NHS
Nottingham
University Hospitals
NHS Trust

We Listen
We Care

Annual Report & Accounts

17/18

Contents

Section 1 – Performance Report

Introduction by the Chief Executive

It is my pleasure to introduce the 17/18 Annual Report for Nottingham University Hospitals NHS Trust (NUH).

17/18 has been a year of change and of transition for NUH, a prelude to the exciting developments that we have embarked upon for 18/19.

The first and most obvious changes have been in the appointments of a new Chair of the Trust Board, Eric Morton, a new Medical Director, Dr Keith Girling, and myself as Chief Executive. The new leadership team is now building on the firm foundations put in place by our predecessors and we are grateful for the commitment and contributions of Louise Scull, Peter Homa and Dr Stephen Fowlie who set the direction for 17/18 and gave the NHS locally and nationally dedicated service over almost 40 years.

In my first few months at NUH I have been impressed by the expertise, skills and passion of the staff here. The reputation of the specialist services we provide is nationally and internationally-recognised. The ethos of team-working is very strong at NUH and together we are making great improvements to the experience of staff through greater engagement and involvement of staff in shaping the future of our hospitals.

NUH is also a well-respected and much-loved local institution, which has the support and loyalty of patients, carers, local people and the huge commitment from Trust Members, volunteers and fundraisers. There is no better example of this from the last year than the huge support that our participation in the BBC Two documentary series, 'Hospital' received. The six episodes, which were filmed in January and February and then shown from 26 March onwards, are in themselves a microcosm of our achievements in 17/18. The series set out to show how the NHS works behind the scenes, telling the story of current hospital care through the eyes of our patients, front-line staff and managers. The filming coincided with the unprecedented demand for emergency care over the winter months, which impacted on NUH and the whole health and social care system locally and nationally. This was the backdrop to the stories which in every case illustrated the trust our patients put in us, and the commitment and dedication of every member of Team NUH in doing the best for them, whatever the circumstances. 'Hospital' has been a great source of pride for us and for so many people touched by the stories it told.

QMC celebrated its 40th anniversary in 2017, a real milestone, which reminded us how far we have developed both in our facilities, but also as a leading teaching hospital. In a blend of Nottingham's heritage with the modern city that it has become, the new tram bridge at QMC, which was officially opened as part of the 40th anniversary celebrations, was named after Sir Peter Mansfield who pioneered the development of Magnetic Resonance Imaging (MRI).

MRI is one of the transformations in healthcare founded in Nottingham in which we continue to lead the world. In April 2017, we launched the National Institute for Health Research Nottingham Biomedical Research Centre (BRC), which has MRI research at its heart and which, over the next five years will translate research findings into new treatments for common conditions such as asthma, depression and arthritis. The BRC will continue to ensure Nottingham's innovators and pioneers contribute to improving health in this country and internationally.

BRCs are a measure of the quality and excellence of our research and in 17/18 we were one of the best performing research providers achieving 100% of trials initiated within the 70-day National Institute for Health Research (NIHR) benchmark. We have led 187 commercial and 498 non-commercial research projects with over 11,000 patients volunteering to take part, the largest number in a single year.

Safety

Safety remains our number one priority and in 17/18 we have again made great progress in ensuring that we provide the best possible standards of care, including achieving or exceeding the national indicators of safe care in most cases. Improving safety improves the experience of care for patients and relatives and in the last year we have made important new developments in caring for the terminally-ill and the bereaved.

We have a renewed focus on supporting patients as best we can in their last days of life. Thanks to funding from our Nottingham Hospitals Charity, we have launched the SWAN initiative, which is a symbol used across our hospitals to represent end of life and bereavement care, acting as a reminder to all staff to pay extra attention to patients, as well as their families and friends, at their greatest time of need.

Through working with the remarkable Forever Stars charity, we opened a second serenity suite at Nottingham City Hospital, to support bereaved families at both maternity units who are unfortunate enough to experience the loss of a baby.

