT survey covers age group, ethnicity, disability, gender, faith and carer status.

A total of 13,285 people chose to provide details about their demographics out of a potential 17,403, a 76 per cent engagement in equality and diversity monitoring questions.

The majority of comments and responses are from White (56 per cent), over 65 and heterosexual (54.8 per cent) people (60.2 per cent). A total of 7.6 per cent of FFT feedback is from people who identify as Black, Asian and Minority Ethnic or 'other' ethnic group.

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

- Communication remains a key theme for improvement. This was of particular importance during the start of the Covid-19 pandemic. We identified a need for improved communication about social distancing and to improve patient, family and carer confidence that all staff and visitors were adhering to the guidelines. As a result of growing public concern about social distancing, the Communications Team led on a trust-wide campaign to raise awareness and to encourage consistent adherence to social distancing guidance in all areas.
- Communication with carers has improved during Covid-19 restricted visitation and the About Me document is now shared prior to patient admission.
- We have updated and promoted a range of information and advice for patients, families and carers on our public website and through social media including:
    - Keeping in Touch – ways to stay connected during restricted visitation
    - Messages for Loved Ones (supporting over 800 families to keep in touch)
    - Spiritual and Pastoral Care
    - Emotional, Mental Health and Wellbeing during Covid-19

- Critical Care developed a compassionate visiting document. Spiritual and Pastoral Care in partnership with Critical Care are supporting families and carers.
- Relatives' Communication Plan introduced on Bestwood Ward offering daily calls to relatives at time's suitable for patients, using ward iPhone/iPad.

Food

- Focused work to raise awareness and improve support with assisting patients at mealtimes and ensuring drinks are readily available.
- Snack trials currently underway for our nutritionally vulnerable patients. Patients will have access to a range of snacks between meals. This new initiative is being costed and will be rolled out to all wards end of February 2021.
- Lots of work in dietetics, catering, nutrition teams about the Finger Food Menu and reminding staff what is available so they can promote it in their areas and with patients. The Dietetics Intranet Page has also been developed for staff to access lots of key catering information.

Clean

- To ensure high standards of cleanliness are maintained we have continued to deliver the twice daily Chlor cleaning on all outbreak wards and have continued to maintain a twice daily cleaning regime on a number of the admission wards to support clinical teams at ward level who are under pressure.
- We implemented a secondary cleaning regime of all touch points located within corridors and public thoroughfares during the Covid-19 pandemic.

Discharge

- Improving discharge shared learning workshop to be facilitated in May 2021
- Meeting booked with discharge coordinators to consider what we can do to improve experience around discharge planning.

Carers

- Further information has been added to the carers' website during the pandemic with helpful information, advice and resources.

Other

- Vaccinations of the public and staff continue being led by the Pharmacy Team. Positive feedback received from public and staff regarding the experience.
- Improving DNACPR project completed.
- Barclay has purchased digital radios for the bays and also we now have a portable phone so as relatives can phone the ward and the phone can be taken to their relative as not everyone has a mobile and there is poor network signal. These have both been well received improvements for patients. Gervis Pearson Bereavement Room improvements are underway where patients and staff voted for which they liked. Overnight chairs for SWAN (end of life) relatives to use following feedback of having no facilities to use funded by the charity. Lister 1 Ward has new PICC chairs and treatment chairs following patient feedback.
- In response to a patient wanting to attend a family wedding, staff at Haywood House arranged for it to take place on the unit.
- Staff transformed Trent Cardiac Centres Gardens for our patients to enjoy.
- In response to patient feedback around improving facilities, Maternity has refurbished the Sanctuary Room at City.
- Further Bereavement Corridor improvements (QMC) as the Friends of QMC supported request for additional artwork for corridor walls.
- In response to patient feedback around being bored, staff on C51 are piloting a range of activities for patients. To support patients during restricted visiting, Boredom Buster activity packs were purchased with support from our hospital charity for patients on wards over Christmas.
- In response to patient feedback that the environment would benefit from being more welcoming, we worked with local artists to create the mural below in children's therapy gym

Social Media and Online Feedback

During the 2020/21 period, we gained 1,938 new followers to our main Twitter account (@nottmhospitals), taking our total followers to 20,758. Just over 7.3 million people have seen our tweets on this channel over the past year and we had just over 220,000 engagements with content.

The main Twitter account received on average, 1,220 Twitter mentions per month during the 2020/21 period. Of these mentions over the year, 398 related directly to patient feedback; 242 (61 per cent) were positive, 91 were negative (23 per cent) and 65 were neutral (16 per cent).

Most tweets about patient feedback cover more than one theme. The most common themes were care standards (62 per cent), staff attitudes and behaviours (43 per cent), appointments (8 per cent), waiting times (5 per cent), parking (4 per cent), and phone communication (4 per cent). The vast majority of these particular tweets were positive with the exception of tweets about parking, waiting times, and phone communication. 73 per cent of tweets relating to waiting times were negative. The majority of these related to longer waits before receiving appointments, due to the impact of the Covid-19 pandemic on services.

We received 106 pieces of feedback from patients/relatives on the Care Opinion and NHS websites. Of these, 74 per cent were compliments and 24 per cent were concerns, with two per cent neutral. Consistent with social media subject of concerns, the comments received related to care standards (81 per cent), and staff attitudes and behaviours (76 per cent). Feedback posted online has reduced significantly overall since 2019/20 when we received 233 comments. We recognise these online options for feedback are very under-utilised and we intend to work with our Patient Participation Group to raise

better awareness of these feedback sites so patients, families and carers know how to access these and can feel confident their feedback will be acted upon by our services.

We have continued to share feedback from Care Opinion and the NHS website on Twitter, most recently on a weekly basis under the hashtag #feedbackfriday. We continue to receive praise nationally for our commitment to openness and transparency, including regularly sharing both positive and negative feedback and our learning from such feedback.

Improving Patient and Public Information and Resources

We continually build on our commitment to providing high quality patient information. We provide all necessary guidance, templates and other information for authors of patient information leaflets, to enable them to produce good quality information in line with the Trust Patient Information Policy and national best practice guidance.

Overall, we have a total of 727 leaflets in use across the Trust, included many translated into a variety of langages. A total of 77 new leaflets were produced in 2020/21. We established a Trust-wide Information Group as a sub-group to the Quality and Safety Committee (QSC). This group is responsible for providing leadership support to drive continuous quality improvements in relation to the production of patient information (including leaflets) and to help improve oversight of information resources through improved governance and reporting. We are committed to ensuring all information produced for patients, families and carers is accessible, inclusive and meets their personal needs.

We have recruited a Patient Experience Quality Improvement Lead to help us develop a Patient Information Improvement Plan as well as a revised strategy and policy for 2021/22 and beyond.

Interpreting and Translation Services (ITS) 2020/2021

Interpreting and Translation Services continue to deliver efficiencies, and the closing financial account for 2020/2021 is £352,000.

We realised £202,258 of savings this year, compared to our baseline spend of £554,258 in 2013/2014, and over the six year period, we have managed to reduce our baseline spend by £968,146 inclusive of the cost of the Interpreting and Translation team. Last year's spend of £479,000 has been reduced by £127,000, mainly due to the pandemic which propelled clinics to use different and more economically efficient platforms.

Over the last 12 months the demand for languages has changed slightly. The top ten language bookings were as follows:

Language F2F	Total bookings 2020/21	per cent difference
Polish	*2,904*	-47%
Urdu	*1,500*	-24%
Romanian	*958*	-37%
Arabic	*944*	-38%
Punjabi	*420*	+6%
Kurdish (all dialects)	*530*	-62%
Farsi	*380*	-30%
Portuguese	*227*	New in top 10
Tigrinya	*200*	-17%
Slovak / Spanish	*169 / 169*	New in top 10

As you might expect, there has been an overall decrease in face-to-face bookings during the pandemic as many routine and elective appointments were cancelled so that efforts could be focused on the treatment of Covid-19 patients. During the first phase of the pandemic, a number of interpreters declined to accept face-to-face bookings for Covid-19 patients. However, this did result in a significant increase in telephone interpreting.

Language Telephone Interpreting	Serviced
Romanian	1,149
Arabic	1,065
Polish	863
Urdu	604
Tigrinya	458
Kurdish (Sorani)	376
Farsi (Persian)	234
Bengali	213
Russian	166
Pashto	156

In normal circumstances, most of the telephone interpreting sessions set out above would have been carried out as face-to-face appointments. The pandemic naturally encouraged staff to overcome any dislike of this mode of communication in order to be able to communicate with their patients. At the same time, video interpreting has been introduced, with clinics making use of online platforms such as MS Teams and DrDoctor.

It is important to emphasise that demand for our interpreting and translation services has not decreased, simply the way the service is delivered has changed. The team focuses more on liaising with patients, and is increasingly asked to advise on local written and spoken translation projects, as well as to facilitate off-site communication between clinicians, patients and their families. Additionally, new interpreting platforms and modes have been introduced in response to the changing requirements of clinics and patients. Video remote interpreting is now available for all spoken and British sign languages.

Covid-19 Vaccination Programme: our Hospital Hubs

We were selected as one of 50 hospital hubs to start vaccinating people with the Pfizer/BioNTech vaccine from 8 December 2020. And, by the end of March 2021, our hospital hubs have vaccinated 45,195 people (including 14,545 members of staff).

Drawing on our extensive experience and demonstrable success of delivering the annual staff flu campaign, teams from across the organisation, including Nursing, Pharmacy, Digital Services, Estates and Facilities Management, Procurement, Human Resources and Communications, were quickly mobilised in November 2020 to begin planning delivery of our part of the largest vaccination programme in NHS history.

The Discharge Lounge at the QMC was identified as the site of our first hospital hub, and was transformed into a fully operational vaccination hub within a week, supported by new systems and processes, including a bespoke booking line that was created by our Digital Services team.

We made local history when the first patient in Nottinghamshire was vaccinated just before 3pm on 8 December, 87 year old Don Colley from Mapperley, a former NHS worker.

Then, in January 2021 a second vaccination hub was established at our City Hospital site, offering the Oxford/Astra Zeneca vaccine.

Statistical modelling suggests that for every 160 vaccinations provided, a life is saved. We are incredibly proud of all staff involved in the vaccination programme through our hospital hubs, both for the lives saved and hospital admissions avoided, and the hope and psychological boost the vaccination programme has given to the people of Nottinghamshire.

Our People

Culture and Leadership Programme

In 2019 we started the NHS Improvement/ Kings Fund Culture and Leadership Programme which explores five cultural elements (vision and values, goals and performance, support and compassion, learning and innovation and teamwork) and follows a three phase framework:

- Discovery phase - a diagnostic of the current state of our culture and leadership, incorporating the perspectives of patients, staff, stakeholders and the Board
- Design phase - developing a strategic response to the outcomes of the discovery phase;
- Deliver phase – practical implementation of that strategic response.

Individuals were recruited from all different professions and backgrounds across the organisation to form a culture change team and support the collection of data during the discovery phase. As well as a staff questionnaire, which invited colleagues (and our partners) to rate leadership across the organisation, focus groups were held with staff and volunteers, Board members and Non-Executive Directors were interviewed, and other relevant data was pulled together (for example from our Staff Survey results, the Workforce Race Equality Standard, and from the General Medical Council survey).

This data was analysed and themed around the five cultural elements, before being shared with the organisation at a co-design event. More than 150 members of staff from a variety of roles and departments attended that session, and were able to provide additional feedback.

The data highlighted a gap in the development of our managers, and in response a Managers' Induction Programme was developed. It was also clear that further work was required to help to embed our Team NUH values. To support this, our expected behaviours have been aligned with the values, and a series of statements have been created. The new Team NUH Awards will also play a part in this.

Our overall Culture and Leadership Strategy was due to be launched in April 2020 to coincide with the anticipated release of the NHS People Plan, which was ultimately launched at the end of July 2020. However, the launch was paused so that we could reflect our learning from the Covid-19 pandemic. For example, the development of the staff wellbeing centres and the supporting wellbeing offer, the changes to how learning and development was delivered, and numerous examples of compassionate leadership and innovation are all important elements to include.

With the additions from the review and the initial actions identified, we are in a strong position to progress the strategy. The associated action plans will now be taken forward throughout 2021, supported through the formation of the Culture and Leadership Committee.

We will build on the work that we have undertaken so far and strive to build on our culture and leadership in alignment with our organisational vision.

NHS national staff survey

This year, 35 per cent (5,709) of our staff responded to the National Staff Survey - Working Through the Pandemic. The median national response rate was 45 per cent.

Highlights from our national survey results across 11 themes include:

- We are above average for three themes (morale, safe environment - bullying and harassment, and safety culture)
- We are average for six themes
- We are below average for one theme (team working)

Here is an overview of some of our achievements over the last year in response to previously identified actions. These will be further progressed in 2020/21:

- The review of our Wellbeing and Attendance Management Policy
- Relaunch of our Staff App to give staff the freedom to be better connected on-the-go, keeping staff up-to-date with the all the latest information for our organisation
- Introduction of new, interactive, Facebook Live sessions for staff, ensuring staff have their questions answered directly by our Executive Directors and Chief Executive

- Creation of a specific group to address areas of concern for our ethnic minority colleagues including recruitment and selection training to support ethnic minority representation on interview panels. We have a long-term goal to recruit and develop a workforce that is reflective of the diverse communities we serve, recognising that increasing the diversity of our people will improve our performance and patient care. We have announced our intention to use Positive Action in our recruitment processes to help achieve greater diversity and improve workforce equality at all levels of the organisation. Positive Action means taking steps to help or encourage certain groups of people with different needs, or who are disadvantaged in some way, to access work or training.
- Development and implementation of a range of wellbeing resources to support staff during Covid-19, including rest spaces, 24/7 access to restaurants, free access to wellbeing apps, and a dedicated intranet site. This builds on our existing Staff Wellbeing programme and continued to develop as we moved into different phases of the pandemic.
- Development of resources to support staff with menopause symptoms at work, and staff hydration.
- Review of our values and behaviours in response to staff feedback that they are hard to remember, difficult to understand and not being lived. The language has been simplified and the supporting behaviours better aligned. A new awards programme was launched in November (see page 92)
- Made a commitment to invest in and improve our environments and estate as part of our Tomorrow's NUH programme (see page 101), and to provide a clear steer on the future of flexible working.

Staff Friends and Family Test

One of the ways in which staff are invited to provide feedback on the quality of care and the likelihood of recommending our organisation as a place to work, is through the Staff Friends and Family Test (FFT), which is usually sent out three times a year. However, in March 2020, NHSE/I advised that due to the Covid-19 pandemic, the staff FFT should be temporarily suspended and that providers would not have to submit their data during this period.

From Quarter 2 (2021) NHS England, is changing the Staff Friends and Family Test guidance so that it will now be referred to as the Quarterly Staff Survey and organisations will be required to participate. From 1 July 2021, for a period of one month all provider organisations are required to implement this new survey with nine questions asked covering motivation, involvement and advocacy. This will then be repeated in Q4 (2021/22) and Q1 (2022/23) with the National Staff Survey running instead in Q3 (2021/22).

Staff Wellbeing

The pandemic brought an increased focus on staff wellbeing, given the physical and mental impact on our staff of coping with both changes in working practice and an increased number of very sick patients.

Alongside our nationally recognised staff wellbeing programme, there has been an increase in local wellbeing activity with the development of local rest spaces, increased numbers of staff wellbeing champions in divisions and more staff seeking wellbeing support from both internal and external sources.

Our Hospital Charity has supported efforts to improve staff wellbeing in numerous ways, including:

- Enhancements to local rest spaces
- Creating/improving green spaces on our campuses to give staff/patients much needed outdoor respite spaces
- Provision of sleep pods to enable staff to rest during very long shifts
- Support for the delivery and distribution of gifts donated by the public and local companies through the Mutual Aid project (the total value of these gifts in kind surpassed £500,000)

All our staff have been affected by the pandemic in some way, whether that be needing to work remotely, being asked to shield, being redeployed to new areas or adapting to changes in working practices. A range of additional staff support materials, relating specifically to Covid-19 and the impact on staff, were therefore developed, including an online information hub with toolkits, information leaflets and resources. Additional wellbeing workshops have also been provided, as well as Psychological First Aid to enable staff to support each other more effectively. Opening hours for our catering outlets were extended to 24 hours a day, and onsite food deliveries arranged to support those unable to get access to supermarkets. Two central rest areas were also created for staff.

The Staff Wellbeing Programme Team quickly adapted their existing wellbeing programme to enable sessions to be delivered virtually. Despite the change in format, there was only a small decrease overall in numbers attending during the year, and predominantly this was as a result of not being able to deliver the Know Your Numbers health check programme. Overall, a total of 98 wellbeing sessions were delivered, with 1,020 participants in total.

- Mental health sessions (includes Psychological First Aid, Coping with Stress and Leading a Healthy Workforce)- 35 sessions 445 participants
- Eat for Wellbeing- 56 sessions, 440 participants
- Walking challenges - 3 challenges, 402 participants
- Menopause at work - 6 sessions, 41 participants
- Cycle2Work- 166 bikes issued to staff

Comments from staff

Mental health courses

"A great course"

It gave me confidence to continue what I had hoped I was already doing, but given extra tools

"Excellent content and it was good to be able to type comments rather than speak"

"Brilliantly ran session. I got so much from it. Thank you so much"

Eat for Wellbeing (Seminars)

"Delivery was clear, Ellen obviously knew the topic and at times I forgot we were all on line and not in the same room."

"I found this to be an extremely good seminar with lots of good information. I will certainly access more of these sessions. Thank you"

Weight management groups

"Just so friendly and supportive. It definitely helped me lost 3/4 of a stone in weight".

"This group/programme has been BRILLIANT! The regular weekly catch-ups with everyone, and the topics covered by the group leads were really helpful to keep focus and to learn tactics to keep going or get back on track, and to gain the confidence that I can sustain

Staff have also been able to access pastoral support from our onsite Chaplaincy team and from the end of 2020, we were able to offer onsite counselling and support for work related issues via the Occupational Health counselling team.

- This is alongside monthly Dr Bike sessions, issuing of around 200 bike security tags and working with local bike agencies to provide loan bikes or donations of bikes to enable staff to travel to work safely
- Weight management support - 12 week Eat Well programme plus a new Eat Well, Get Active 12 week programme. The average weight loss was 6kg or 7 per cent of weight
- An eight-week mindfulness course for staff to increase resilience to stress.