Over the last year, we have further reduced falls and falls resulting in harm. In 17/18, NUH recorded 100 fewer falls than the previous year. We had a period of six months without an avoidable stage four pressure ulcer and further reduced stage three pressure ulcers. We achieved our goal of 50% fewer pressure ulcers over a three-year period.

We risk assessed 95.22% of eligible patients within 24-hours (against the 95% national target) for venous-thromboembolism (VTEs or blood clots).

There are areas in which we fell below the targets we set. We did not achieve our target of fewer than 91 cases of C. difficile (101 cases for 17/18 vs 93 the previous year), and we had two cases of MRSA bacteraemia. We continue to do all we can to reduce hospital-acquired infections.

A more detailed analysis of the safety and quality of or services is available in the 17/18 Quality Account and a summary is provided on page 10.

Performance

For much of the year NUH, remained one of the country's strongest performers for 18-week waits for planned care (operations). However, the impact of cancelling so many planned operations as a result of the demand for emergency care during January to March, means that we now have more work to do to get back on track. Our aim for those patients who unfortunately had their operations cancelled at the end of 17/18 is to re-book them as quickly as possible to reduce the time that they wait for their surgery.

We didn't achieve the national four-hour emergency access standard for a further year, despite the relentless focus on patient flow, reducing discharge delays and positive developments that have enabled closer working between NUH and the wider health and social care system in Nottinghamshire. Meeting this standard will remain our focus for 18/19; both our patients and staff deserve a better experience and we are determined to make the improvements we know are possible. We have learned from the unprecedented demand we experienced at the start of the year and have plans in place at NUH and in partnership with health and social care services locally that will lead to improvements in the timeliness of care for our emergency patients.

NUH achieved all but one of the main cancer targets; falling short of the national target of 85% of patients being seen and treated for cancer within 62-days of referral from their GP for the year. We made very significant improvements in the final months of the year, meeting the target in February and March and we aim to consistently do so for the year ahead.

The more detailed analysis of our performance is available on page 12 onwards.

Finance

17/18 marked year two of our three-year programme to get back into financial balance.

This has been a challenging endeavour and one which I am very pleased to say our staff have risen to. We exceeded the year-end control total (deficit position) that we agreed with our regulator and to do this we identified and achieved £40m savings across all areas of our hospitals.

As a result of our actions, and some one-off income linked to our performance, we started 18/19 in a much better financial position and we remain on course to deliver the additional £41m savings this year which will enable us to end 18/19 back in surplus. See pages 19-20 for fuller information.

NHS70 and the year ahead

July 2018 marks the 70th anniversary of the creation of the NHS and so it is a great opportunity not only to celebrate the achievements of the past, but also to focus on how we can all make our contributions to the future development of our NHS.

70 YEARS OF THE NHS 1948 - 2018

We have now launched our ambitious and far-reaching strategy for the next ten years, and this envisages a number of significant developments which will aim to improve the quality of our services and secure our position as a leading teaching hospital and as a centre of clinical excellence. Central to this is working even closer with our patients, our partners and our staff to shape the future of health and social care services for the local communities we serve in the next decade and beyond.

The health and social care system is also changing and NUH has played a full and active part in the development of the Nottingham and Nottinghamshire Transformation Partnership (STP) and in the plans for the Greater Nottingham Integrated Care System (ICS), which will see health and social care working even closer in partnership with the aim of providing care to patients which is comprehensive, high quality and fully integrated.

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

Tracy Taylor
Chief Executive

6,415
Compliments
5,892 in 16/17

637
Complaints
656 in 16/17

2,293 new Twitter followers
now over 14,000

1.3m
inpatient meals served

6,613
volunteers
150 more than 16/17

£109K
saved a day
£40m for the year

Over 90%
of patients screened for high risk red sepsis
5,000+ sets of obs automatically screened for sepsis daily

17/18 year in numbers

543
average ED attends
1.2% increase on 16/17

2m+
viewers
watched BBC TWO's 'Hospital' documentary each week

Overview of NUH

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

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

QMC

- Emergency Department (A&E)
- East Midlands Major Trauma Centre
- Nottingham Children's Hospital
- Maternity
- University of Nottingham's School of Nursing and Medical School