The Staff Physiotherapy Team continued to deliver musculoskeletal support to staff, offering telephone and virtual consultations, as well as face-to-face appointments for those needing in person treatment. In total the team had in the region of 1,374 contacts with staff, more than half of which were face-to face.

External provider Health Assured continued to provide telephone counselling to staff needing support, as well as advice, coaching for managers and healthy lifestyle information via its website and app. Health Assured received 1,532 calls and handled 149 counselling cases by telephone or virtually since March 2020. There were close to 3,000 visits to their website. Top reasons cited for using the service were anxiety and low mood, relationship advice/support, bereavement and employment issues.

Some aspects of planned wellbeing work had to be paused due to the pandemic, including completion of the new Wellbeing and Attendance Policy. However, Staff Menopause and Staff Hydration policies were launched during the year. Looking ahead, the key staff wellbeing priorities for 2021-2 are:

- Complete and launch the new Wellbeing and Attendance Policy
- Develop and launch a new programme of trauma response training and increased trauma support for staff with support from NHS Charities
- Appoint a Wellbeing Guardian at Board level to ensure staff wellbeing continues to be prioritised, and staff are able to access the support they need to recover from the impact of the pandemic
- Launch Menopause Advocates to continue to increase menopause awareness and support
- Continue working with the Hospital Charity to make improvements to more local rest spaces and to improve access to cycle parking for staff

Spiritual and Pastoral Care

Our chaplains saw a surge in requests for support from staff as the pandemic began, and this has continued throughout the year. The team has distributed more than 2,000 wooden holding hearts and holding crosses to staff over the last year. At the peak of the pandemic, they saw a 30 fold increase in the number of staff seeking and being offered support for a variety of concerns affecting their emotional and spiritual wellbeing. Chaplains are part of the wide

range of emotional support available to our staff, and they provide support and training for both individuals and for groups. Sometimes this is prearranged, an opportunity for an individual, or a group, to take time out and talk things through; or to have a more structured time of reflection. Often the support the spiritual and pastoral care team provides to individual members of staff is in unscheduled encounters around the hospital, this is because chaplains are uniquely accessible around the hospital, especially in clinical areas, every day.

Recognising the value of rites and services for those who work at Nottingham University Hospitals, our chaplains have also conducted a number of memorials over the last year, to help colleagues to pay their respects to members of staff who have died. The team provides regular religious services in the multi-faith rooms in the hospital. Where such face-to-face meetings have not been possible during the last year, the team has provided online services, meditative reflections, and Thoughts for the Day for staff to access, whether via the chaplains' Twitter, Facebook and Instagram pages, or via the intranet.

Summary of types of support:

- One-to-one emotional and spiritual support, both ad hoc and by appointment (self-referral or line manager referral)
- General support of clinical teams (usually by request) – from attendance at handover, regular walk-throughs, MS Teams and reflective practice sessions, to guided meditations
- Training for groups – for example in having difficult conversations, or coping with grief and loss
- Staff memorial services – by request
- Rites – both religious and non-religious to mark specific events (for example Remembrance Day)
- Religious services of worship/prayer
- Online meditations and reflections

Staff Vaccination and Testing

Staff vaccination was a key element of our Covid-19 vaccination programme, and as of 30 March 2021, 14,545 members of staff had received their first dose of the vaccine, equating to almost 83 per cent of our total workforce. Getting vaccinated against Covid-19 has not only helped to protect our staff against the virus, it has also had an impact on their mental wellbeing.

In March 2021 our QMC vaccination hub was nominated for a Team NUH Award in the 'United' category. A remarkable achievement considering that, just four months earlier in November 2020, the Covid-19 vaccination programme was still just an idea and an ambition.

Teams also worked tirelessly on a staff testing programme, which allowed us to reduce the spread of the virus and meant more staff could return to work quicker following negative tests.

Equality and Diversity

During the year, the Equality and Diversity team has achieved a lot. Here are some of the highlights for 2020/21:

- Continued support for the Equality and Human Rights Commission Initiative 'Working Forward', to make our workplace the best it can be for pregnant women and new parents
- Shortlisted for Patient Experience Network National Awards (PENNA) for our #Weartocare Autism Awareness work and hospital noise reduction project that improves patient experience for young people who are autistic
- Ongoing work as part of the Nottingham Autism Champions Network Partnership, supporting Nottingham's Autism Strategy

- Delivered ICS partnership events for Nottinghamshire Pride 2020, Disability History Month 2020, Black History Month 2020 and an event for Black Lives Matter
- Established a new local WRES Metrics Group
- Supported the re-launch of the BAME (Black, Asian, and Minority Ethnic) staff network
- 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 the BAME Staff Network. 500 active members of staff support these groups and help to further the equality, diversity and inclusion agenda.
- Continued our commitment to address the wider impacts of health inequalities through the provision of work opportunities for young people not in education, employment or training 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 more than 3,000 pledges made by Team NUH. Our full allocation of badges was taken up within six weeks.
- Signed a new three year contract with the disability access platform 'AccessAble' to provide our patients and visitors with digital images and extensive information on accessibility, including travelling and parking, and can be accessed as a webpage or an app.
- Completed the fourth Future Leaders programme, which addresses the under representation of ethnic minority and other protected characteristics at senior leadership levels across Nottingham City
- Partnered with the 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 and Patient feedback. An ongoing programme of work, including staff awareness, training, and gender neutral toilet provision is underway.
- Supported HCA academies throughout the pandemic to ensure that staff were trained in inclusion and anti-racist practice and behaviours.
- Ran a successful pilot of the Prince's Trust Care Certificate HCA programme for our Institute of Nursing and Midwifery. Further programmes will run in 2020/21;
- Continued to support the Lilya's Legacy #hospitalweartocare campaign project. Lilya Coleman Jones was a young patient with autism who was being treated on one of our wards and was significantly affected by the noise from the televisions. Lilya identified that headphones and splitters could help reduce anxiety for patients and reduce noise across all wards, and steps have been taken to introduce this.
- In partnership with other statutory organisations, we held our third public equality partnership event in recognition of Disability History Month with the theme of Disability: Leadership, Resistance and Culture.
- Actively promoted the Time to Talk Day on 6 February and provided drop-in sessions, encouraging staff to have conversations about mental health to challenge prejudice and stigma.
- 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 marking this annual event.
- Marked Holocaust Memorial Day on 27 January with Assistant Chief Executive, Tim Guyler, planting a memorial tree. This was supported by Rabbi Tanya from the Nottingham Liberal Synagogue.
- Released 22 editions of the People Inclusion (PINC) Newsletter, which goes out to more than 700 members of staff, and focuses on equality, diversity, inclusion and the importance of widening participation.
- Recognised International Women's Day on 11 March, and published our Gender Pay Gap report on the same day.
- Set up of a new ENT Communication Group to address inequalities experienced by the deaf community. Membership of the group has been extended to key groups to support ongoing conversations.

- Established a steering Group for DFN Project SEARCH, with plans to recruit additional people on to the programme during 2021.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity, inclusion and human rights legislation are complied with.
The monitoring of actions are tabled at the Equality and Diversity Action Group, (EDAG), which is a sub-group of the People Management Committee with the Chair reporting to the People and Culture Committee.
Equality Diversity and Inclusion initiatives continue to be measured by the regulatory metrics such as the Workforce Race Equality Standard (WRES) including local Race Equality Metrics; Model Employer; Workforce Disability Equality Standard (WDES) and Staffability - a local survey with additional metrics to be launched by NHSE/I in 2021. Additional metrics are also measured through:

- the National Staff Survey (NSS)
- Staff Friends and Family Test (SFFT)
- Starters and Leavers surveys
- NHS Nottingham and Nottinghamshire CCG
- 360 Assurance
- ICS work streams and Health Inequalities implementation plans, guided by the NHS People Plan and local People Strategy.

The metrics enable us to identify where we are achieving well in terms of the staff experience, and what needs to improve.

Promotion of equality of service delivery to different groups

We are pleased to meet the requirements of the Public Sector Equality Duty, (Section 149 of the Equality Act 2010) to eliminate discrimination, harassment, victimisation and any other prohibited conduct, by having robust policies in place. These policies ensure a zero tolerance approach to all forms of discrimination, including gender diverse provisions, which are not currently a recognised protected characteristic under the Equality Act.

We have systems in place to support staff to speak up against any discrimination, bullying and harassment, and we publish related metrics on this in line with our statutory requirements (WDES, and WRES). In addition, we have a dedicated HR group that specifically meets to review any emerging bullying and harassment issues, both informal and formal, pertaining to race. We have established staff networks that signpost to HR and offer support to staff. These cover race, disability (including carers) and sexual orientation including gender identity and diversity.

As part of our policies and procedures, Equality Impact Assessments (EQIAs) are mandatory to ensure due regard is given to all protected characteristics, and to identify and address any adverse impacts that the service identifies. EQIAs are checked by a committee with representation from our staff inclusion networks.

We work to ensure that all staff, patients, carers and stakeholders are committed to equality of opportunity, treatment and behaviour; have equal access to employment, promotion and development; have equal access to services and have their needs considered as we develop services. This means that equality and human rights are embedded into our business planning and are fully considered within our governance structures. They are also part of the personal development of all staff. We support our zero tolerance approach to all forms of discrimination through staff inclusion networks to enable staff to voice

any issues. Colleagues can also consult with the networks when considering the impact of their service on the diverse groups of people we serve.

As a response to the racial injustices in society brought to prominence in 2020, we have supported the development of a new BAME Strategy and action plan, with three new posts created to support this work. We have also commissioned new training provision to increase understanding of inclusion issues including:

- How to have difficult conversations where race is a factor
- Understanding gas-lighting and micro-aggressions
- Understanding white privilege
- How to be an inclusion ally
- Autism awareness
- Supporting staff shielding
- Gender diversity

We have introduced a high quality interpreting and translation provision to increase access for our patients where English is not their first language. We have improved provision for patients who require sign translation and we have improved our communication methodology. As a result of the pandemic, significant innovations have been made through digital interpreting platforms, keeping people connected and safe. DFN Project SEARCH will also be relaunched in September 2021, as mentioned previously.

We have renewed our Disability Confident accreditation status and Mindful Employer Charter; these schemes support better inclusion – including the commitment 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.

Freedom to Speak Up

Freedom to Speak Up (FTSU) Guardians were introduced across the NHS following Sir Robert Francis's FTSU Review in 2015. Their role is to work with leadership teams to create a culture where people can speak up to protect patient safety and highlight anything that affects the working life of staff.

Taking every opportunity to listen to staff views is important to us. We are committed to creating a culture where all staff, whatever their role, feel able to raise any concerns they may have, as this improves both patient safety and staff engagement. We appointed a FTSU Guardian in 2016 as a stand-alone role to provide independent and impartial advice and support to colleagues, and since then we have developed further mechanisms to support staff to speak up. These include:

- introducing open door sessions with our executive team
- increasing director and non-executive director walk arounds
- establishing and strengthening staff networks
- encouraging psychological safe spaces through a Creating the Conditions for Speaking Up masterclass to support managers and leaders in understanding the importance of making space and time for conversations.

The FTSU role continues to be visible across our organisation. It is introduced and explained to all staff as part of the induction process, and is also part of the managers' induction. The FTSU Guardian is supported by a network of champions, and offers regular We are Listening sessions across the Trust. Our FTSU Guardian has also supported facilitated engagement sessions within departments that required additional support during the pandemic.

Number of freedom to speak up contacts by quarter:

Period	Q1	Q2	Q3	Q4	Total Contacts
2019 – 2020	10	12	18	11	51
2020 – 2021	23	8	34	15	90

One of the key themes emerging this year was advice on practical support available to staff during the pandemic, particularly linked to personal protective equipment, infection control measures and social distancing. Other prevalent themes were a culture of bullying within a team, linked to attitudes and behaviour, management and leadership styles. Some elements of unsafe patient care due to staffing pressures were also highlighted to the FTSU Guardian.

We have seen positive progress in the development of a speak up culture across our organisation. In fact, the FTSU index published by the National Guardian's Office, ranks us two per cent above the national average for a speaking up culture. This is based on the four questions linked to safety culture within the NHS staff survey.

The FTSU Guardian reports to the People and Culture Committee each quarter, and to the Trust Board bi-annually, providing an overview of the themes and trends of concerns raised. We continue to work closely with the National Guardian's Office and with local and regional colleagues to promote FTSU across the Trust.

In early 2021, our Trust Board completed the FTSU self-review developed by NHS England/NHS Improvement to support boards to reflect on the speaking up culture of their organisation. The Board recognised that we have more work to do to ensure consistency of approach to understanding, investigating and feeding back on the types of concerns raised through other routes prior to contact with the Guardian, and this will be a focus within the 2021/2022 FTSU delivery plan.

Health and Safety

Ensuring and maintaining 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.

We have systems and arrangements in place for health and safety through our health and safety policies and compliance review process. These have been designed to support us in meeting our legal and statutory obligations.

Over the last year, 3,789 health and safety incidents were reported via our Datix Risk Management System, this is an increase of 457 incidents on the previous year (2019/20). Of those 47 fell within the definitions of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and accordingly were reported to the Health & Safety Executive in accordance with our statutory duties. This compares to 43 incidents reported in the previous year. All incidents were subject to review and investigation, to ensure that learning and any necessary improvements are put in place to mitigate the risk of a reoccurrence.

Significant effort and resource is put into reviewing incidents with the aim of promoting awareness and learning, as we maintain that a large proportion of accidents are preventable. This is achieved through changes to our policies, improvements in our health and safety arrangements and compliance systems, and in developing our training and awareness programmes.

Any health and safety concerns that arise are reported to the health and safety team and monitored by our Health and Safety Committee until a resolution is achieved.

It has been a challenging year with the Covid-19 pandemic, however, we have still delivered and progressed several key initiatives:

- Our mask fit testing programme was implemented, reviewed and continued to receive support to ensure appropriate levels of safety for our staff, in response to Covid-19.
- We implemented a Covid-19 RIDDOR panel to support the organisation in accordance with our statutory responsibilities.
- Our internal health and safety compliance review process was rolled out, with 247 areas now taking part and measuring compliance against agreed health and safety policies and standards.
- We developed and implemented phase one of our health and safety audit programme.
- We established 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 was carried out in order to enhance their effectiveness.
- Our health and safety committee structures were also reviewed and redesigned to maintain their effectiveness and accountability.

NUH Honours Awards are replaced by Team NUH Awards

In November 2020 we launched a new awards programme; the Team NUH Awards. These awards are aligned to our values and behaviours, and seek to reward those exemplifying them.

There are eight categories, one for each of the seven Team NUH values (**T**rust, **E**mpower, **A**mbitious, **M**indful, **N**urturing, **U**nited, and **H**onest), which receive nominations from staff and one category dedicated to nominations from the public.

Nominations are open all year and are judged quarterly in March, June, September and December, with all of the winners going through a final round of judging, which will take place in September 2021 when an official ceremony will be held. The ceremony will include a category dedicated to our volunteers. This is a move away from annual recognition to a quarterly awards process, rewarding more people, more often. All of our staff and volunteers are eligible for the awards, and nominations from the public can be submitted via our website.

To date we have completed one round of the judging process and are pleased to announce the winners and highly commended in each category as:

Trust Award

- Winner – **Jenna Moore**, Switchboard Team Leader
- Highly Commended – **Joanne Waterfall**, Senior Neonatal Staff Nurse

Empower Award

- Winner- **Gillian Priday**, Macmillan Clinical Nurse Specialist for Long Term Survivors of Teenage and Young Adult Cancer
- Highly Commended – **Sharon Littlewood**, Phlebotomy Clinical Educator

Ambitious Award

- Winner – **Sonny Mandac**, Department Manager, Eye Casualty
- Highly Commended - **Sally Wood**, Recognise and Rescue Matron

Mindful Award

- Winner – **Tamzin Gordon**, DREEAM Admin Clerical Assistant
- Highly Commended - **Paula Welch,** Haemostasis and Thrombosis Nurse Specialist

Nurturing Award

- Winner – **Nikki Camina**, Paediatric Rheumatology Nurse
- Highly Commended – **Ward F18,** Trauma and Orthopaedics

United Award

- Winner – **Matt Bodell**, Hospital at Night Coordinator
- Highly Commended – **Ellie Knowles**, Volunteer

Honest Award

- Winner – **Clare Cooper**, Patient and Family Liaison Officer
- Highly Commended - **PALS**

Public Team NUH Award

- Winner – **Laura Bennett**, Clinical Nurse Specialist Children's Burns and Plastics
- Highly Commended - **Gynaecology Oncology Team**

In September, we will host a live virtual broadcast event for all of the winners and highly commended from throughout the year. We will be joined by sponsors of the event, as well as external partners to come together in celebration and recognition of our staff at Nottingham University Hospitals.

Our Volunteers

Volunteer organisations across the UK were dramatically affected, with the onset of the Covid-19 pandemic as people were required to comply with the national lockdown, and stay at home.

Our volunteering service accordingly stood down all volunteers in March 2020, with some of our registered volunteers moving over to the NHS Volunteer Responders scheme on an interim basis. However, as pressure increased on hospital services and resources, a number of our low risk volunteers were brought back to undertake essential volunteer duties in April 2020, and to help support our Teams Helping Teams volunteer staffing project.

By the end of February 2021, we had more than 1,130 registered and guest volunteers offering their support to enhance patient care and promote our Values through volunteering.

Voluntary services paid team

The voluntary services paid team were fortunately able to continue to work. Initially the team acted as an information point for continued volunteering enquires, and later worked to collate short term requests for support, both internal and external. The voluntary services paid team also participated in touch point cleaning, mask distribution and other ad hoc tasks to support the Covid-19 response. One of the team's most important roles was to provide a vital link for existing volunteers who were isolated at home.

Volunteer participation

As already noted, while a number of established volunteer placements and roles were initially put on hold and many registered volunteers obliged to stay at home, the continued need for volunteers quickly became apparent. Here are some examples of how our volunteers have supported the organisation over the last year:

Teams Helping Teams (paid staff volunteering)

At the start of the pandemic, one of the first activities was the implementation of a staff volunteer scheme entitled Teams Helping Teams. This scheme was created to help fill the void left by the registered volunteers, as well as to carry out new tasks and requests as part of the pandemic response such as touch point cleaning and ward mealtime assistance.

Meet and Greet volunteer services

Meet and Greet volunteer services at the entrances to our hospitals were able to be quickly restored offering patients a warm welcome, directional advice and escorting services. Further to the standard meet and greet, volunteers also began also offering guidance on hand gel and mask wearing etiquette. Hospital entrances continue to be busy, so meet and greet services are still very much in demand.