Nottingham City Hospital

- Cancer Centre
- Cardiacw Centre
- Stroke Services
- Maternity
- Supports our urgent and emergency care pathway with a number of emergency admissions units

Ropewalk House

- Outpatient services, including Breast Screening
- Our internationally-renowned Hearing Services

120
lives saved thanks to the Major Trauma Centre

11,360
patients recruited to research trials
2,000 more than 16/17

£4.2m
raised by NUH Charity
comprising of fundraising, in memory gifts, donations, legacies and investments

4.6% **increase**
in overall emergency admissions

18.5%
increase in emergency admissions (not via ED)

23%
increase in respiratory-related admissions

6.8m
pieces processed through laundry

957,810
Medilink journeys

We Listen We Care

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

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

NUH is a key partner in the development of a new £300m Defence and National Rehabilitation Centre (DNRC) at Stanford Hall, Leicestershire. This important facility will be a centre of excellence for injured service men and women and NHS patients in the East Midlands. It will further enhance rehabilitation, helping patients and their families to return to normal more quickly.

Our annual budget is just under £1billion.

We're one of the largest employers in the region, with around 15,446 staff based at QMC, Nottingham City Hospital and Ropewalk House and in a number of community facilities.

Performance against key strategic objectives

17/18 key strategic objectives

This is a summary of how we did against our main strategic objectives for 17/18.

Strategic objectives	Action/milestone	Achievement
High quality clinical services	Quality priorities (High Five)	See page 10 for the detailed achievements on our quality priorities
	Establish the NIHR Nottingham Biomedical Research Centre	**Achieved** – the NIHR Nottingham Biomedical Research Centre was launched on 1 April 2017
	Increase patient participation in research	**Achieved** – more people volunteered to take part than ever before
	Invest, grow and deliver high quality specialised services	**Ongoing** – we continue to develop our services to meet the needs of patients, including introducing new techniques, developing our expertise and utilising technology
Modern and efficient facilities	Create "Tomorrow's NUH" by developing plans to modernise our buildings and upgrade facilities with clinical leaders and system partners, including an urgent and emergency care centre	**Ongoing** – these plans are now incorporated into our new strategy (see page 11)
	Further digitise our hospitals including the roll-out of Electronic Patient Record and updating our radiology and pathology ordering systems	**Ongoing** – the roll-out of Digital Health Records, as well as replacement ordering systems is now well advanced.
	Update medical equipment and our buildings: replacing Cath Lab imaging and MRI scanners at City Hospital; replacing the heating system at City Hospital and improving access to QMC by opening a dedicated tram entrance	**Achieved** – the Tram Bridge was opened to mark the 40th anniversary of the QMC. Since August 2017, NUH has made its gas boiler the leading heating source, reducing the Trust's carbon footprint by around 8,000 tCO2. For more information about our environmental achievements, please see page 19
	Reduce travel times for our most critically-injured patients by opening an on-site helipad to support QMC's Major Trauma Centre	**Not achieved** – our original plans for the helipad have been postponed in order to provide the best possible solution as part of the wider developments as part of "Tomorrow's NUH". These plans are now part of our Strategy (see page 11)
Excellent staff delivering nationally-renowned patient experience	Better support our staff through health and wellbeing personal and career development	**Ongoing** – we set up the People Committee and Staff Experience Group to develop plans around the feedback from staff. These plans include dedicated work around health and wellbeing as well as career development and retention of skilled staff
	Strengthen NUH's employment brand; making Nottingham and NUH great places to live and work	**Ongoing** – we have launched a new recruitment campaign, which sets NUH apart as an employer and for the career development opportunities that we offer across all professions and grades

Strategic objectives	Action/milestone	Achievement
	Build our future workforce to support new models of care, including developing alternate roles such as Nurse Associates	**Achieved** – our first Nurse Associates joined NUH in 2017. Our workforce planning will continue to reflect the changing models of care and the wider health and care system changes as part of the STP
	Starting our Magnet journey; to become nationally-recognised for the standards of our nursing and midwifery care	**Achieved** – we are making excellent progress on Magnet plans, now working towards assessment and accreditation in 2019
	Improve the experience of our doctors in training	**Achieved** – we are one of only a few hospitals with a Junior Doctor Co-ordinator and we continue to invest in our support for trainees throughout their time with us
Affordable health and social care system	Achieve our £10.7m control total (deficit plan) by being more efficient and productive and meeting our agreed activity (income) plans	**Achieved** – please see page 19 and Section 3 for the details of our financial performance
	Develop an Integrated Care System (ICS) across Nottinghamshire with our system partners, supporting seamless care for our patients as part of the Nottingham and Nottinghamshire Sustainability and Transformation Partnership (STP)	**Ongoing** – Nottinghamshire was confirmed as one of the first wave Integrated Care Systems (ICS) by NHS England in 2017. From April 2018, ICSs will operate with new financial flexibilities and use new tools for better understanding local health data

QMC opens tram bridge in anniversary year

A new bridge providing direct access from the tram into QMC opened on the day the hospital celebrated its 40th anniversary (28 July 2017).

The bridge took just under eight months to build and cost £1.4m. The bridge is 90-metres long and eight metres off the ground, with two rest areas and folded seating areas. A meet and greet area for volunteers is available at the junction where the tram bridge meets the B Floor corridor to help to direct patients and visitors to various points in the hospital.

Several thousand passengers use the tram daily to get to and from QMC, with the new bridge connecting them directly to the hospital's outpatients clinics, B Floor wards, X-ray department and access to the main reception areas. Following a competition inviting suggestions from the public, the bridge was named after Nottingham scientific pioneer, Sir Peter Mansfield, who was the co-inventor of the MRI scanner, which has revolutionised treatment and care across the world.

Patricia Petman (below), tram volunteer and patient, who officially opened the new bridge, said, "The new bridge will make an enormous difference not only to patients and visitors (who will arrive at the centre of the hospital) but also to the tram volunteers, who have shown dedication over the last two years standing in all weathers to help visitors find the quickest and easiest ways into the hospital. I can't wait to see the look of amazement when our passengers first see how easy it is to access the hospital and how close they are to key destinations, with the opening of this bridge."