The table below provides an overview of the scale of the support provided by our meet and greet volunteers across all campuses over the last year:

	Directions Given	Escorted	Wheelchair Journeys	Totals
April	1,490	140	33	1,663
May	1,694	233	23	1,950
June	2,518	324	10	2,852
July	3,624	277	38	3,939
August	6,394	413	158	6,965
September	7,066	479	236	7,781
October	5,923	578	236	6,737
November	7,424	614	275	8,313
December	6,709	713	154	7,576
January	1,073	1,069	263	2,405

Social distance champions

Supplementary to our meet and greet volunteers, a number of social distance volunteers were also assigned to our entrances. Wearing high visibility jackets, they were able to remind patients and staff of their obligation to social distance whilst in public areas. They were later also deployed to lift bay areas and busy corridors.

Touch point cleaning

Touch point cleaning was initially established as part of the Teams Helping Teams staff volunteers project. However, with such a large hospital area to cover, our registered volunteers who were at low risk were also drafted into assist undertaking:

- Cleaning of touch points such as door handles, electronic key pads, push doors, hand rails, lift buttons etc
- Wiping down surfaces such as windowsills and corridor seating.

Touch point cleaning took place within public areas such as main corridors, entrances, main stairwells. This type of cleaning did not require specialist training and is a low risk activity providing the correct personal protective equipment (PPE) is worn.

Mask distribution at entrances

When mandatory mask wearing within hospital buildings was introduced, registered volunteers immediately started to support this initiative by providing cover at hospital entrances between 8.30am and 3.30pm daily to supply masks to patients and staff as they arrived at the buildings.

Later, when mask dispensers were introduced, our registered volunteers continued to provide support by making hourly mask top-up runs during week days to relieve the pressure on our estates teams.

Messages for Loved Ones service

With restricted visiting introduced in hospitals, the Messages for Loved Ones service was launched to help families stay in touch relatives who were in hospital, and help prevent patients feeling isolated and vulnerable.

Twice a day, our registered volunteers visited our Patient Advice and Liaison Service (PALS) offices at both QMC and City Hospital to collect and deliver message to hospital wards.

- The volunteers also supported other ad hoc tasks in response to the pandemic.

Tranquillity Garden

Four volunteers joined forces with the James Wright Medicine Division to help maintain the newly opened Tranquillity Garden, making the space usable and welcoming to both patients and staff.

Zephyr's

Zephyr's volunteers offer emotional support to all those affected by pregnancy loss or the death of a baby or child, including to siblings and grandparents.

Despite the challenges of the pandemic, volunteers continued to offer virtual support from their homes through online sessions. Many have taken on fundraising challenges, provided social media support, and also carried out important admin tasks online too.

It is a testament to Zephyr's volunteers and the Zephyr's project team and manager that such important support for families has been able to move online and continue despite the pandemic.

Celebrating Successes- Volunteer Long Service

There were 112 volunteers eligible for long service awards this year, ranging from 5 years' service (69 volunteers) up to 35 years' service (4 volunteers).

We were unable to hold our usual official award ceremony during 2020, and instead volunteers received their long service badge and thank you card from the Trust Chief Executive Tracy Taylor and Trust Chairman Eric Morton through the post.

However, we very much hope that in the latter part of 2021, we can hold either a joint event or serval mini 'thank you' sessions to acknowledge and celebrate the achievements and support from our incredible long-term volunteers.

In summary, the way in which volunteering has operated and been delivered within our hospitals over the last year has been unique. What has remained clear thoughout is the vital part that our registered volunteers play. Partnerships forged between staff and volunteers continue to strengthen our team working and enhance the delivery of care.

Nottingham Hospital Radio

Throughout the pandemic our radio has continued to broadcast to our patients, providing three live request shows a week – Mondays, Wednesdays and Fridays from 5-7pm presented by Steve Coulby.

It was also featured prominently in an article published by the New York Times looking at the role of hospital radios generally during the pandemic.

The level of commitment and determination shown by the team to provide a continued service is a testament to their dedication, with the whole team going above and beyond repeatedly in this very difficult year.

Our Performance

Emergency Planning

Incident response

The year has been dominated by the Covid-19 response, with the Resilience team actively engaged in managing and supporting the Incident Coordination Centre (ICC) since March 2020. We have undertaken a number of structured debriefs throughout the pandemic in order to capture learning from earlier phases, and more will be carried out as we transition from Wave 3 towards a phase of organisational recovery. By capturing this learning, we can assess the performance of our plans, structures, arrangements and response effectively in order to further expand and strengthen these for the future.

In preparation for the end of the EU Exit transition period a tactical working group, chaired by the Director of Corporate Governance, was established to respond to national, regional and local guidance and actions. As part of this response, the group produced an EU-Exit specific risk assessment and business continuity plan to understand and minimise the risk to our organisation's activities, including those issues that could impact on wider Nottingham and Nottinghamshire health partners. Since January 2021, there have fortunately only been a few minor, isolated incidents of delays in the supply chain, and these were escalated effectively and resolved via the National Supply Disruption Service and regional EU Exit lead.

Also during 2020/21, the role of the Tactical Support Adviser has been reviewed and agreement reached to amend the remit to support the response and management of critical/major incidents. Operational incident response will be redirected to existing on-call teams, primarily Estates and Facilities, and Digital Services. In recognition of the change in function, the roles are now known as Emergency Planning Tactical Advisers (EPTAs). Five volunteers have been recruited and trained to date, resulting in a total of eight EPTAs, thereby increasing the resilience of the on-call rota.

During 2020/21 we transitioned to using Everbridge for critical and major incident call out as well as first line response. This system enables communication of notifications and alerts to a wide audience very rapidly. It also enables real time and regular updates to be communicated as the incident unfolds.

Core standards

This year's Emergency Preparedness Resilience and Response (EPRR) core standards process was amended nationally to take account of the significant resources being expended to manage the Covid-19 response. The amended process recognised that 'the detailed and granular process of previous years would be excessive while we prepare for a potential further wave of Covid-19, as well as upcoming seasonal pressures and the operational demands of restoring services.'

As a consequence, we were asked to provide a report to the Clinical Commissioning Group covering:

- progress to address the improvements outlined in the 2019/20 EPRR assurance letter
- the process of capturing and embedding the learning from the first wave of the Covid-19 pandemic
- inclusion of progress and learning in winter planning preparations.

The report produced was signed off by the Board and issued to the CCG in accordance with their stated timeframe. Work on the Trust Evacuation and Shelter Plan and Climate Change Adaptation Plan will be carried forward into 2021/22.

Training and exercising

The silver on-call refresher training was further developed this year, with monthly sessions incorporating both operational and EPRR topics to prepare people for the role.

The business continuity learning events have continued and been well received by leads as a means to share and embed best practice. A table-top exercise for the loss of medical gases took place in January

2021 completing the testing programme for 2019/21. Further table-top exercises will be developed in the coming year in order to test each element of the business continuity plans during the next two year business continuity training and exercising period 2021/23.

In August 2020, the Resilience team facilitated 'Exercise Surfboard' in order to test the response to a second wave of Covid-19. The exercise objectives were to; understand the impacts of a local outbreak and interaction with the local authority outbreak control plan; assess the capability to upscale capacity for Covid-19 patients; assess potential service curtailment to mitigate for staff absences; and review the response to the first wave. The exercise presented several scenarios based on realistic worst-case planning assumptions. Learning from the exercise informed second wave planning.

Business continuity planning

We have continued to improve our business continuity plans, following the transition to new format plans in 2019/20, with the addition of learning from incidents, including Covid-19. Following the first wave in July 2020, a checklist was developed to encourage the key learning to be added, with a particular emphasis on staff redeployment.

The Business Impact Analysis (BIA) has been used to analyse the resources that underpin the most critical activities across the organisation. Two pieces of work have been completed this year using this information, strengthening overall resilience:

- The ICT applications used to support critical and essential activities have been categorised according to the level of impact that system downtime would have on continuity of the activity. From this, a priority restoration order has been established for use by Digital Services in the event of a full network outage.
- Key suppliers identified in individual BIAs as supporting critical and essential activities have been contacted for assurance on their business continuity arrangements

It is the intention during the year 2021/22 to fully exploit the information gathered through the BIA process to further strengthen emergency plans.

Our Partners

Integrated Care System (ICS)

What is the ICS?

The Nottingham and Nottinghamshire ICS is a partnership of a wide range of organisations (including the NHS, councils and the voluntary sector) that assess the health and social care needs of the Nottingham and Nottinghamshire population, and plan and coordinate services to meet those needs.

More and more people need care across a lot of different settings, whether they are visiting clinics or hospitals, in nursing homes or living at home with a carer. It is important to ensure that our entire care system is well coordinated and working together efficiently so that each person is able to access the care they need.

The development of integrated care systems is a national strategy set out in the NHS Long Term Plan. The Nottingham and Nottinghamshire ICS was one of the first ten to be established in the country.

The government has recently published a white paper setting out further changes to health and social care legislation, and this will further embed the role of system working.

Our role in the ICS

Our strategic objectives recognise the importance of working closely with our partners to provide sustainable services that meet the needs of the population we serve. Indeed, the commitment is captured within our Partners promise, underpinning our strategy: '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'.

This year has seen system partners come together in many different guises to support the response to the Covid-19 pandemic, and we have played an active part in the system response. We have also continued to support the progress of other initiatives where Covid-19 has allowed, working to prevent illness and provide more services closer to where people live.

In 2020/21 the ICS has operated at a number of levels:

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

Achievements in 2020/21

The integration agenda has continued to progress during 2020/21. Achievements include:

- Implementation of a Covid-19 incident response structure as per government guidelines. This has seen multi-agency working to; prepare for and manage Covid-19 outbreaks; provide support to care homes and other community organisations; continue partnership working to keep primary and secondary care organisations working to meet population need; and planning and roll out of the largest vaccination programme we have seen.
- Management of patient flow across our system, keeping beds and services open to meet Covid-19 and non-Covid-19 demand.
- Provision of mutual aid support to partner organisations.
- Recruitment and sharing of staff and volunteers to support service continuity.
- Implementation initiatives to help health and social care staff to keep themselves and their families safe.

- Implementation of significant wellbeing initiatives, sharing approaches and ideas across partners.
- Implementation of major transformation programmes to establish new ways of working, many of which will be sustained in the medium-term. For example:
    - The roll-out of technology to support virtual appointments in primary and secondary care
    - Established clinical networks and mutual aid partnerships with other acute providers
    - Integrated teams to support the management of discharges from an acute setting
    - The development of Primary Care Networks to provide resilience when needed across primary care providers
    - Implemented changes to pathways to meet changes in population need that have resulted from Covid-19
- Continued development of partnership working with all system partners, including:
    - Tri-partite partnership arrangements with the other two statutory NHS providers in the ICS
    - Monthly webinars to promote primary and secondary care clinician integration
    - Development and agreement of a set of ICP priorities for each of the three ICPs and active support of their delivery through programme leadership and membership
    - Agreement of shared capital and revenue financial management arrangements for NHS ICS partners
    - Development and agreement of the ICS Inequalities Strategy.

Looking forward to 2021/22

The response to Covid-19 has accelerated significant elements of the integration of our system working, whilst this has slowed in other areas. 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 and recovery
- continue to develop the partnerships that are needed to underpin a population focused approach
- shift the focus of service delivery to become more preventative, proactive, and person-centred
- Prepare for and implement the changes needed when legislative changes are made.

Nottingham Hospitals Charity

As the official charity for the Queen's Medical Centre, City Hospital, Ropewalk House and Nottingham Children's Hospital, Nottingham Hospitals Charity has supported the organisation throughout the pandemic, celebrating the incredible care and dedication shown by Team NUH and continuing its fundraising efforts.

The last year has provided a very real reminder of the charity's mission to support patients and staff at the hospital, and that mission continues to be front of mind for the whole charity team and fundraisers.

Of course, Covid-19 will continue to impact our hospitals in the longer term, and so the charity is working to launch a new appeal to support research into Long Covid-19. This appeal will aim to raise £50,000 to fund vital research into the condition, its symptoms and improving treatment for patients.

As well as the need to focus on the immediate challenges presented by Covid-19, the Charity has continued to fund a number of vital projects across Nottingham's hospitals, including patient facilities and equipment, research and innovation, staff education and welfare, and new building work and major refurbishment.

The charity has worked closely with us to make sure donations have been directed to those areas within our hospitals that need the most help, providing more than £3.8million funding in total over the last 12 months.

Help Our Hospitals emergency Covid-19 appeal

Launched in March 2020, the Help Our Hospitals emergency appeal in aid of our staff working throughout the pandemic, far surpassed initial fundraising expectations by reaching over £300,000 – more than triple the initial target.

Combined with grants from NHS Charities Together, so far the charity has been able to commit to fund projects worth over £500,000, examples include:

- Four sleep pod recliners, placed in the Emergency Department, Critical Care, Maternity and a surgery ward at City Hospital
- Commitments to improving 83 staff areas and kitchens, including complete refurbishment of Linden Lodge on the City campus
- Two staff Wellbeing Centres, one at QMC and one at City
- Bike storage including a brand new bicycle compound
- 1,000 Boredom Busters activity packs for patients in hospital during the pandemic
- A Covid-19 research area, including resuscitation equipment, an ECG machine, waiting room furniture and other essentials
- Team NUH pin badges for staff
- Refreshments for vaccination teams

NHS Charities Together has benefited from the wider national groundswell of support for the NHS and we are working with them to deliver a number of projects here in Nottingham.

They include:

- A new role to co-ordinate ethnic minority community activities through the Shared Governance Council, under leadership of Dr Liz Calderbank
- Work with Nottinghamshire Integrated Care Partnerships and East Midlands Ambulance Service to deliver health related community projects that aim to reduce hospital attendances tackle social isolation, loneliness and mental health as well as the promotion of vaccination programmes in the City's ethnic minority communities

Individual projects which truly make a difference

As well as fundraising to support our staff throughout the pandemic, the charity has also delivered a number of projects which are entirely separate to Covid-19.

In 2020, we worked with the charity and University of Nottingham to deliver an exciting £3million project – a new intra-operative MRI scanner and suite for Nottingham Children's Hospital.

This project, which took over three years, was officially unveiled to donors and stakeholders in December 2020, and is now being used for diagnostic scans.

The Big Appeal also continued to encourage donations for the Neonatal Unit, through the Baby MRI campaign, which has raised more than £150,000 to improve MRI capacity for small babies. This project will come to fruition in 2021-2022.

In September, the charity officially opened the Trent Cardiac Garden – a redevelopment of the garden space outside Trent Cardiac Centre to provide an area that can be used by staff and patients.

The Zephyr's Centre provides support for patients and families who have experienced the loss of a baby or child. Despite the Covid-19 restrictions, the service has continued to run, albeit remotely, with the support of the charity. The Zephyrs Appeal – an ongoing 'ask' for public donations – continues to resonate with Nottingham's community.

Another notable project delivered this year was funding towards the East Midlands Regional Paediatric Sexual Assault Service, based at Nottingham Children's Hospital. The Charity has committed over £300,000 to help improve the long term outcomes of children and young people who have been sexually assaulted and abused in Nottinghamshire.

You can find out more about the charity by visiting www.nottinghamhospitalscharity.org.uk

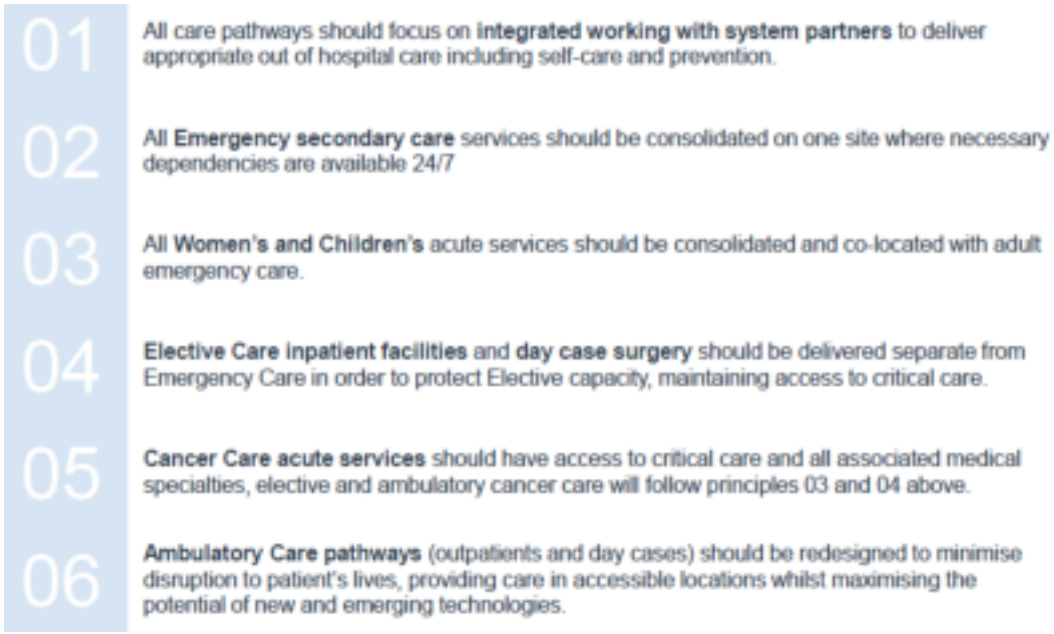
Tomorrow's NUH – driving forward a once in a lifetime opportunity to reconfigure our hospital estate

In September 2019, the Government announced its Health Infrastructure Programme (HIP), a rolling programme of investment in hospital buildings to enable the NHS to achieve the vision set out in the NHS Long Term Plan and respond to the changing healthcare needs of our growing and ageing population. We were named as one of 21 Trusts in the programme's second wave, and accordingly we will receive funding that will allow us to redevelop and upgrade our hospitals by 2030.

We are committed to creating modern, fit for purpose environments that will not only support our staff to deliver effective and efficient patient care long in to the future, but will also help us to educate the next generation of healthcare workers. We have named this ambitious transformation programme Tomorrow's NUH.

We were quickly able to establish that building a brand new, single site hospital for Nottingham to replace City and QMC would be extremely costly and could not be delivered within the timeframe required. However, what we can achieve is a combination of new buildings and refurbishment of current parts of our estate. Throughout 2020 we worked with partners across the local Integrated Care System, as well as with stakeholders, staff, patients and carers, to gain clarity on our plans for the future of our hospitals - the way we want to run our services and the estate configuration options that would best support those plans.