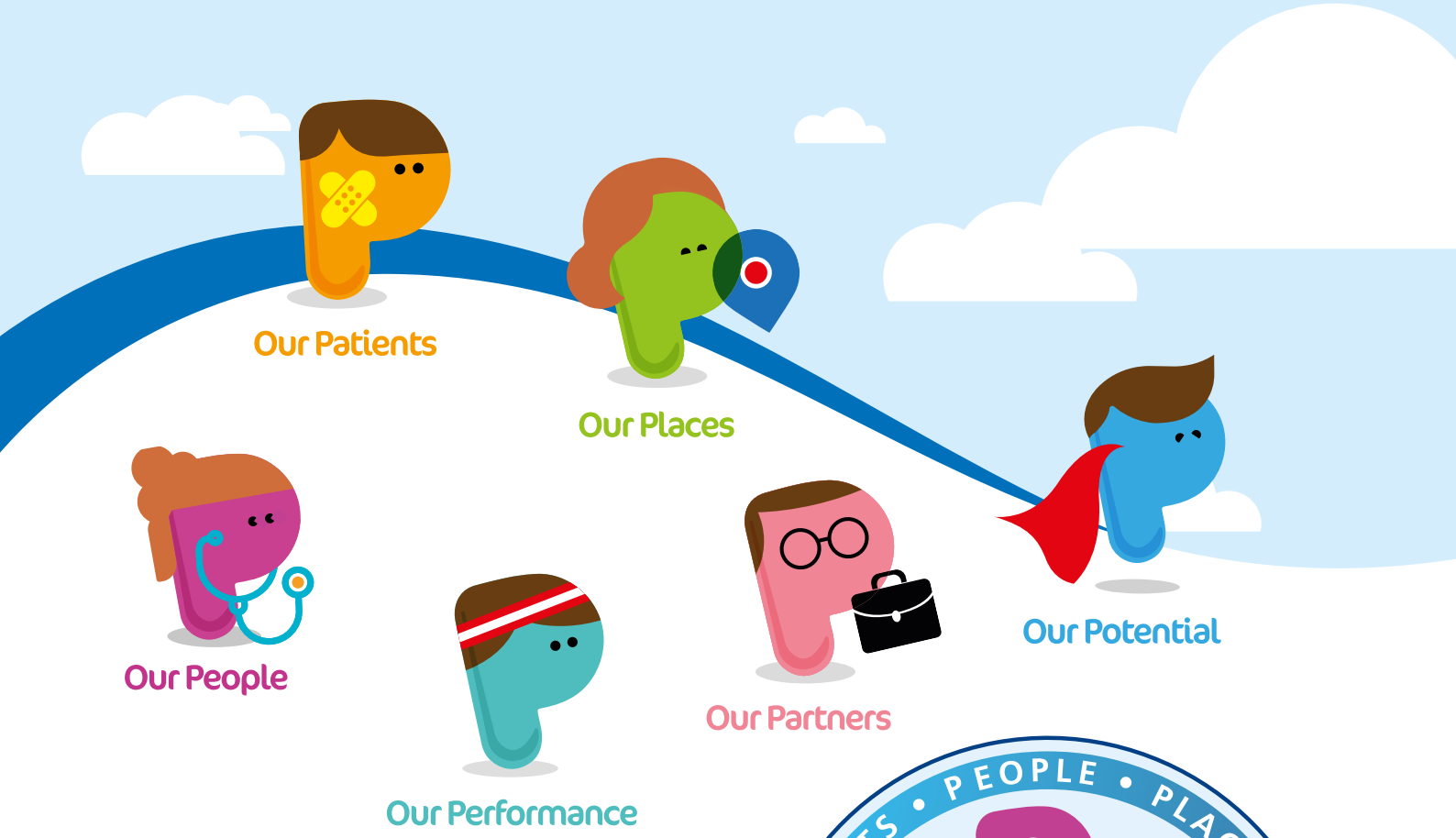
Quality priorities – High Five

Feedback from our patients, their families, carers, partners and staff from a range of sources – in addition to national standards and developments – informs our annual quality improvement priorities.

This is how we did against the priorities we set ourselves in 17/18:

Priority	Action/milestone	Achievement
Reducing harm	Acting 'harm-free' in every interaction with every patient	**Achieved** – NUH consistently performs well with a consistent harm-free care rate of <98%.
	Helping each patient get up and dressed as soon as they are well enough	**Achieved** – our EndPJParalysis initiative has now been adopted as national policy, and extended to our Emergency Department (EDFit2Sit)
	Thinking 'safety-first' in every drug prescription or administration	20% reduction in missed doses and achievement of 17/18 Commissioning for Quality and Innovation (CQUIN) target
Respecting	Sharing information about treatment (including end of life care) and transfer with each patient and (with patient agreement) their relatives	**Achieved**
	Being considerate and kind to each patient (and their loved ones), and to each colleague	**Achieved** – during the year 98.2% of our patients reported via our real-time surveys that they were treated with dignity and respect whilst in hospital
Recognising and rescuing	Taking all observations on time, and escalating quickly	**Achieved** – e-Observations are now in use across all wards in NUH
	Advising each patient smoker to give-up, and referring for cessation help	**Achieved** – NUH set itself a target of a 20% increase in referral to smoking cessation services which it achieved by quarter four of 17/18
Predicting	Thinking ahead to reduce delays for each patient	**Did not achieve** – we did not transfer 95% of patients from our Emergency Department (ED) within four hours of their arrival (81.4% vs the >95% requirement), despite the relentless focus on flow and reducing discharge delays and positive developments that have enabled more closer working by staff across the health and social care system
Giving confidence	Helping keep our hospitals cleaner and clutter-free	**Ongoing** – patient feedback is encouraging, but an external independent review of cleanliness standards demonstrates there is more to do to consistently meet the required standards

For further information, see our 17/18 Quality Account, available on our website: **www.nuh.nhs.uk/trust-reports**



Long-term Strategy

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

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

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

1 **Patients**
2 **People (staff)**
3 **Places**
4 **Partners**
5 **Performance**
6 **Potential**

Underpinning each promise, we have described key milestones for years one, two and three so that we can closely monitor our progress, which we will publish quarterly. These have been developed through consultation with NUH staff, leaders and Board members.

Our year one milestones form the basis of our Organisational Annual Plan. This will ensure specific plans are in place for each area and service to implement our strategy, enabling appropriate resources to be directed, to ensure achievement of the vision and our promises.

As part of progressing our strategy, this summer we will also work with patients and staff to review and refresh our values, based on our principles of: We Listen, We Care.

Copies of our Strategy and the Organisational Annual Plan are available on our website: **www.nuh.nhs.uk/trust-reports**

Operational performance

Operational performance at a glance

	16/17	17/18	Increase/ decrease	% change
Emergency attendances	195,782	220,045*	+24,263	+12.4%
Daycases	82,708	82,891	+183	+0.2%
Electives	23,186	21,788	-1398	-6.0%
Non-electives	97,575	102,853	+5278	+5.4%
Outpatients – first attendances	269,624	275,536	+5912	+2.2%
Outpatient – follow-up attendances	582,444	626,686	+44,242	+7.6%
Outpatient – procedures	223,277	253,415	+30,138	+13.5%

*17/18 emergency attendances includes attendances at the Urgent Care Centre from 1 November 2017.

Operational performance summary

Quality measure (% unless shown)	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	NUH peer average 17/18	Target 17/18
Patients waiting < 62-days from urgent referral to treatment for all cancers	86.8	84.9	82.4	84.6	81.4	79.4	75.9	80.4	80.1	85
Patients waiting < 31-days from diagnosis to first treatment for all cancers	97	96.5	96.3	96.4	96.6	96.6	96.3	97.0	96.6	96
Patients waiting < 31-days for subsequent treatments for all cancers – surgery	95	94.9	94.5	96.5	96.7	94.7	94.3	95.4	94.7	94
Patients waiting < 31-days for subsequent treatments for all cancers – drug treatment (%)	99	99.7	99.4	99.8	99.5	99.6	99.1	99.0	99.3	98
Patients waiting < 31-days for subsequent treatments for all cancers – radiotherapy (%)	89.5	97.4	99.3	99	99.3	98.9	98.8	98.2	97.9	94

Quality measure (% unless shown)	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	NUH peer average 17/18	Target 17/18
Patients waiting < 2-months from referral to treatment for all cancers – referrals from national screening programmes	91	91.5	94.2	99	92.2	94.4	91.7	91.7	89.8	90
Patients waiting < 2-weeks from urgent GP referral to date first seen for all urgent suspected cancer referrals	94	94.8	93.6	94.7	90.7	91.9	93.8	95.5	94.5	93
Patients waiting < 2-weeks from urgent GP referral to date first seen for urgent suspected breast cancer referrals	95.6	94.6	93.2	93.9	91.3	90.8	93.9	97.4	93.2	93
Patients waiting < 18-weeks from referral to admitted treatment	94.4	90.5	95.6	96.6	98.2	97.5	95.9	93.8	89.4	92
Patients waiting longer than four-hours from arrival to admission, transfer, discharge	97	93.9	93.9	93.3	86.3	86.8	76.6	80.4	86.5	95
Breaches of the 28-day readmission guarantee as % of cancelled operations	7.92	10.15	13.31	3.2	1.9	3	2	3.4	8.1	0
Midnight bed occupancy	86	83.4	85.1	84.6	88.7	83.4	85.8	87.2	89.4	N/A

Operational performance overview

In the 70 years since the NHS was first established, 17/18 has been one of the most challenging years to date. Despite the challenges and the headlines, there have been real achievements in improving the care for our patients. We delivered strong performance in our 'Friends and Family' Test (and are consistently one of the strongest performers in our peer group for Emergency Department and Inpatients), and we continue to have high performance in our waiting times for diagnostic tests and key patient safety and experience indicators.