The clinical model we established is based on six clinical design principles. These helped us to whittle down the longlist of possible estate configuration options to a shortlist, from which a preferred option was agreed by the programme board in March. A programme of further staff engagement around the detail of the clinical model is now underway.



The preferred option recommended by the Tomorrow's NUH Programme Board would see future services provided from two main campuses: the Queens Medical Centre (QMC) and City Hospital.

Our plans which our subject to public consultation would see emergency, family care and our cancer centre consolidated at QMC, with the majority of elective surgery, both routine and cancer surgery, delivered from the City hospital site. We will continue to provide ambulatory care such as outpatients and day procedures and treatments on both sites. This split of emergency and elective care will help to protect our elective capacity, so that planned operations do not end up being cancelled as a result of seasonal pressures. The reconfiguration will also make it much easier for us to ensure sufficient and safe staffing levels.

Between November 2020 and January 2021, the Clinical Commissioning Group for Nottingham and Nottinghamshire led initial public engagement into the Tomorrow's NUH programme in the context of its wider strategic approach, *Reshaping Health Services in Nottinghamshire*. This showed strong support for the proposed model of future hospital services. Further engagement to inform the public about the options appraisal process is scheduled for May 2021.

Both our programme business case and the CCG's pre-consultation business case will be submitted to NHS England/NHS Improvement and the Department of Health and Social Care by September 2021, and a 12 week public consultation will take place towards the end of 2021. This will inform preparation of the outline business case during 2022. Our intention is for construction work to begin in 2024.

More information about Tomorrow's NUH is available at: https://www.nuh.nhs.uk/tomorrows-nuh

National Rehabilitation Centre

Following a wide-ranging public consultation, which ended in September 2020, Nottingham and Nottinghamshire Clinical Commissioning Group approved proposals for the construction of a specialist 70-bed NHS rehabilitation facility at the Stanford Hall Rehabilitation Estate near Loughborough in Leicestershire. It will sit alongside the Ministry of Defence's new Defence Medical Rehabilitation Centre, which started treating patients in late 2018. They also confirmed that we would be the NHS provider for the clinical service at the centre.

The National Rehabilitation Centre (NRC) will provide cutting edge rehabilitation in state of the art facilities for those who have suffered serious injury or illness. Through partnerships with the University of Nottingham and Loughborough University, the centre will also incorporate specialist facilities for research, development and innovation in rehabilitation treatment, as well as delivering the National training and education centre for rehabilitation. Co-location with the defence facility will allow the sharing of expertise and evidence-based practice to ensure the best possible patient outcomes for both centres. It will also provide access to specialist equipment within the Ministry of Defence centre such as the hydrotherapy pool and the CAREN (Computer Assisted Rehabilitation Environment) which creates a virtual reality environment with gait re-education to aid balance, particularly with artificial limbs.

Planning permission is already in place, and construction will hopefully commence during 2022 subject to the approval of the final business case . Our existing rehabilitation services will be transferred to Stanford Hall from their current base at Linden Lodge on the City Hospital site, and we are hoping to be treating patients at the new facility in 2024. Initially, we will be treating NHS rehabilitation patients from across the East Midlands.. Certainly the NRC is intended to pave the way for similar clinical centres across the NHS in England, acting as the hub in a hub and spoke model.

Security

During this challenging year, our team's priority has continued to be the safety and security of our people, property and premises - protecting them from harm through robust actions that respond effectively to the security demands placed on the organisation.

Our team has expanded in order to fully support the clinical response to the pandemic, including putting measures in place around the storage and administration of the vaccine. Within this, an increased number of team leaders has improved our levels of resilience and support.

Our team has continued to drive ahead with its improvement strategy and staff development, even though the security landscape has continued to change at pace, with national counter-terrorism threats and the impact of the pandemic.

Over the last 12 months, security management staff have been given industry-recognised health and safety training, and the numbers of qualified first aiders have increased dramatically. This will continue through a training and development plan supported by the Estates and Facilities training team.

Our partnership with Nottinghamshire Police remains strong, and the police presence on the QMC site has provided visible additional support for our Emergency Department staff. The pandemic brought a

number of new challenges for this area of the business, including working with HM Prison Service on special arrangements to support our treatment for prisoners with Covid-19.

The ever present issue of violence and aggression being directed at our staff has also unfortunately increased during the pandemic. This has required special approaches from both clinical staff and security officers in order to engage with and seek to calm these patients. Occasionally, some particularly difficult patients have required round-the-clock security supervision in order to ensure the safety of clinical staff. While these instances have fortunately been few and far between, there were sadly some occurrences of assaults on both security and clinical staff.

The main other security threat at our hospitals was theft. Security management installed CCTV cameras at all gas storage areas as a deterrent, and this has contributed significantly to a 100 per cent drop in gas thefts in comparison with last year's figures. In addition, the police have made significant progress with apprehending criminals carrying out thefts of catalytic converters and this has helped reduce such thefts at our sites. A full review of bicycle thefts was carried out and a comprehensive communications campaign was put in place to encourage staff to check and challenge people, and to help promote good security awareness to our cyclists.

Ropewalk House in the centre of Nottingham is the smallest of our three sites, and over the last few years has had difficulties with alarm and CCTV failures. This risk was identified by the security management team, and a project to change and upgrade the alarm and CCTV systems was launched. This was completed in February 2021. The upgrades not only expand the security footprint at Ropewalk House from a detect and deter perspective, but also allow the security teams at QMC and City Hospital to be alerted through the Everbridge communications platform when an alarm is triggered at Ropewalk House.

Our Potential

Digital Services

With the NHS in the grip of a global pandemic, 2020 was one of the most challenging years on record for our Digital Service. The year saw wholescale digital change throughout the organisation and the widespread adoption of Microsoft Teams for meetings and collaboration, adoption of secure home-working for circa 2,000 staff daily. The 'digital footprint' of the organisation grew by 30 per cent to over 20,000 PCs/laptops and Apple devices and the service delivered a challenging capital programme for infrastructure and systems of more than £12m.

Operationally, the Digital Service Desk created over 140,000 support tickets throughout 2020 in response to almost 200,000 support calls, with 60 per cent of these being resolved within the same-day and with an overall annual excellent satisfaction score of 93 per cent.

Digital Services also supported the organisation in the fast-delivery of its Covid-19 vaccination hubs, fast-tracking the IT deployment, systems integration with national systems and providing staff to assist with patient-flow.

Digital Vision and Strategy, one year in……

Last year our Digital Services commenced its five year (2020-2025) Digital Plan, driven by the Digital Vision and Strategy approved at Trust Board in January 2020. The strategy focused on improving information management and technology (IM&T) in the following areas – which mirror our organisation's promises:

1) **Places and digital infrastructure:** Nottingham University Hospitals network upgrades, Data-centre server and storage upgrades, migration to Windows 10, iOS device upgrades and exceptional cyber security.
2) **People, systems and devices:** Improved systems access, increased devices available to staff by around 30 per cent and enabled remote working for around 20 per cent of the workforce.
3) **Patients:** Improved patient access to services through My Online Care, remote consultations, and appointments including the ability to facilitate patient initiated follow-ups, commenced the introduction of digital letters to address accessible information standards. Improved sharing of patient information across the health community including healthcare and social care data via Health and Care Portal.
4) **Potential:** Embedded digital transformation and commenced Trusted Research Environment activities to maximise research opportunities.
5) **Performance:** Focussed improvements in systems uptime, increased provision for capture and use of real-time information for hospital management (capacity and flow). Data warehouse improvements for real-time reporting and predictive modelling.
6) **Partners:** Improvements in information sharing across multiple systems, digital collaborative set up across the health community. Community Portal hosted by our organisation is accelerating in terms of usage and shared benefits. Alongside Sherwood Forest Hospitals NHS Trust we have also commenced a joint partnership for the provision of Digital Pathology services and were successful in obtaining £5.5m from NHS England and £2.5m from InnovateUK to transform this digital service and partnership.

The strategy also sets out a vision for the future of IM&T that supports the delivery of care and the use of technology to support patients.

What we plan to do this year

We have a number of digital plans that will enable digital transformation across the health system. All of the following are key but not exhaustive schemes in-plan to commence in 2021.

Hospital Electronic Patient Record Programme

Since 2012 we have adopted a best-of-breed approach to our core systems. We acknowledge that there is a difficulty in this approach with interoperability and the requirements for multiple logins to systems for staff to complete their daily duties. There is a drive within the organisation to rationalise these core systems used for patient care into a single Electronic Patient Record which is mobile, real-time and also incorporates e-Prescribing and Medicines Administration. The ambition is to reach EMRAM HIMSS Level 7, which is seen as the panacea of digital maturity in the healthcare setting and an aspiration for us to become a national benchmark.

Hospital Digital Collaboration Programme

In 2020, we invested in the NHS Digital N365 programme, which has given organisation-wide access to the Microsoft collaboration suite. There is a focussed plan to adopt digital collaboration, which is already underway as a result of the adoption of MS Teams during the Covid-19 pandemic. This programme will be expanded to use other platforms available under this agreement, such as SharePoint and OneDrive. In addition to the Microsoft suite, there will be integration into the Cisco suite of technologies around Webex, which are heavily used across the whole of the NHS for multi-disciplinary team meetings.

Also under this programme will be remote access initiatives to further increase the ability for agility and remote working, as well as standard adoption of remote consultations. This will include virtual clinics and the deployment of patient facing technologies to give patients more choice in how they interact with the organisation and manage their healthcare.

Digital Infrastructure Programme

Continuation of this rolling programme will require upgrade to networks and data centre facilities to cyber-secure hybrid-cloud capabilities that are also in line with Tomorrow's NUH planning considerations. We will maintain a fleet of devices (PCs, mobiles and tablets) to ensure they are functioning well and compliant with a sustained upgrade and replacement programme. This plan will also ensure that every clinician has their own mobile device, so that systems access and patient care is not inhibited by technology.

These same digital initiatives and standards will be incorporated into new builds and new regional developments, including the National Rehabilitation Centre.

Digital Workforce Programme

There will be a development of a Digital Workforce Strategy to enhance the digital capabilities of our most important resource - our people. This will ensure better adoption and uptake of future technologies, as well as ensuring there are sufficient resources to support and exploit the full-capabilities of the digital future.

Longer Term

In addition to the programmes of work described above, there is also consideration to what the digital future may look like. These are the current growth areas that have been identified in digital health that we will consider:

- Robotic Process Automation
- Robots – (surgical, pharmaceutical, logistical)
- Artificial Intelligence
- Real-time analytics and predictive modelling
- Smart Buildings
- Wearables for patient self and hospital remote care

Overall, the focus of the Digital Vision and Strategy will be to provide enabling technologies critical to the successful delivery of the clinical and non-clinical functions of the hospital and its role in system-wide transformation throughout the Integrated Care System.

These activities will be blended with national mandated NHS five-year forward view deliverables and health and social care priorities outside of the acute transformation work. The revised digital strategy in 2021 will set out a vision for the future both for IM&T, that supports the delivery of care, and the use of technology to support patients.

How the investment will support digital transformation plans

The investment into digital is critical to supporting a number of transformation plans that will improve the patient experience and deliver better health outcomes. A number of objectives have been identified in order of priority, where we will aim to provide:

1) **Shared electronic patient records:** The ability to have shared electronic patient records along a patient pathway where all parties can contribute to the care planning and delivery. This will involve seamless movements across the patient pathway between organisations without having to ask the patient for information repeatedly, or re-key data. This is fundamental to the delivery of the frailty and multi-morbidity pathway.

2) **Improve real-time data capture:** The intent is to capture data directly from clinicians and share with staff who are subsequently involved in the care of that patient across the healthcare system.

3) **Develop public facing digital services:** This will enable digital contact to become the default route when engaging with services, and will be supported by the creation of a Digital Health and Care People Senate.

4) **Analytics and intelligence to support all of our initiatives:** We will develop our population health management capability in alignment with analytics and intelligence. This approach will be supported with appropriate resources that include better analytics, tools and techniques. We will do this by establishing a health and care analytics collaborative that embeds a systematic approach to developing and monitoring system outcomes, and proactively finds and enables new interventions. The intent is to augment artificial intelligence and human skills in designing care services.

5) **Complete the digitisation of providers by 2024**: This will be supported by the delivery of the ICS CCSS through the continued implementation of technology enabled care. This will involve implementation of full electronic patient records in acute care and the GP IT Futures Programme; which will enable all staff to work in any location where appropriate. Digitisation will support rationalising and modernising diagnostic services and reporting. This will then enable the visibility of capacity across all care settings and the ability to schedule the move of patients quickly. This also includes the roll-out of electronic prescribing and drug administration.

6) **Develop a single summary health and care record**: This will support workflows by interoperability of health and care data and systems. A single health and care record will be made available to all staff. We will also agree and embed system wide standards for data capture and exchange. This will ensure consistent capture and availability of patients' wishes

7) **Improve the digital literacy of the workforce**: The capability and capacity of our digital and informatics specialists will support developing the culture, investment and governance. This will

enable a workforce plan for digital specialists and will continue to develop governance arrangements that include a Digital Design Authority for the ICS.

"When we think of Covid-19 we tend to associate it with elderly patients. However, some younger people have also contracted the virus, so this research is much needed to understand more about genetic susceptibility overall."

- Principal investigator Megan Meredith, a research nurse experienced in emergency and critical care research

Research and Innovation

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

Covid-19

Our research skills, resources and facilities have been and continue to be at the forefront of the Covid-19 response, supporting national, regional and local studies designed to give our patients access to life-saving treatments, therapies and vaccines as quickly as possible. Clinical research has been at the heart of the Government's plans for the pandemic, with new science, new discoveries and ultimately new vaccines resulting from our world-leading research teams.

By the end of March 2021, 10,258 patients, healthcare staff and volunteers had been recruited into Covid-19 research studies.

The impact of Covid-19 on our portfolio of clinical research was considerable; for the first time ever we suspended the majority of our planned research activities.

Our research teams, our research partners in Nottingham and across the region have worked tirelessly to bring their expertise to meet this urgent public health challenge. Through the willingness of staff, patients and the public to volunteer to help our research, we have been able to contribute to significant breakthroughs in establishing effective treatments and latterly to increasing our understanding of the long-term impacts that Covid-19 will have on people as they recover.

Nottingham contributed to research discoveries through a number of national trials including:

- RECOVERY – this is the world's biggest trial involving hospital patients, and has resulted in the identification of life-saving treatments such as Dexamethasone and Tocilizumab; both drugs reduce the severity of illness and help avoid death
- Synairgen – a trial using a preparation of Inteferon Beta (SNG001) showed that patients who received the drug were more than twice as likely to recover compared to those receiving placebo
- REMAP-CAP – this research established that inexpensive, widely available steroids improve the odds that very sick Covid-19 patients will survive the illness
- Oxford/AstraZeneca vaccine – we provided analytical and laboratory support through the NIHR Nottingham Clinical Research Facility to the study which led to this vaccine being licensed for use in the UK

Clinical researchers at our organisation are also working as part of the GenOMICC (Genetics of Mortality in Critical Care) study, one of the high priority research studies now urgently seeking answers to Covid-19. This is one of eight trials relating to Covid-19 which are being run by the DREEAM research team at NUH. The eight-strong team are working closely with clinical staff in the Emergency Department, Critical Care and Major Trauma teams at both QMC and City Hospital.

"We know that Covid-19 can be a devastating illness for some patients with significant levels of infection; this new research platform will enable us to develop accurate models to predict which patients are likely to go on to develop physical and psychological conditions once they have recovered from the initial infection.

"Whilst a lot of focus is quite rightly on potential of Covid-19 infection - and we are also supporting research which is giving us more data about the epidemiology of the virus - potentially the biggest health impacts both for individuals and society as a whole are those that come as a consequence of Covid-19 infection rather than from the acute effects of the virus itself."

- Professor Ian Hall, one of the lead investigators for this research

Answering the questions on Long Covid-19

Our Covid-19 research portfolio will continue into 2021/22, with further trials evaluating treatments and the development of new vaccines. Alongside this, we are also supporting a significant programme of research into Long Covid.

The Nottingham Recovery from Covid-19 Research Platform (NoRCoRP) brings together projects examining the impacts and lasting effects of Covid-19. It aims to translate findings from patients who are known to have contracted the virus into new approaches to treatment to support their recovery.

It also aims to provide new insights for the NHS and social care, enabling services to be more responsive to the long-term impact of caring for patients, some of whom seem to be at risk of developing longer term conditions as a consequence of Covid-19.

How patients helped our Covid-19 research

During Covid-19, we have been continuing to work with patients to support our urgent public health and high priority research into treatments, tests and vaccines.

With no face-to-face discussions possible, a virtual taskforce was set up comprising people who were ready and willing to respond rapidly to the changing needs of researchers and support Covid-19 trials. Discussions took place through video conferencing on a regular basis.

In 2020/21, the taskforce advised on 40 clinical trials and also on topics from representation in research to use of data. Involvement has been flexible and varied; video sessions, phone calls, teleconferences, and emails. The members of the taskforce have been involved from concept, during local set-up, and throughout recruitment, including study amendments. The taskforce approach is now continuing with an annual programme of 'Research Lounge' discussions, bringing together patients, staff and members of the public together with researchers to discuss current topics or to help answer research questions.

Thank you to everyone who has contributed, and to the members of the taskforce for their rapid response to our Covid-19 research.

High priority clinical research

In 2020/21, in addition to the rapid response to Covid-19, our clinicians continued to innovate, translating the findings from research into new technology and treatments to tackle some of the biggest health challenges facing our communities. Our partnerships with industry and the medical technology and pharmaceutical sectors are vital to enable patients to benefit from our research. Commercial research also enables us to continually reinvest in our research infrastructure, putting Nottingham in the best possible position for further expansion of our research activities.

We are particularly proud of the breadth of clinical professionals now engaged in research through our development of clinical academic careers. Both the NIHR Nottingham Biomedical Research Centre, which is hosted by us, and the Institute of Nursing and Midwifery Care Excellence have enabled us to expand training and education for professionals at every stage of their careers. This year, their hard work has been recognised with national Fellowship and Lectureship awards.

World-first in renal research

Renal research specialists based at the City Hospital have supported pioneering research into a chronic kidney disease. They randomised the first patient in Europe into a study investigating the impact of a new type of drug to slow the progression of Alport Syndrome. This is a rare and serious genetic condition which damages patients' kidneys, as well as causing hearing loss and eye abnormalities.