Cancer

Our cancer services are amongst the largest in the UK. We receive around 1,450 two-week wait referrals per month, and an average of 150 patients subsequently receive treatment on the 62-day pathway. NUH also has a high proportion of complex tertiary pathways. By the end of 17/18 our performance was above the 85% national target thanks to the dedicated and focused work of staff across all cancer pathways.

Referral to Treatment (RTT)

The unprecedented demand for emergency care has impacted on our 18-week referral-to-treatment performance and although NUH has consistently been in the highest performers for delivery of this waiting time target, the impact of cancelling routine operations at the start of 2018 has had a direct effect on our performance. However, despite this we have remained above the 92% national target throughout 17/18.

Patients waiting below 18-weeks for planned operations (%)

11/12	12/13	13/14	14/15	15/16	16/17	17/18
90.5	95.6	96.6	98.2	97.5	96.1	92.9

Emergency care

We did not admit, discharge or transfer 95% of patients from our Emergency Department (ED) within four-hours of their arrival (81.4% vs the 95% national standard). This is despite the relentless focus on flow; reducing discharge delays; and positive developments that have enabled closer working by staff across the health and social care system.

We had an average of 543 A&E attendances to QMC a day in 17/18, a 1.3% increase on 16/17. This is in the context of a 12.1% reduction in ED attendances from 16/17 (399 in 17/18 from 454 in 16/17) as a result of changes in service provision with the expansion of the primary care streaming service which is located adjacent to our ED and receives less seriously ill patients. These patients would have previously attended our ED.

We had a 4.6% overall increase in emergency admissions over the year. There was a 23.1% increase in respiratory-related admissions compared to the previous year – which is just under 900 extra patients (see below for more detailed information about winter).

Performance and improvement plans for urgent and emergency care continue to be overseen by the A&E Delivery Board, chaired by NUH's Chief Executive and attended by leaders from across health and social care in Nottingham.

Winter preparedness

Extra hospital and community beds, changes to the way patients are assessed for their post-hospital care needs and closer working between agencies meant that health and social care partners across the system went into their busiest months of the year better prepared than ever.

NUH planned to open up to 30 extra respiratory beds at City Hospital between December 17 and early April 18. National monies received in mid-December enabled a further winter ward to be opened. The demand on services was such that additional escalation beds were opened and elective activity was significantly reduced to accommodate emergency demand.

Additional community care packages, assessment capacity and community beds came on line from the beginning of October 17 to coincide with a new way of assessing patients' post-hospital care needs outside of the hospital setting (called Discharge to Assess), which will lead to hospital beds being used more effectively. It aimed to reduce length of stay for medically safe patients and delays with transfers of care.

A new Integrated Discharge Team Manager was introduced to work in partnership with community providers, NUH staff and other system partners to reduce discharge delays and unnecessary delays for patients. Further improving discharge processes remained a key focus going into the New Year and there was a renewed focus on early actions and decision-making across every ward to prevent our patients experiencing long bed waits and reducing the risk of patients being cared for in an overcrowded ED.

This included:

- **Red 2 Green**

  Red2Green is a visual system to identify the positive days that contribute towards a patient's discharge and the wasted time in a patient's journey and this is now in place across every NUH ward. Nervecentre (our Trust-wide electronic bed management system) is updated to reflect the actions taken so ward staff are aware of the current status of their patients. See page 15 for further information.