Dr Matt Hall, Consultant Nephrologist and Principal Investigator at Nottingham University Hospitals for the Alport study acknowledged that NUH were 'ahead of the game' in setting up the study. As well as Dr Hall, the other member of our renal team who was instrumental in getting the study off the ground was Dr Sarah Brand, senior research nurse in the renal and transplant unit, who is study co-ordinator and administered the new drug to the first patient volunteer. The female patient, who lives in Nottinghamshire, received the first of a course of sub-cutaneous injections as part of the Phase II study of experimental drug SAR339375 (also known as Lademirsen) as a new way of treating Alport Syndrome.

"The agreement is a huge benefit to patients as it means they are able to get a quicker diagnosis and the correct management of the condition, which is urgently needed for young people suffering from constipation, as it affects their everyday life. Being involved in the MAGIC research project through YPAG has been an amazing opportunity. We've been part of the process the whole way through, from designing the packing to being able to present at conferences with Professor Marciani. It's important as we are able to make sure the study is child-friendly, giving input on how the patient may feel from the view of a young person."

- Olivia Ibbotson, YPAG volunteer

Young people help new device become a reality

We successfully reached an agreement with JEB Technologies, a specialist medical device manufacturing company, to make technology developed through the MAGIC (MAGnetic resonance Imaging in paediatric Constipation) clinical research trial available to healthcare providers in the UK and worldwide.

Childhood constipation is a serious and painful gastroenterological condition suffered by one in 10 children and young people, and becomes chronic in a third of patients. An estimated 600,000 children go to their GP with this problem annually, and at least 27,500 are admitted to hospital in England alone. Thanks to this agreement, these young patients will soon benefit from a better way of diagnosing and managing their condition.

The MAGIC clinical research trial which started in Nottingham in 2015 has been led by Professor Luca Marciani, Professor of Gastrointestinal Imaging at the University of Nottingham, and funded by the NIHR.

A group of children from the Nottingham-based Young Person's Advisory Group (YPAG) has worked closely with Professor Marciani throughout the project to ensure the research into paediatric constipation is relevant to their needs. They are also co-authors of a scientific publication that has recently been accepted by the Journal of Paediatric Gastroenterology and Nutrition. This level of patient and public involvement is unusual and another unique aspect of this project.

Translating research into new treatments

More than 15,000 patients suffering from respiratory, gastrointestinal, hearing loss, musculoskeletal and mental health disorders benefited from access to innovative therapies through the NIHR Nottingham Biomedical Research Centre (BRC), research underpinned by our world-leading expertise in MRI.

Over the last 12 months, the centre's research has produced breakthrough results in our understanding of:

- why some patients develop the fatal respiratory illness, Idiopathic Pulmonary Fibrosis (IPF)
- the hearing condition Tinnitus, for which there is no cure
- a genetic link between gut health and hardening of the arteries which can lead to heart disease

- the impact of some cancer drugs on hearing loss.

During 2020-21 the Nottingham BRC carried out 454 translational research projects; supported 233 early researchers in their careers; and published 670 research articles available to all researchers which will help to develop new treatments for patients.

Patient-led research

The Nottingham BRC supports new research through its annual programme of Innovation Fund awards. The Innovation Fund aims to pump-prime initial research and provide opportunities for new researchers. One example is an award made jointly to a patient and an early career researcher to fund MRI scans to investigate a link between leaky gut and Ankylosing Spondylitis (AS), an inflammatory arthritis condition primarily of the spine.

Shaun Beebe, who was diagnosed with the condition in his twenties, is the lead recipient, and will work on the study with Early Career Researcher, Hannah Williams, and gastroenterologist Dr Giles Major from the University of Nottingham. They are also collaborating with rheumatologists Prof Dennis McGonagle and Dr Sayam Dubash from Leeds BRC.

The disease affects 1-2 per cent of the population, slowly immobilising the spine over decades, and can spread to the heart and eyes. There is currently no cure.

Mr Beebe, now a Head of Operations for the University of Nottingham's Faculty of Science, has researched his condition extensively, and suggested to the team that MRI could be used to discover more about a known link between gut and spine in Ankylosing Spondylitis.

AS is thought to be caused by environmental and physiological factors triggering a genetic inheritability, with around 60 per cent of patients having sub-clinical gut inflammation, and perhaps a 'leaky gut'. The study will image 20 patients to assess gut permeability, which could lead to a more patient- friendly procedure than the current hours of repeated urine tests.

Establishing the link between leaky gut and inflammation could also lead to better treatment pathways, and indicate ways the same method could help with other conditions such as the link between inflammatory bowel disease and arthritis.

Expertise in experimental medicine at the heart of Nottingham University Hospitals

The NIHR Nottingham Clinical Research Facility is at the heart of the work we do to develop treatments from the earliest phases of research studies, essential to establishing and ultimately licensing new medicines and technology.

In the last year, as well as supporting the development of new vaccines for Covid-19, we also undertook a flu vaccine study in partnership with Public Health England, to compare the effectiveness of different types of seasonal influenza vaccines in people aged 65 years and above. Other developments included the evaluation of novel interventions to improve musculoskeletal outcomes in frail older people; adaptation of biological safety protocols; and the development of MRI to change the way new drug treatments for bowel disorders can be evaluated.

In total 477 studies took place in the Nottingham CRF in our organisation, an increase of 37 studies from the previous year. The CRF has been particularly successful in working with both large companies and SMEs, delivering 137 studies in collaboration with the Life Sciences Industry and generating over £6m of commercial income to the Trust.

Supporting Research Careers

Currently more than 400 nurses, midwives, doctors and health professionals are directly involved in helping to deliver research trials here each year. The Research and Innovation department supports the development of research careers in a number of ways, including through the planned establishment of the Research Futures School which will be developed in 2021/22.

Assistant Professor Vicky Booth has this year become a HEE/NIHR ICA Clinical Lecturer at the University of Nottingham and is also Allied Health Professional Clinical Academy Co-Lead for Nottingham University Hospitals. Assistant Professor Booth and one of our midwives Dr Kerry Evans are the first of their professions at Nottingham University Hospitals to have received this type of clinical lectureships for non-medics from the NIHR.

The HEE/NIHR ICA Clinical Lectureship programme is a difficult award to secure, with only 30 such grants awarded around the country. A previous winner of the Clinical Lectureship is Dr Joseph Manning, Charge Nurse in the Paediatric Critical Care Outreach Team at Nottingham Children's Hospital, who was the first children's nurse in the country to receive this award.

As an Allied Health Professional, Vicky has been supported and championed in her research by Professor Pip Logan, an occupational therapist and NIHR senior investigator, who has worked as her PhD supervisor.

We celebrated yet another success with an NIHR award at post-doctoral level. Dr Katie Robinson started an NIHR Advanced Fellowship on 1 September, which further demonstrates the variety and depth of research and clinical talent in various roles throughout the organisation.

In 2020/21 our key performance achievements were:

Key Performance Indicators	**2019/20**		**2020/21**	
	Target	**Actual**	**Target**	**Actual**
Minimum per cent of patients offered the opportunity to participate in research	30%	20%		
Number of patients recruited in NIHR studies	14,000	14,115	12,000	12,795
Total Research and Innovation Income	£26M	£25.9M	£26M	£28.5M

Draft 2021/22 Annual Plan Milestones (subject to review and agreement by the Trust Board)

Our plans for 2021/22 aim to make progress on the strategic challenges and risks our organisation faces following the Covid-19 pandemic. The Board has developed a Delivering Excellence Framework, which focuses on three strategic pillars for measuring quality of care in terms of benchmarked outcomes for clinical care, patient experience and staff experience. Our annual goals are shaped around the three pillars, which aims to support in managing the continued uncertainty and recovery efforts in response to Covid-19 and enable delivery against our strategic objectives. A designated Executive Director lead will own and deliver against the priorities set within each pillar.

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

Financial Performance

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
Adjusted Financial Performance [2]	ICS Financial Control Total Delivered	n/a	6.7	0	Met [1]
Reported Surplus before impairment and impact of capital donations/grants (Break Even Duty)	Expenditure does not exceed income	n/a	16.2	0	Met
External Finance Limit (EFL)	How much more (or less) cash NUH can spend over that which it generates from its activities.	75.0	-52.7	127.7 Underspend	Met [3]
Capital Absorption Rate	NUH is required to pay a dividend to DHSC of 3.5 per cent 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	86.6	86.3	0.3	Met

1 Trust as part of the ICS with partner organisations performance met the revised ICS Control Total for 2020/21

2 Adjusted Financial Performance removes the impact of impairments, capital donations, and the donated PPE I&E impact

3 Due to the fundamental changes to provider cash funding this year, the EFL target and performance is subject to confirmation

Alongside the statutory duties mentioned above, NHS Improvement (NHSI) would usually measure the use of resources through the Single Oversight Framework (SOF). This was suspended during 2020/21 due to the Covid-19 pandemic.

Summary of financial performance

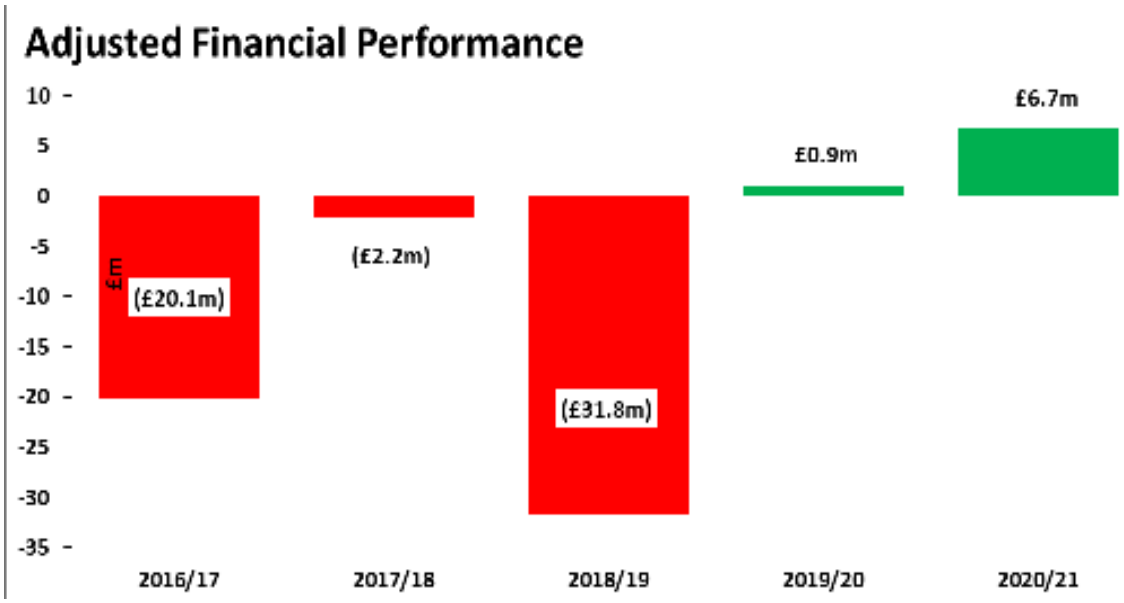
As a result of the Covid-19 pandemic the funding regime for the organisation changed in 2020/21; the organisation's income was established on a block contract basis with funding top ups to support the expenditure run rates and any additional funds required to address specific Covid-19 related items such as the additional cost of personal protective equipment - PPE. We also had a much smaller efficiency target for 2020/21 and delivered £3.2m in line with that plan.

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. We delivered a £16.5m reported surplus before adjustment for the impact of impairment reversals £0.1m, the removal of capital donations and grants £7.3m, and the net impacted of PPE consumables donated by Department of Health £2.4m. This gave an adjusted financial performance total of £6.7m surplus.

We are required to meet certain statutory financial duties in order to demonstrate appropriate financial stewardship and control. In 2020/21 we achieved its annual breakeven financial duty after

the inclusion of top up funding relating to the pandemic, as well as its other statutory financial duties, including maintaining capital spending, cash and borrowing within the limits set by the Department of Health. We invested £95m in its capital infrastructure in 2020/21, to primarily ensure patients were treated in the best possible clinical environment whilst addressing specific factors arising from the Covid-19 pandemic.

Since being established, we have achieved 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 ongoing Covid-19 response since March 2020. Our adjusted financial performance for the last five years is shown below.



Cash

Our cash position grew by £100.2m to £126.2m in 2020/21. We operate within the NHS finance regime, which enables all providers to access revenue support. During the year of the pandemic the Department of Health suspended the typical NHS finance regime, which enables all providers to access deficit support either through interim revolving working capital loans or revenue support loans. Specific Covid-19 and top up funding was introduced this year which enabled us, along with the vast majority of NHS bodies, to operate from a cash perspective without access to additional financial 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 (PDC). Although this removes the liability of the organisation to repay this debt, PDC dividend does currently attract a higher cost of capital (3.5 per cent) than the cost of servicing the loans (1.5 per cent).

The organisation had a cash balance of £126.2m at 31 March 2021. We remained within our cash limit set by Department of Health and Social Care.

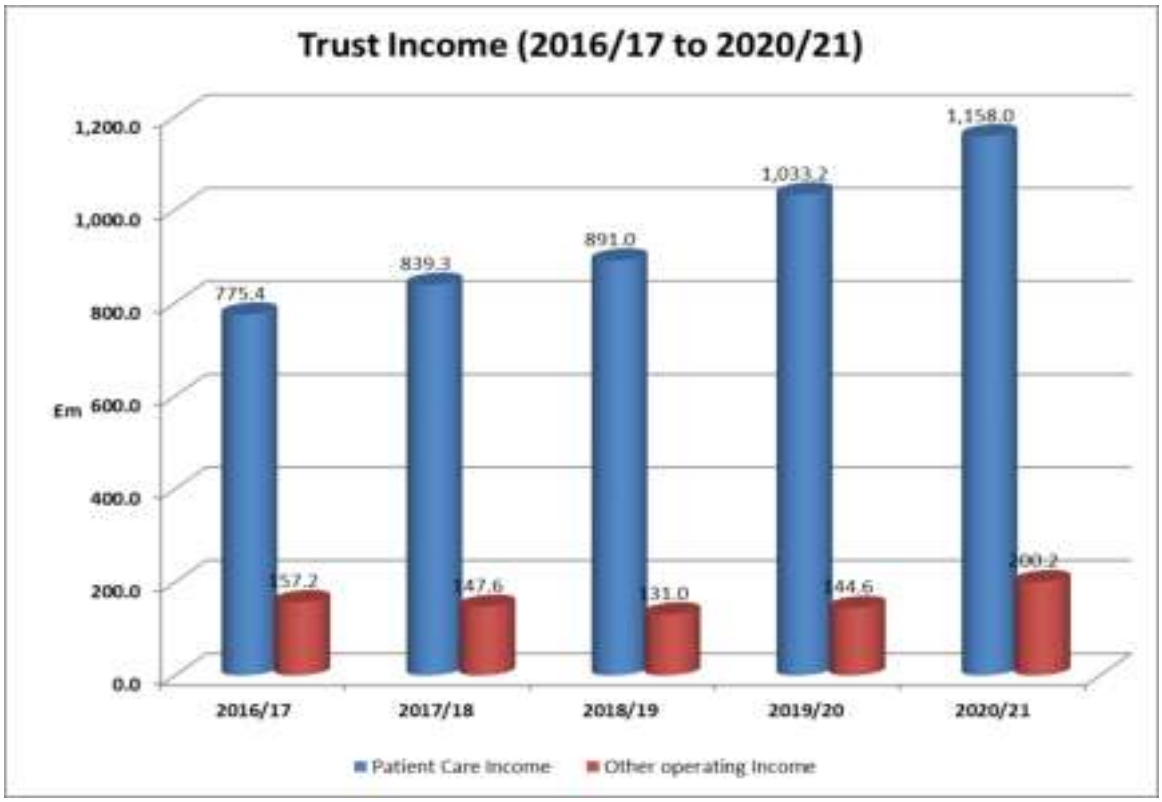
Capital Investment

We invested more than £96.1m in its capital infrastructure in 2020/21 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.

We invested over £96.1m in capital infrastructure and equipment in 2020/21 and remained within the limit set by the Department of Health and Social Care.

Income

Our turnover increased to £1.358bn – an increase of £180m (15 per cent).



Patient Care Income (£1.158 billion)

Our income is mainly generated from CCG Commissioners for the delivery of acute care (£638.6m) and NHS England for specialised patient care activities (£499.2m). This represented a £128.3m (13 per cent) increase on the levels received in 2019/20.

The way income is earned by the organisation changed in 2020/21 in response to the pandemic, nationally mandated block payments were arranged to cover the cost of services to ensure that NHS organisations had sufficient funding to respond to the crisis and could focus on delivering safe patient care during this challenging time.

The block payments were based on costs incurred during 2019/20, uplifted to cover increased costs including the pay award and inflation. The other main changes that impacted on patient care income for the organisation are;

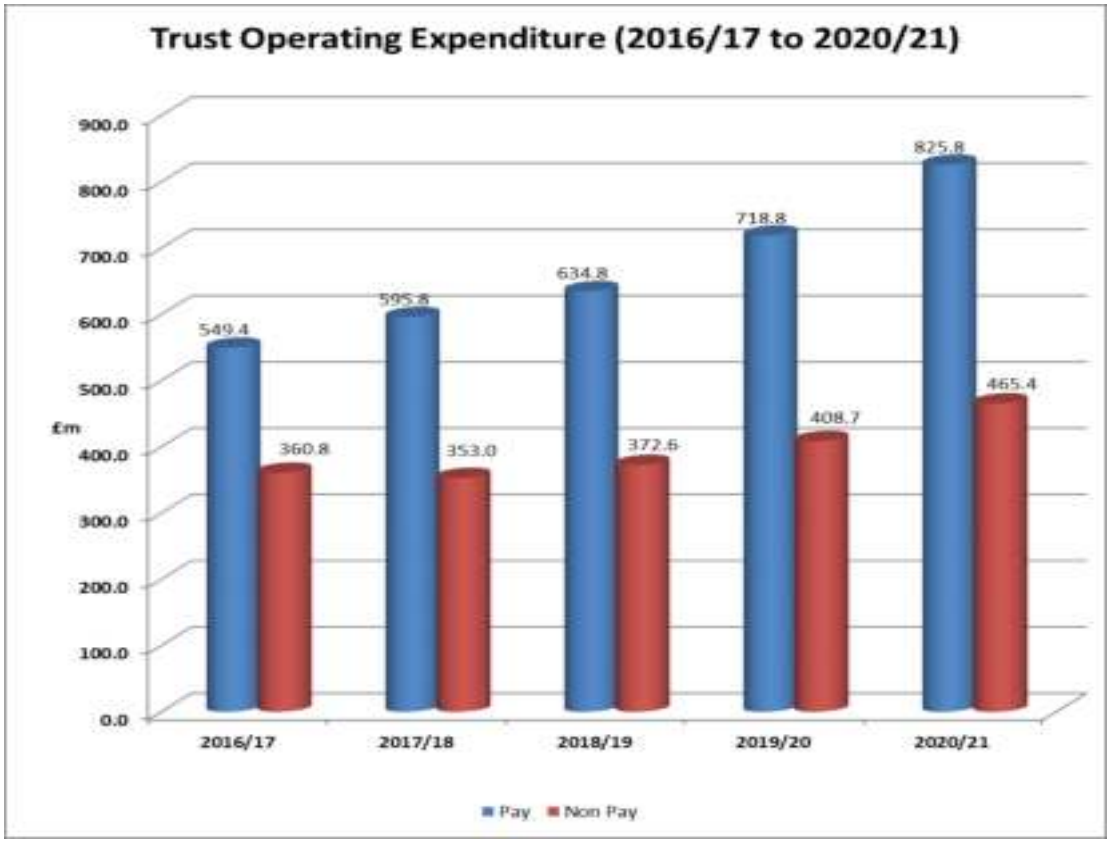
- Inflationary increases of £27m, and estimated growth of £9m this is offset by increases in costs for staffing (including the pay award), inflationary pressures and increased demand for services
- National blocks included an element of funding to ensure system costs were covered, this benefited the Trust by £24.2m
- Expenditure on pass through high cost drugs increased and was covered by additional income earned of £24m
- Additional to the national block payments funding was agreed to deliver service development and restoration of planned care during the year £5.3m
- Additional funding for Covid-19 costs of £29.6m, this is relating to and offset by the increased costs of delivery during the pandemic.

Non-patient care income (£200.2m)

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 £55.6m in 2020/21. The main increase related to the Covid-19 reimbursement and top up funding of £71.8m to address financial sustainability during the pandemic. PSF/FRF funding was removed for the financial year 2021/21 and this accounts for a reduction of £26.3m from 2019/20. The other main change was an increase of £8.3m within capital grants and donations, with the grant for the City Energy Project and the donation of IMRI scanner from the NUH charity being the two most significant items.

Expenditure

Expenditure (including non-operating items) of £1.328bn were incurred in delivering our services in 2020/21 compared with £1.181bn in 2019/20; an increase of £43.4m (10.6 per cent). A trend analysis of operating expenses is shown in the graph below:

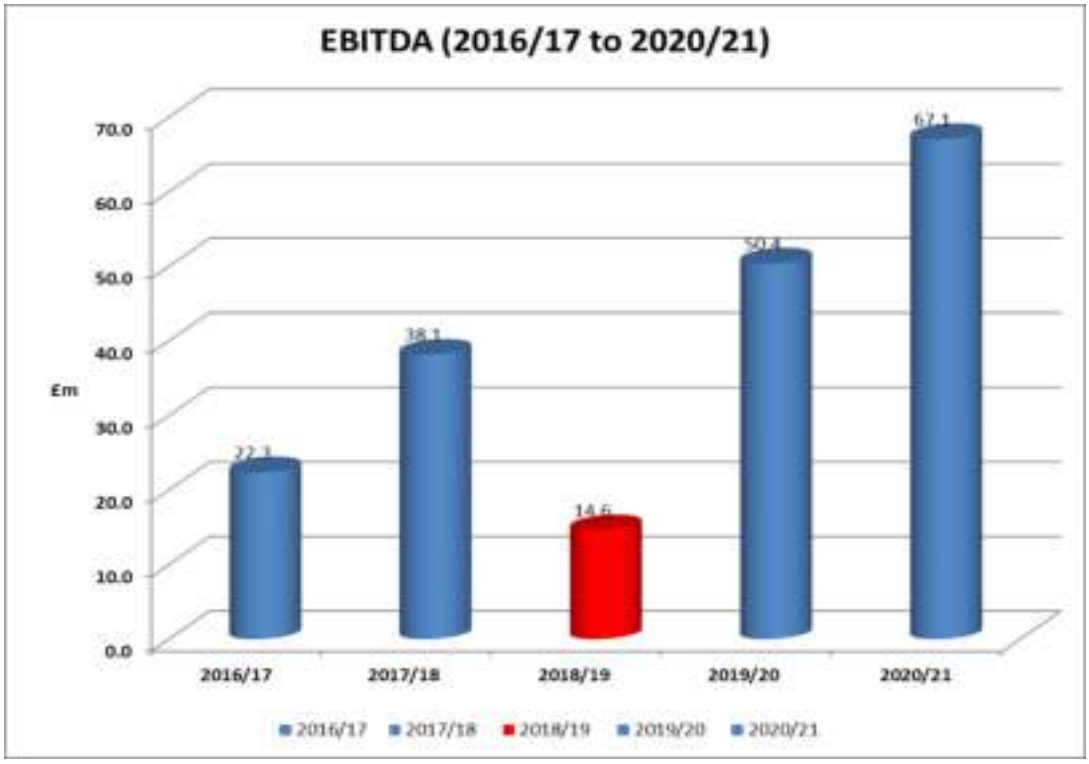


Staffing costs increased by £107m (15 per cent), which included inflationary increases of £17.8m; additional staffing due to Covid-19 £23.1m; and an overall increase in the annual leave accrual of £15.3m relating to the inability of staff to take all of the annual leave entitled during the pandemic. The overall size of our workforce increased by 566 WTE to 16,244 employees in 2020/21.

Our non-pay expenditure increased year on year by £56.7m (excluding non-operating items), representing an increase of 14 per cent, mainly associated with delivering front line care (clinical supplies and services, including medicines - £20.6m, higher clinical negligence costs of £5.4m, and other expenditure relating to the Covid-19 response £5.2m) Premises costs increased by £14.0m largely driven by investment throughout the physical Trust estate in order to make changes arising from the Covid-19 pandemic. This included introducing partitions and adapting entrances, as well as the investment needed on IT hardware to support new ways of working.

EBITDA

EBITDA is defined as earnings before interest, tax and dividend. Our financial position for 2020/21 was a surplus EBITDA of £67.1m, its highest level for five years.

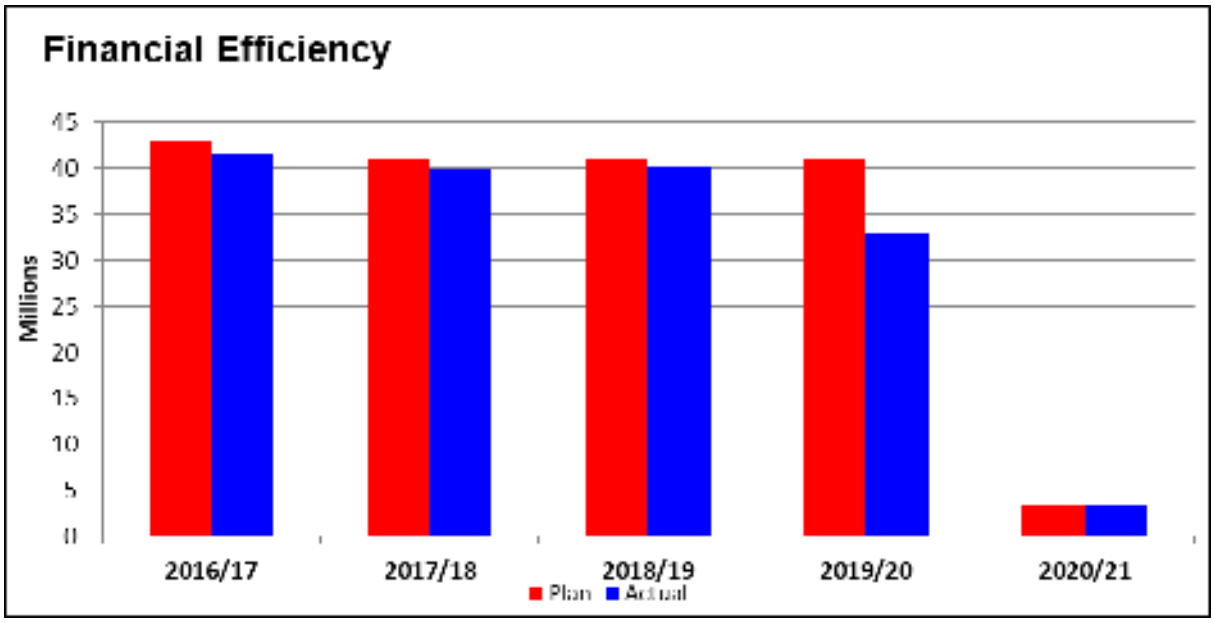


Non-operating Items

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 £1.7m 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 £3.2m savings against a target of £3.2m, which is shown alongside the prior year's performance in the table below:



The details below sets out the savings delivered across the divisions and individual work streams.

Carter Work stream Category	Actual (£000s)
Corporate & Admin	29
Estates and Facilities	193
Hospital Medicine and Pharmacy	352
Imaging	35
Pathology	160
Procurement	732
Workforce (Nursing)	135
Workforce (Other)	62
Other Savings Plans	1,548
Total	**3,246**

Division	Actual (£000s)
Ambulatory Care	0
Cancer & Specialties	607
Clinical Support	256
Corporate	0
Estates and Facilities	476
Family Health	44
Medicine	541
Surgery	1,322
Total	**3,246**

Towards the end of 2019/20 the organisation set out its commitment to follow a Quality Improvement (QI) and waste reduction strategy for identifying opportunities for efficiencies. The Trust QI strategy was focused under three tiers of work:

- Tier 1 – Trust agreed priority areas, Improving Inpatients, Improving Outpatients and Improving Diagnostics, led by the Director of Strategy and supported by the Improvement and Transformation Team (ITT). These projects would be Trust-wide, large and complex and likely run for more than one year. The ITT identify where the opportunities for improvement lie and work with the services to both develop the plans and to deliver the identified projects.
- Tier 2 – other large scale and complex projects that were identified through enabling programmes of work such as the WAVE (a specialty focused 17 week process that uses data to identify opportunities to improve the quality of patient care and to reduce waste). Quality improvement projects identified through the WAVE process would be for specific services / clinical specialties and would focus on ideas not already under the Tier 1 programme of work.
- Tier 3 – smaller scale projects identified and delivered by the Divisions.

At the beginning of 2020/21 our day to day operational activities were overtaken by the Covid-19 pandemic; normal day to day routine significantly changed including annual planning with a new funding regime being agreed that paid the trust a blocked level of income. A small efficiency target of £3.2m was in place for the year allowing operational colleagues to completely focus on managing Covid-19.

Despite the challenge of managing Covid-19, tier 1 and tier 2 initiatives did continue allowing improvements to be identified that supported restoration and recovery of services in between the Covid-19 waves; the focus was on releasing capacity rather than cost reduction as the patient waiting lists grew. For 2021/22 the focus for the quality improvement and waste reduction programme will continue to be on managing the backlog of patients that are awaiting treatment and initiatives that can be identified to release bed capacity, improve theatre throughput and increase outpatient capacity both virtual and face to face. The funding regime has been agreed as a block contract for the first half of 2021/22 as, nationally and locally, we see what the impact of Covid-19 and the vaccination programme will mean.

Property Valuation

Following the full site revaluation of our property that was last undertaken in 2018/19, an interim desktop valuation was again completed by our valuers, Gerald Eve for 2020/21. This year the impact of indexation changes from the building price index was a downwards move of two base points from 330 to 328, with the location factor element for Nottingham and Gedling remaining unchanged.

Taking the indexation changes into account this resulted in an overall impairment on some Trust properties and upward revaluations on other buildings, with an overall net decrease of £9.4m in the value of the Trust asset base (including in year 2020/21 capital additions). This included a reversal of the land impairment that was applied in 2019/20 in recognition of the expected economic downturn precipitated by the first wave of the pandemic.

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 £96.1m 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:

Schemes	£m
Estates infrastructure and compliance priorities; includes City Hospital roof replacement	13.696
Replacement of obsolete minor medical equipment, including £1.5m MRI installation	5.737
COVID-19 - City endoscopy ventilation, bulk oxygen infrastructure and other schemes	9.784
CT & MRI - interOperative MRI, replacement MRI, Treatment Centre installation	9.954
Adult Critical Care medical equipment and Intensive Care expansion	8.290
City Energy Project (part of £24.67m project)	4.585
ICT - pathology lab., clinical sustainability, digitisation and E-prescribing, medicines administration and other business as usual.	12.773
Robotic expansion	3.684
Radiotherapy equipment replacement	3.513
HIP2 PBC / PCBC development	3.347
Phase 2 floor redesign (B3 expansion)	3.000

NHSE/I gifted equipment - testing/imaging/other	1.905
National Rehabilitation Centre - business case development and enabling works	2.698
Lister 2 (previously Simpson Ward City campus) - increase in ward capacity	1.659
CAS oncology SDEC unit / burns theatre	1.650
Mortuary upgrades (QMC & City Hospital)	1.645
Car parking - technology & infrastructure	1.200
HEFPA filtration units	1.073
NUH ward renewal project	1.040
Other small schemes	4.831
Total Capital Expenditure	**96.064**

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 90 per cent of the value and 86 per cent by volume of the invoices we processed**,** which still benchmarks in the upper quartile of all providers.

The Financial Outlook

Like most acute providers, nationally, we have been exposed to unprecedented operational and financial pressures in relation to the Covid-19 response over the last year. Despite these pressures in 2020/21 we have delivered a surplus of [£6.7m] on a control total basis. This excludes the impact of impairments and other non-performance related DH accounting.

The financial regime that has been in operation during 2020/21 has led to a suspension of the normal activity based contract arrangements between providers and commissioners for the entire year. These have been replaced by system envelopes with block contracts based on actual spend from 2019/20 with additional incremental Covid-19 costs also reimbursed.

For the first six months of 2020/21 the financial framework included top up expenditure to enable providers to break even. This amended financial regime came with clear expectations that while finances should not be a barrier to managing the response to the pandemic normal financial management and governance requirements remained in place throughout and that all claims for additional funding could be subject to external audit.

For the second half of 2020/21 the financial regime was changed to reflect policy expectations that the NHS would begin to recover from Covid-19 and to incentivise restoration and recovery of normal activity. While system envelopes and block arrangements remained there was no longer a reimbursement of all reasonable costs to break even and systems were expected to operate within a financial envelope including most Covid-19 costs. Another key assumption was the recovery of all non NHS income, which has not been possible.

Delivery of a surplus in the second half has only been possible due to additional monies being received for all trusts in relation to other income shortfalls and timing of investments.

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-19 phase and ultimately into business as usual.

There has not been an immediate return to the normal historical approach to full year planning for the first half of 2021/22. Instead there has been a planning approach focused on the first six months of 2021/22 which is largely a continuation of the regime in place for the second half of 2020/21 with a few significant exceptions. The main focus of the planning guidance for the first half of 2021/22 has been the delivery of elective and cancer related work. The financial regime for the first half incentivises delivery in relation to this with an incentive scheme in place for the system to earn more

income as long as it meets non-emergency activity thresholds based on delivery of activity in the equivalent month of 2019/20.

There is not yet any indication of the timing, structure or value of the financial regime in place within the NHS for the second half of 2021/22. However, there is a clear expectation that there will be a transition towards business as usual which is applied to the financial regime would see overall funding levels reduced from those currently experienced as a result of the pandemic.

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. 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 and Expenditure (I&E) plan.

We have made arrangements to carry on securing economy, efficiency and effectiveness in the use of resources and remain committed to making best use of resources, working with our partners across the health and care system.

The Finance Team continue to review and model the implications for our income and expenditure and cash plans for 2021/22 from NHS England planning guidance. The ongoing development of a longer term five year financial model 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.

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 2020/21 Group Accounting Manual issued by the Department of Health and Social Care. They represent a "true and fair view" of our activity in 2020/21, 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 and review of our arrangements for securing economy, efficiency and effectiveness in our use of resources (value for money).

KPMG charged audit-related fees of £95,950 (excluding VAT) for The Trust and £12,000 (excluding VAT) for HPSN.

We have not received any non-audit services from KPMG in 2020/21.

Fraud awareness

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

Foreword to Accounts

The Accounts for the year ended 31 March 2021 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: 10/06/2021

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: 10/06/2021

Rupert Eggington
Chief Financial Officer (on behalf of the Trust Board)
Date: 10/06/2021

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Nottingham University Hospitals NHS Trust ("the Trust") for the year ended 31 March 2021 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2021 and of the Group's and Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State 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 2020/21.

Basis for opinion

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

Going concern

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

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Group's and Trust's business model and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

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

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group and Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk of incentive for revenue to be manipulated into the wrong period around the year end and the risk that Group management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included combinations of unexpected posting relating to cash, journals made by people who typically do not post journals and journals posted at the end of the financial period.
- Assessing significant estimates for bias.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify revenue had been recognised in the correct accounting period.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

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

As the Group is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

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

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

The Group is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. Under paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 the Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account (the breakeven duty). In reporting on compliance with the breakeven duty the Trust is required to comply with the Department of Health and Social Care's 'Guidance on Breakeven Duty and Provisions', We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

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

As outlined in the section of this report dealing with statutory reporting matters, we made a Section 30 referral to the Secretary of State on 25 June 2021.

Whilst the Group is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

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

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

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

Other information in the Annual Report

The 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; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required 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 2020/21. 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 2020/21.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 124, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and 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, on Page 123 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

Significant Weakness – Economy, Efficiency and Effectiveness

We have identified one significant weakness in relation to concerns raised in the Care Quality Commission report received by the Trust in October 2020 with regard to maternity services. In response to the report, the Trust have established a maternity oversight committee to oversee the implementation of the Action Plan. In the period to 31 March 2021, the Trust has been unable to evidence sufficient progress in relation to embedding actions.

Recommendation:

The following recommendation is raised in respect of the significant weakness above:

- The Trust should continue to maintain the current level of focus and direct resources to improve the levels of service provided by the maternity services at the Trust.

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

As explained in the statement set out on page 123, 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

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

On 25 June 2021, we referred a matter to the Secretary of State under section 30 (1)(a) of the 2014 Act in relation to the breach of the Trust's breakeven duty due to the surplus of £6.683 million in 2020/21, and the cumulative breakeven duty position of a deficit of £39.733 million at 31 March 2021.

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 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Sarah Brown
for and on behalf of KPMG LLP
Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH
25 June 2021

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.
HCOP Health Care of Older People.
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.

We Listen
We Care

Nottingham University Hospitals NHS Trust
Annual Accounts for the Year Ended 31 March 2021

Consolidated Statement of Comprehensive Income

		Group	
		2020/21	2019/20
	Note	£000	£000
Operating income from patient care activities	3	1,158,048	1,033,229
Other operating income	4	200,183	144,616
Operating expenses	6, 8	(1,328,125)	(1,165,843)
Operating surplus/(deficit) from continuing operations		**30,106**	**12,002**
Finance income	11	10	349
Finance expenses	12	(2,380)	(4,086)
PDC dividends payable		(11,080)	(11,005)
Net finance costs		**(13,450)**	**(14,742)**
Other gains / (losses)	13	26	(61)
Corporation tax expense		(184)	(177)
Surplus / (deficit) for the year from continuing operations		**16,498**	**(2,978)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-
Surplus / (deficit) for the year		**16,498**	**(2,978)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(14,962)	(4,750)
Revaluations	19	5,540	1,474
Total comprehensive income / (expense) for the period		**7,076**	**(6,254)**
Surplus/ (deficit) for the period attributable to:			
Non-controlling interest, and		-	-
Nottingham University Hospitals NHS Trust		16,498	(2,978)
TOTAL		**16,498**	**(2,978)**
Total comprehensive income/ (expense) for the period attributable to:			
Nottingham University Hospitals NHS Trust		7,076	(6,254)
TOTAL		**7,076**	**(6,254)**

Statements of Financial Position

	Note	Group 31 March 2021 £000	Group 31 March 2020 £000	Trust 31 March 2021 £000	Trust 31 March 2020 £000
Non-current assets					
Intangible assets	16	15,419	8,746	15,419	8,746
Property, plant and equipment	17	588,121	545,161	588,121	545,161
Receivables	23	8,292	8,698	8,292	8,698
Total non-current assets		**611,832**	**562,605**	**611,832**	**562,605**
Current assets					
Inventories	22	27,836	25,414	26,016	23,381
Receivables	23	51,859	89,328	53,787	95,283
Cash and cash equivalents	26	126,172	25,990	125,335	24,118
Total current assets		**205,867**	**140,732**	**205,139**	**142,782**
Current liabilities					
Trade and other payables	27	(217,202)	(157,148)	(221,103)	(163,052)
Borrowings	29	(3,379)	(94,639)	(3,379)	(94,639)
Provisions	32	(3,203)	(2,480)	(3,203)	(2,480)
Other liabilities	28	(13,688)	(16,579)	(13,688)	(16,579)
Total current liabilities		**(237,472)**	**(270,846)**	**(241,373)**	**(276,750)**
Total assets less current liabilities		**580,227**	**432,491**	**575,599**	**428,637**
Non-current liabilities					
Borrowings	29	(20,550)	(23,889)	(20,550)	(23,889)
Provisions	32	(7,672)	(5,359)	(7,672)	(5,359)
Total non-current liabilities		**(28,222)**	**(29,248)**	**(28,222)**	**(29,248)**
Total assets employed		**552,005**	**403,243**	**547,377**	**399,389**
Financed by					
Public dividend capital		572,995	431,309	572,995	431,309
Revaluation reserve		75,927	89,372	75,927	89,372
Income and expenditure reserve		(96,917)	(117,438)	(101,545)	(121,292)
Total taxpayers' equity		**552,005**	**403,243**	**547,377**	**399,389**

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

Tracy Taylor
Chief Executive Officer
Date **10 June 2021**

Consolidated Statement of Changes in Equity for the year ended 31 March 2021

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020	**431,309**	**89,372**	**(117,438)**	**403,243**
Surplus/(deficit) for the year	-	-	16,498	**16,498**
Other transfers between reserves	-	(4,023)	4,023	**-**
Impairments	-	(14,962)	-	**(14,962)**
Revaluations	-	5,540	-	**5,540**
Public dividend capital received	141,686	-	-	**141,686**
Taxpayers' and others' equity at 31 March 2021	**572,995**	**75,927**	**(96,917)**	**552,005**

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

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £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**

Statement of Changes in Equity for the year ended 31 March 2021

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020	**431,309**	**89,372**	**(121,292)**	**399,389**
At start of period for new FTs				**-**
Surplus/(deficit) for the year	-	-	15,724	**15,724**
Other transfers between reserves	-	(4,023)	4,023	**-**
Impairments	-	(14,962)	-	**(14,962)**
Revaluations	-	5,540	-	**5,540**
Public dividend capital received	141,686	-	-	**141,686**
Taxpayers' and others' equity at 31 March 2021	**572,995**	**75,927**	**(101,545)**	**547,377**

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**

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.

Statements of Cash Flows

	Note	Group 2020/21 £000	Group 2019/20 £000	Trust 2020/21 £000	Trust 2019/20 £000
Cash flows from operating activities					
Operating surplus / (deficit)		30,106	12,002	29,330	11,074
Non-cash income and expense:					
Depreciation and amortisation	6.1	37,012	35,350	37,012	35,350
Net impairments	7	(67)	3,010	(67)	3,010
Income recognised in respect of capital donations	4	(8,607)	(307)	(8,607)	(307)
(Increase) / decrease in receivables and other assets		37,385	(24,872)	36,766	(28,391)
(Increase) / decrease in inventories		(2,422)	(3,348)	(2,638)	(3,206)
Increase / (decrease) in payables and other liabilities		40,688	24,830	43,160	28,409
Increase / (decrease) in provisions		3,050	3,236	3,050	3,236
Tax (paid) / received		(176)	(29)	(2)	
Net cash flows from / (used in) operating activities		**136,969**	**49,872**	**138,005**	**49,175**
Cash flows from investing activities					
Interest received		10	349	10	349
Purchase of intangible assets		(7,351)	-	(7,351)	-
Purchase of PPE and investment property		(70,098)	(41,423)	(70,098)	(41,423)
Sales of PPE and investment property		87	22	87	22
Receipt of cash donations to purchase assets		6,461	-	6,461	
Net cash flows from / (used in) investing activities		**(70,891)**	**(41,052)**	**(70,891)**	**(41,052)**
Cash flows from financing activities					
Public dividend capital received		141,686	9,582	141,686	9,582
Movement on loans from DHSC		(91,992)	520	(91,992)	520
Capital element of finance lease rental payments		(1,801)	(1,748)	(1,801)	(1,748)
Capital element of PFI, LIFT and other service concession payments		(448)	(583)	(448)	(583)
Interest on loans		(744)	(1,917)	(744)	(1,917)
Other interest		-	(35)	-	(35)
Interest paid on finance lease liabilities		(147)	(200)	(147)	(200)
Interest paid on PFI, LIFT and other service concession obligations		(1,860)	(1,849)	(1,860)	(1,849)
PDC dividend (paid) / refunded		(10,590)	(11,727)	(10,590)	(11,727)
Net cash flows from / (used in) financing activities		**34,104**	**(7,957)**	**34,104**	**(7,957)**
Increase / (decrease) in cash and cash equivalents		**100,182**	**863**	**101,218**	**166**
Cash and cash equivalents at 1 April - brought forward		**25,990**	**25,127**	**24,118**	**23,952**
Cash and cash equivalents at 31 March	26	**126,172**	**25,990**	**125,336**	**24,118**

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 2020/21 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 Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Note 1.3 Basis of Consolidation

Charitable Funds
Nottingham University 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.

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 2021 is £10,875k (31 March 2020, £7,839k).

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).

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 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. The GAM 2020-21 has deleted the sections on PSF and FRF and does not now require PSF and FRF to be included in the analysis of other operating income.

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.

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, e.g., 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 have 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.

The freehold property known as Nottingham University Hospitals NHS Trust was valued as at 31 March 2021 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation – Global Standard 2020 and the national standards and guidance set out in the UK national supplement (November 2018), 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.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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 i.e.:
- 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 items of property, plant and equipment.

Note 1.11.6 Private Finance Initiative (PFI) transactions

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

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

Note 1.11.7 Useful lives of property, plant and equipment

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

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

The minimum useful economic life of 1 year is applied to any component part of a building as part of the valuation process, when the Trust has an intention to dispose, or has declared a building element as vacant.

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, e.g., 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, e.g. 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, e.g. 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 lives of intangible assets

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

	Min life	**Max life**
	Years	**Years**
Intangible assets - internally generated		
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 the 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 Climate Change Levy (CCL)

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

Note 1.17 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, i.e., 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 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 and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On de-recognition, 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 De-recognition

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

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

Note 1.18 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.18.1 The Trust as lessee

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for 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 0.95% (2019-20: negative 0.50%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A nominal short-term rate of negative 0.02% (2019-20: negative 0.51% 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 0.18% (2019-20: positive 0.55% 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% (2019-20: 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% (2019-20: 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 total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed as a note 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. The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities except for:

- donated and grant funded assets,
- 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
- any PDC dividend balance receivable or payable; and
- any specific income allocations (e.g. PSF incentive allocations) specifically excluded from the dividend calculation

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

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

Note 1.25 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% - 2019-20) 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 expense in the period in which they arise.

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

Note 1.28 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 2020/21.

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 2020/21.

- **IFRS 16 Leases**

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

- **IFRS 17 Insurance Contracts**

Application is required for accounting periods beginning on or after 1 January 2021, but the standard is 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	
	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000	£000	£000
Income	1,357,979	1,177,533	252	312	1,358,231	1,177,845
Surplus / (Deficit)	15,724	(3,733)	774	755	16,498	(2,978)
Segment net assets	547,375	399,389	4,628	3,854	552,003	403,243

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 2020-21 is £ 43.040m, of which £42.788m is from Nottingham University Hospitals NHS Trust (99.4%). The comparative figure for 2019-20 is £35.409m, of which £35.097m is from Nottingham University Hospitals NHS Trust (99.1%).

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.7

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Acute services		
Block contract / system envelope income*	946,194	855,022
High cost drugs income from commissioners (excluding pass-through costs)	141,238	118,186
Other NHS clinical income	12,595	17,498
Community services		
Income from other sources (e.g. local authorities)	5,193	5,354
All services		
Private patient income	1,859	3,313
Additional pension contribution central funding**	30,149	27,807
Other clinical income	20,820	6,049
Total income from activities	**1,158,048**	**1,033,229**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	499,154	453,884
Clinical commissioning groups	638,579	555,401
Department of Health and Social Care	7	22
Other NHS providers	9,564	10,512
NHS other	167	228
Local authorities	5,193	5,354
Non-NHS: private patients	1,337	2,385
Non-NHS: overseas patients (chargeable to patient)	522	928
Injury cost recovery scheme	3,504	4,256
Non NHS: other	21	259
Total income from activities	**1,158,048**	**1,033,229**
Of which:		
Related to continuing operations	1,158,048	1,033,229
Related to discontinued operations	-	-

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

	2020/21	2019/20
	£000	£000
Income recognised this year	522	928
Cash payments received in-year	237	281
Amounts added to provision for impairment of receivables	301	95
Amounts written off in-year	164	152

Note 4 Other operating income (Group)

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	28,496	-	**28,496**	26,456	-	**26,456**
Education and training	48,932	1,396	**50,328**	44,382	984	**45,366**
Non-patient care services to other bodies	5,704		**5,704**	12,040		**12,040**
Provider sustainability fund (2019/20 only)			**-**	18,138		**18,138**
Financial recovery fund (2019/20 only)			**-**	8,206		**8,206**
Marginal rate emergency tariff funding (2019/20 only)			**-**	3,368		**3,368**
Reimbursement and top up funding	71,828		**71,828**			**-**
Income in respect of employee benefits accounted on a gross basis	5,238		**5,238**	6,285		**6,285**
Receipt of capital grants and donations		8,607	**8,607**		307	**307**
Charitable and other contributions to expenditure		20,037	**20,037**		2,521	**2,521**
Rental revenue from operating leases		750	**750**		765	**765**
Other income	9,195	-	**9,195**	21,164	-	**21,164**
Total other operating income	**169,393**	**30,790**	**200,183**	**140,039**	**4,577**	**144,616**
Of which:						
Related to continuing operations			200,183			144,616
Related to discontinued operations			-			-

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

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	4,097	4,272
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 2021 £000	31 March 2020 £000
within one year	-	-
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**-**	**-**

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

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

2020/21:
The Trust disposed of medical equipment. The sales proceeds of £87k were received and the Net Book Value of the equipment assets disposed was £1k resulting in a profit on loss on disposal of £26k.

Note 5.4 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.

	2020/21	2019/20
	£000	£000
Income	-	4,379
Full cost	-	(4,659)
Surplus / (deficit)	**-**	**(280)**

There is no relevant income above £1m in 2020/21.
Car parking income ceased during 2020/21 as part of the response to COVID-19.
Car parking expenditure is included in operating expenditure.

Note 6.1 Operating expenses (Group)

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	7,187	6,742
Purchase of healthcare from non-NHS and non-DHSC bodies	985	3,314
Staff and executive directors costs	825,779	718,808
Remuneration of non-executive directors	150	97
Supplies and services - clinical (excluding drugs costs)	137,925	129,706
Supplies and services - general	9,870	9,466
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	150,007	124,811
Inventories written down	485	371
Consultancy costs	3,335	1,966
Establishment	8,882	8,191
Premises	46,253	32,186
Transport (including patient travel)	4,648	5,056
Depreciation on property, plant and equipment	33,190	29,505
Amortisation on intangible assets	3,822	5,845
Net impairments	(67)	3,010
Movement in credit loss allowance: contract receivables / contract assets	1,327	1,750
Increase/(decrease) in other provisions	(73)	-
Change in provisions discount rate(s)	128	220
Audit fees payable to the external auditor		
audit services- statutory audit	130	106
other auditor remuneration (external auditor only)	4	4
Internal audit costs	203	192
Clinical negligence	34,163	28,786
Legal fees	881	615
Insurance	946	816
Research and development	29,787	26,651
Education and training	7,473	10,972
Rentals under operating leases	3,886	3,493
Redundancy	-	45
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	4,365	5,062
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	3,152	4,230
Car parking & security	206	277
Hospitality	115	163
Losses, ex gratia & special payments	953	546
Other	8,028	2,841
Total	**1,328,125**	**1,165,843**
Of which:		
Related to continuing operations	1,328,125	1,165,843
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration (Group)

	2020/21 £000	2019/20 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	4	4
Total	**4**	**4**

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £5 million (2019/20: £5 million).

Note 7 Impairment of assets (Group)

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(67)	3,010
Total net impairments charged to operating surplus / deficit	**(67)**	**3,010**
Impairments charged to the revaluation reserve	14,962	4,750
Total net impairments	**14,895**	**7,760**

An interim valuation of the Trust's property estate was conducted by Gerald Eve LLP an independent firm of professional valuers. The Valuers have taken into account the most recent published set of BCIS cost data, published 26th March 2021. This shows the all-in Tender Price Index (TPI) for March 2021 reducing from 330 to 328, with the Location Factors for Nottingham at 1.04 and Gedling at 1.00. Both location factors have remained unchanged since last year. Last year the Valuers applied a -10% reduction to land value to reflect their assessment of the likely effects from the first Covid19 shutdown on development land pricing. The latest assessment has concluded the uncertainty from Covid19 that was applied to land valuations last year to no longer be required and the land impairment has been reversed.

The major impairments including any reversals in 2020/21 included:

- Land City hospital (£1.3m) reversal;
- Land QMC hospital (£0.6m) reversal;
- Roads / Service areas / Footpaths City hospital £1.1m;
- Substation & Theatres £0.7m;

Total Net Impairment £0.067m (reversal)

Note 8 Employee benefits (Group)

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	635,732	554,713
Social security costs	56,075	49,578
Apprenticeship levy	2,873	2,599
Employer's contributions to NHS pensions	99,560	91,461
Pension cost - other	333	274
Termination benefits	-	45
Temporary staff (including agency)	54,908	40,997
Total gross staff costs	**849,481**	**739,667**
Recoveries in respect of seconded staff	-	-
Total staff costs	**849,481**	**739,667**
Of which		
Costs capitalised as part of assets	699	1,141

Note 8.1 Retirements due to ill-health (Group)

During 2020/21 there were 6 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £105k (£121k in 2019/20).

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

Note 9 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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

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 10 Operating leases (Group)

Note 10.1 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 for buildings.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	568	602
Contingent rent	182	163
Total	**750**	**765**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	86	60
- later than one year and not later than five years;	138	91
- later than five years.	261	18
Total	**485**	**169**

Note 10.2 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.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	3,886	3,493
Total	**3,886**	**3,493**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	1,385	1,753
- later than one year and not later than five years;	3,447	3,554
- later than five years.	99	418
Total	**4,931**	**5,725**
Future minimum sublease payments to be received	-	-

Note 11 Finance income (Group)

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	10	349
Total finance income	**10**	**349**

Note 12.1 Finance expenditure (Group)

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	387	1,995
Finance leases	147	200
Interest on late payment of commercial debt	-	35
Main finance costs on PFI and LIFT schemes obligations	917	960
Contingent finance costs on PFI and LIFT scheme obligations	943	889
Total interest expense	**2,394**	**4,079**
Unwinding of discount on provisions	(14)	7
Total finance costs	**2,380**	**4,086**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	35

Note 13 Other gains / (losses) (Group)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	26	-
Losses on disposal of assets	-	(61)
Total gains / (losses) on disposal of assets	**26**	**(61)**
Other gains / (losses)	-	-
Total other gains / (losses)	**26**	**(61)**

In 2020/21 the Trust disposed of medical equipment. The sales proceeds of £87k were received and the Net Book Value of the equipment assets disposed was £1k resulting in a profit on loss on disposal of £26k.

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income.

The trust's surplus/(deficit) for the period was £15.7 million (2019/20: £(3.7)million).

Note 15 Discontinued operations (Group)

The Group has no discontinued operations.

Note 16.1 Intangible assets - 2020/21

Group and Trust	Software licences	Development expenditure	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020	**17,475**	**25,146**	**42,621**
Additions	7,351	-	**7,351**
Reclassifications	3,144	-	**3,144**
Valuation / gross cost at 31 March 2021	**27,970**	**25,146**	**53,116**
Amortisation at 1 April 2020 - brought forward	**14,238**	**19,637**	**33,875**
Provided during the year	3,822	-	**3,822**
Amortisation at 31 March 2021	**18,060**	**19,637**	**37,697**
Net book value at 31 March 2021	**9,910**	**5,509**	**15,419**
Net book value at 1 April 2020	**3,237**	**5,509**	**8,746**

Note 16.2 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	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 17.1 Property, plant and equipment - 2020/21

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**24,538**	**415,854**	**-**	**41,761**	**136,664**	**1,291**	**53,925**	**3,267**	**677,300**
Additions	-	9,222	-	62,986	15,604	-	901	-	**88,713**
Impairments	-	(18,373)	-	-	-	-	-	-	**(18,373)**
Reversals of impairments	1,964	1,514	-	-	-	-	-	-	**3,478**
Revaluations	518	(10,627)	-	-	-	-	-	-	**(10,109)**
Reclassifications	-	21,288	-	(34,850)	9,737	-	681	-	**(3,144)**
Disposals / derecognition	-	-	-	-	(9,074)	-	-	-	**(9,074)**
Valuation/gross cost at 31 March 2021	**27,020**	**418,878**	**-**	**69,897**	**152,931**	**1,291**	**55,507**	**3,267**	**728,791**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**-**	**-**	**-**	**90,331**	**1,218**	**38,136**	**2,454**	**132,139**
Provided during the year	-	15,649	-	-	11,313	18	6,107	103	**33,190**
Revaluations	-	(15,649)	-	-	-	-	-	-	**(15,649)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(9,010)	-	-	-	**(9,010)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**92,634**	**1,236**	**44,243**	**2,557**	**140,670**
Net book value at 31 March 2021	**27,020**	**418,878**	**-**	**69,897**	**60,297**	**55**	**11,264**	**710**	**588,121**
Net book value at 1 April 2020	**24,538**	**415,854**	**-**	**41,761**	**46,333**	**73**	**15,789**	**813**	**545,161**

Note 17.2 Property, plant and equipment - 2019/20

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 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	(2,951)	(5,388)	-	-	-	-	-	-	**(8,339)**
Reversals of impairments	79	500	-	-	-	-	-	-	**579**
Revaluations	351	(13,740)	-	-	-	-	-	-	**(13,389)**
Reclassifications	-	11,038	-	(13,961)	(1,149)	-	4,072	-	**-**
Disposals / derecognition	-	-	-	-	(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	-	14,863	-	-	7,755	40	6,663	184	**29,505**
Revaluations	-	(14,863)	-	-	-	-	-	-	**(14,863)**
Disposals / derecognition	-	-	-	-	(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**

Note 17.3 Property, plant and equipment financing - 2020/21

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	27,020	385,635	-	69,897	58,392	55	11,264	710	**552,973**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	12,048	-	-	-	-	-	-	**12,048**
Owned - donated/granted	-	21,195	-	-	1,905	-	-	-	**23,100**
NBV total at 31 March 2021	**27,020**	**418,878**	**-**	**69,897**	**60,297**	**55**	**11,264**	**710**	**588,121**

Note 17.4 Property, plant and equipment financing - 2019/20

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
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/granted	-	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 18 Donations of property, plant and equipment

The Trust received equipment valued at £1,905k which was centrally procured by the DHSC during 2020/21. This was on a non-cash basis and was fully funded by grants from the DHSC as part of the COVID-19 response.

The Trust received a donation of £2.9m for an IMRI Scanner from the NUH Charity.

Note 19 Revaluations of property, plant and equipment

The freehold property known as Nottingham University Hospitals NHS Trust was valued as at 31 March 2021 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation – Global Standard 2020 and the national standards and guidance set out in the UK national supplement (November 2018), 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 Investment Property

The Group and Trust have no investment properties.

Note 21 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 Trust. The Trust has no interest in any other entities.

Note 22 Inventories

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Drugs	10,142	10,106	8,537	8,073
Consumables	17,577	15,191	17,362	15,191
Energy	117	117	117	117
Total inventories	**27,836**	**25,414**	**26,016**	**23,381**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £288,433k (2019/20: £257,011k). Write-down of inventories recognised as expenses for the year were £485k (2019/20: £371k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £15,300k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above. The closing balance relating to PPE was £2,451k.

Note 23.1 Receivables

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Current				
Contract receivables	47,540	86,888	51,215	93,262
Capital receivables	71	71	71	71
Allowance for impaired contract receivables / assets	(7,036)	(6,192)	(7,036)	(6,192)
Prepayments (non-PFI)	8,011	5,491	8,006	5,491
PFI lifecycle prepayments	-	559		559
Finance lease receivables	901	511	901	511
PDC dividend receivable	983	1,473	983	1,473
VAT receivable	1,299	420	(597)	1
Other receivables	90	107	90	107
Total current receivables	**51,859**	**89,328**	**53,633**	**95,283**
Non-current				
Contract assets	4,156	4,896	4,156	4,896
Prepayments (non-PFI)	-	195	-	195
Finance lease receivables	978	978	978	978
Other receivables	3,158	2,629	3,158	2,629
Total non-current receivables	**8,292**	**8,698**	**8,292**	**8,698**
Of which receivable from NHS and DHSC group bodies:				
Current	27,167	66,367	27,167	66,367
Non-current	3,158	2,824	3,158	2,824

Note 23.2 Allowances for credit losses - 2020/21

	Group and Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2020	**6,192**	**-**
New allowances arising	66	-
Changes in existing allowances	1,261	-
Utilisation of allowances (write offs)	(483)	-
Allowances as at 31 Mar 2021	**7,036**	**-**

Note 23.3 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	**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 23.4 Exposure to credit risk

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

Note 24 Other assets

The Group and Trust have no other financial assets.

Note 25.1 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 25.2 Liabilities in disposal groups

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

Note 26.1 Cash and cash equivalents movements

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

	Group		Trust	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
At 1 April	**25,990**	**25,127**	**24,118**	**23,952**
Net change in year	100,182	863	101,217	166
At 31 March	**126,172**	**25,990**	**125,335**	**24,118**
Broken down into:				
Cash at commercial banks and in hand	863	1,899	26	27
Cash with the Government Banking Service	125,309	24,091	125,309	24,091
Total cash and cash equivalents as in SoFP	**126,172**	**25,990**	**125,335**	**24,118**
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**126,172**	**25,990**	**125,335**	**24,118**

Note 26.2 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 2021	31 March 2020
	£000	£000
Bank balances	-	-
Monies on deposit	-	8
Total third party assets	**-**	**8**

Note 27.1 Trade and other payables

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Current				
Trade payables	29,613	37,486	38,114	43,603
Capital payables	36,815	20,347	36,815	20,347
Accruals	135,155	84,309	135,047	84,309
Receipts in advance and payments on account	-	208		208
Social security costs	15,619	13,599	10,974	13,562
VAT payables	-	215		215
Other taxes payable	-	213		37
Other payables	-	771		771
Total current trade and other payables	**217,202**	**157,148**	**220,950**	**163,052**
Non-current				
Total non-current trade and other payables	**-**	**-**	**-**	**-**
Of which payables from NHS and DHSC group bodies:				
Current	12,552	17,824	12,552	17,824
Non-current	-	-	-	-

Note 27.2 Early retirements in NHS payables above

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

Group and Trust	31 March 2021 £000	31 March 2021 Number	31 March 2020 £000	31 March 2020 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 28 Other liabilities

	Group and Trust	
	31 March 2021	31 March 2020
	£000	£000
Current		
Deferred income: contract liabilities	13,688	16,579
Total other current liabilities	**13,688**	**16,579**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 29 Borrowings

	Group	
	31 March 2021	31 March 2020
	£000	£000
Current		
Loans from DHSC	1,271	92,366
Obligations under finance leases	1,855	1,801
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	253	472
Total current borrowings	**3,379**	**94,639**
Non-current		
Loans from DHSC	7,958	9,213
Obligations under finance leases	1,912	3,767
Obligations under PFI, LIFT or other service concession contracts	10,680	10,909
Total non-current borrowings	**20,550**	**23,889**

Note 29.1 Reconciliation of liabilities arising from financing activities (Group)

Group and Trust- 2020/21	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**101,579**	**5,568**	**11,381**	**118,528**
Cash movements:				
Financing cash flows - payments and receipts of principal	(91,992)	(1,801)	(448)	**(94,241)**
Financing cash flows - payments of interest	(744)	(147)	(917)	**(1,808)**
Non-cash movements:				
Application of effective interest rate	386	147	917	**1,450**
Carrying value at 31 March 2021	**9,229**	**3,767**	**10,933**	**23,929**

Group and Trust - 2019/20	Loans from DHSC	Finance leases	PFI and LIFT 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**

Note 30 Other financial liabilities

The Group and Trust have no other financial liabilities

Note 31 Finance leases

Note 31.1 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 2021	31 March 2020
	£000	£000
Gross lease receivables	**1,879**	**1,489**
of which those receivable:		
- not later than one year;	901	511
- later than one year and not later than five years;	978	978
Net lease receivables	**1,879**	**1,489**
of which those receivable:		
- not later than one year;	901	511
- later than one year and not later than five years;	978	978
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

Note 31.2 Nottingham University Hospitals NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group and Trust	
	31 March 2021	31 March 2020
	£000	£000
Gross lease liabilities	**3,895**	**5,843**
of which liabilities are due:		
- not later than one year;	1,948	1,948
- later than one year and not later than five years;	1,947	3,895
- later than five years.	-	-
Finance charges allocated to future periods	(128)	(275)
Net lease liabilities	**3,767**	**5,568**
of which payable:		
- not later than one year;	1,855	1,801
- later than one year and not later than five years;	1,912	3,767
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as expense in the period	-	-

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

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 32.1 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 2020	**859**	**2,021**	**284**	**4,675**	**7,839**
Change in the discount rate	19	109	-	-	**128**
Arising during the year	40	50	-	4,154	**4,244**
Utilised during the year	(73)	(87)	(73)	(1,089)	**(1,322)**
Unwinding of discount	(4)	(10)	-	-	**(14)**
At 31 March 2021	**841**	**2,083**	**211**	**7,740**	**10,875**
Expected timing of cash flows:					
- not later than one year;	73	87	211	2,832	**3,203**
- later than one year and not later than five years;	300	358	-	145	**803**
- later than five years.	468	1,638	-	4,763	**6,869**
Total	**841**	**2,083**	**211**	**7,740**	**10,875**

Note 33 Contingent assets and liabilities

	Group and Trust	
	31 March 2021	31 March 2020
	£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	**-**	**-**

Note 34 Contractual capital commitments

	Group and Trust	
	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	27,271	10,970
Total	**27,271**	**10,970**

Note 35 Other financial commitments

The Group and Trust have no other financial commitments.

Note 36 Defined benefit pension schemes

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

Note 37 On-SoFP PFI, LIFT or 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 was party to a managed service arrangement for a PET scanner and this contract ended in December 2020.

The Group and Trust have no LIFT arrangements.

Note 37.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

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

	Group and Trust	
	31 March 2021	31 March 2020
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**19,116**	**20,483**
Of which liabilities are due		
- not later than one year;	1,146	1,391
- later than one year and not later than five years;	6,730	5,184
- later than five years.	11,240	13,908
Finance charges allocated to future periods	(8,183)	(9,102)
Net PFI, LIFT or other service concession arrangement obligation	**10,933**	**11,381**
- not later than one year;	253	472
- later than one year and not later than five years;	2,825	1,810
- later than five years.	7,855	9,099

Note 37.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	Group and Trust	
	31 March 2021	31 March 2020
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**64,888**	**70,936**
Of which payments are due:		
- not later than one year;	3,665	6,067
- later than one year and not later than five years;	19,805	15,237
- later than five years.	41,418	49,632

Note 37.3 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	
	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**5,999**	**7,010**
Consisting of:		
- Interest charge	917	960
- Repayment of balance sheet obligation	448	553
- Service element and other charges to operating expenditure	3,691	4,608
- Contingent rent	943	889
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	674	454
Total amount paid to service concession operator	**6,673**	**7,464**

Note 38 Off-SoFP PFI, LIFT and other service concession arrangements

Nottingham University Hospitals NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT 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 2021	31 March 2020
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**3,152**	**4,230**
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	3,152	4,230
- later than one year and not later than five years;	12,608	16,920
- later than five years.	8,668	15,863
Total	**24,428**	**37,013**

Note 39 Financial instruments

Note 39.1 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 39.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2021	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	47,825	-	-	**47,825**
Other investments / financial assets	1,879	-	-	**1,879**
Cash and cash equivalents	126,172	-	-	**126,172**
Total at 31 March 2021	**175,876**	**-**	**-**	**175,876**

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**

Note 39.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2021	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	51,057	-	-	**51,057**
Other investments / financial assets	1,879	-	-	**1,879**
Cash and cash equivalents	125,335	-	-	**125,335**
Total at 31 March 2021	**178,271**	**-**	**-**	**178,271**

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**

Note 39.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	9,229	-	**9,229**
Obligations under finance leases	3,767	-	**3,767**
Obligations under PFI, LIFT and other service concessions	10,933	-	**10,933**
Trade and other payables excluding non financial liabilities	181,856	-	**181,856**
Provisions under contract	10,875	-	**10,875**
Total at 31 March 2021	**216,660**	**-**	**216,660**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £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, LIFT 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**

Note 39.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	9,229		**9,229**
Obligations under finance leases	3,767		**3,767**
Obligations under PFI, LIFT and other service concessions	10,933		**10,933**
Trade and other payables excluding non financial liabilities	185,990		**185,990**
Provisions under contract	10,875		**10,875**
Total at 31 March 2021	**220,794**	**-**	**220,794**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £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, LIFT 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**

Note 39.6 Fair values of financial assets and liabilities

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

Note 39.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2021 £000	31 March 2020 restated* £000	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	197,745	244,515	197,745	244,515
In more than one year but not more than five years	12,124	13,312	12,124	13,312
In more than five years	18,165	21,659	18,165	21,659
Total	**228,034**	**279,486**	**228,034**	**279,486**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 40 Losses and special payments

	2020/21		2019/20	
Group and trust	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	184	220	244	246
Stores losses and damage to property	4,227	485	3,333	371
Total losses	**4,411**	**705**	**3,577**	**617**
Special payments				
Ex-gratia payments	122	327	120	203
Total special payments	**122**	**327**	**120**	**203**
Total losses and special payments	**4,533**	**1,032**	**3,697**	**820**
Compensation payments received		-		-

Note 41 Gifts

The Trust has made no gifts during the year.

Note 42 Related parties

The Department of Health and Social Care is the parent department of Nottingham University Hospitals NHS Trust.

Entities which are under the same government control as the Trust are regarded as related parties. The main entities within the public sector with which the Trust had dealings during 2020/21 are shown below.

Bassetlaw CCG	NHS Resolution (formerly NHS Litigation Authority)
Cambridge University Hospitals NHS Foundation Trust	North Derbyshire CCG
Department of Health and Social Care	Nottingham City CCG
Derby and Derbyshire CCG	Nottingham City Council
Doncaster CCG	Nottingham City Council
East Leicestershire & Rutland CCG	Nottingham North & East CCG
East Staffordshire CCG	Nottingham West CCG
Erewash CCG	Nottinghamshire County Council
Hardwick CCG	Nottinghamshire County Council
Health Education England	Nottinghamshire Healthcare NHS Foundation Trust
Her Majesty's Revenue and Customs	Rushcliffe CCG
Leicester City CCG	Sheffield CCG
Lincolnshire East CCG	Sherwood Forest Hospitals NHS Foundation Trust
Lincolnshire West CCG	South East Staffordshire & Seisdon CCG
Mansfield & Ashfield CCG	South Lincolnshire CCG
Nene CCG	South West Lincolnshire CCG
Newark & Sherwood CCG	Southern Derbyshire CCG
NHS Blood and Transplant Authority	United Lincolnshire Hospitals NHS Trust
NHS Commissioning Board - N&D at (Dental / Public Health)	University Hospital of Derby and Burton NHS Foundation Trust
NHS Commissioning Board (Specialised)	University Hospitals of Leicester NHS Trust
NHS England	University of Nottingham
NHS England (Military)	West Leicestershire CCG
NHS Pensions	

Nottingham University Hospitals Charity (NUH Charity) is a wholly owned private subsidiary of the Trust and is regarded as a related party. During 2020/21 the Trust received £4.1m from NUH Charity (£1.3m in 2019-20).

Trust Board members are regarded as related parties. The disclosure of the compensation paid to management, expense allowances and similar items paid in the ordinary course of the Trust's operations are included in the notes to the accounts and in the Remuneration Report.

No other related parties have been identified by the Trust.

Note 43 Transfers by absorption

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

Note 44 Prior period adjustments

There are no prior period adjustments.

Note 45 Events after the reporting date

There are no adjusting events after the reporting date.

Note 46 Final period of operation as a trust providing NHS healthcare

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

Note 47 Better Payment Practice code

Non-NHS Payables	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid in the year	204,243	794,312	200,601	631,775
Total non-NHS trade invoices paid within target	177,364	708,623	172,754	555,023
Percentage of non-NHS trade invoices paid within target	86.8%	89.2%	86.1%	87.9%
NHS Payables				
Total NHS trade invoices paid in the year	5,362	194,741	4,912	169,654
Total NHS trade invoices paid within target	3,305	179,075	1,845	153,528
Percentage of NHS trade invoices paid within target	61.6%	92.0%	37.6%	90.5%

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 48 External financing

The trust is given an external financing limit against which it is permitted to underspend

	2020/21 £000	2019/20 £000
Cash flow financing	(52,737)	6,908
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**(52,737)**	**6,908**
External financing limit (EFL)	75,044	38,995
Under / (over) spend against EFL	**127,781**	**32,087**

Note 49 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	96,064	49,465
Less: Disposals	(64)	(84)
Less: Donated and granted capital additions	(9,693)	(307)
Charge against Capital Resource Limit	**86,307**	**49,074**
Capital Resource Limit	86,622	49,188
Under / (over) spend against CRL	**315**	**114**

Note 50 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus / (deficit) (control total basis)	6,683
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**6,683**

Note 51 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
Breakeven duty in-year financial performance		7,256	5,010	4,764	9,133	701	750
Breakeven duty cumulative position	26,288	33,544	38,554	43,318	52,451	53,152	53,902
Operating income		722,169	742,215	784,605	812,969	847,938	874,090
Cumulative breakeven position as a percentage of operating income		4.6%	5.2%	5.5%	6.5%	6.3%	6.2%

	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000
Breakeven duty in-year financial performance	(47,154)	(20,108)	(2,168)	(31,771)	883	6,683
Breakeven duty cumulative position	6,748	(13,360)	(15,528)	(47,299)	(46,416)	(39,733)
Operating income	870,621	934,771	987,499	1,021,952	1,177,845	1,358,231
Cumulative breakeven position as a percentage of operating income	0.8%	(1.4%)	(1.6%)	(4.6%)	(3.9%)	(2.9%)