- **SAFER**

  The SAFER system works with Red2Green to combine elements of best practise for the benefit of the patient. NUH's Cancer and Associated Specialties (CAS) Division has really embraced the target of 35% of discharges from hospital being completed before midday. This has the huge benefit of getting patients home earlier in the day, which has particular benefits for patients in the winter months. It also improves flow within the hospital, allowing the Division to transfer patients out from our ED and admission areas much faster. A contributing factor has been the provision of Nurse-Facilitated Discharge. Nurses have been trained to work to pre-agreed parameters and once a patient meets agreed criteria the registered nurse is able to discharge the patient – previously this could only done by a doctor. Our Urology ward, Harvey Two, at the City Hospital has taken this a step further and have developed nurse supplied To Take Out medications (TTOs). Trained nurses can now supply prescribed medication on the ward, rather than waiting for the Pharmacy Department to process a prescription. This has helped to improve discharge rates.

- **Frailty hub**

  The Medicine Division has established a frailty hub in ED with the aim of providing a positive and timely experience of care for frail patients to enable a comprehensive geriatric assessment to be completed as early as possible and to prevent unnecessary admission to hospital.

Busiest winter on record

In the three months from January to March 18, our services faced relentless demand from people with respiratory issues and those who were frail, elderly and with high levels of acute illnesses. Health and social care organisations across Nottinghamshire were better prepared for this winter, including the contingency of extra hospital and community beds to increase capacity as demand grew.

The pressures on emergency services across the system were such that, going into January further cancellations of routine operations were needed to ensure patient safety. A reduction of 30% in routine surgery during January was originally planned; however, all routine operations were cancelled during January. Even with this and the system's strengthened and robust planning for winter, demand significantly outweighed the capacity available in the early part of this year across the system, which meant exceptional actions had to be taken.

The knock-on effect on our planned (elective) operations led to NUH's performance dropping to 92.9% at the end of 17/18. Although this remained higher than the national 92% target there is now work to do to reinstate headroom within this standard.

The experience of 17/18 has once again demonstrated that ED performance needs to be managed as a health and social care system. NUH is reviewing and redesigning the way that planned and emergency care is currently delivered both within and outside of hospital and will implement new ways of working to achieve better results for patients. The successful achievement of this system transformation will deliver new service models which result in patients staying healthier for longer, receiving care in or closer to their home wherever possible only being in hospital when this is the best place for their care. This can only be achieved through working closely with social care providers and our commissioners in educating patients and providing sufficient capacity outside hospital to facilitate the discharge and flow of patients through the hospital.

Going into 18/19, achieving the national 95% emergency access standard remains a key focus for health and social care in Nottingham. Priority areas for the A&E Delivery Board include:

- System-wide capacity review
- Discharge process
- Consistency of provider internal systems and processe

Green light for discharge

As part of our work to improve the quality of patient care, a new way of working across health and social care organisations in Nottinghamshire was introduced. Red2Green days aim to support teams to prevent delays in patient pathways and give patients as many precious days to spend at home with their loved ones as possible.

A 'red' day is when nothing positively contributes to minimising a patient's length of stay in hospital or in the community and a 'green' day gets patients closer to being medically safe and going home or to a more appropriate place of care.

The campaign has been embraced by staff at NUH and community partners, including Nottinghamshire Healthcare NHS Foundation Trust and Nottingham CityCare Partnership, with significant benefits for patients. The Red2Green days initiative was rolled out across over two-thirds of wards at NUH during 2017 (60 of 90 wards) and across community care homes in Clifton, Wollaton and Basford.

2 million TV coverage

people on average watching 'Hospital' each week

Most watched TV programme at 9pm in the East Midlands region

Media

National

National media coverage we have had includes: BBC News, BBC Radio Four, Guardian, Daily Telegraph, Times, Daily Mirror, Daily Mail, Daily Express and Radio Times.

International

Episode Three went worldwide via BBC World and publications from USA, Italy and Indonesia

# #

Twitter

Top trending topic for Episode One | Trending in the top five for the other five episodes | 1.3M Twitter impressions so far

Facebook

110% increase in click-throughs from our recruitment campaign

153% increase in reach for NUH page

NUH website

20K+ visits to the Team NUH recruitment section of the NUH website during 'Hospital'

We are the Hospital

The BBC Two documentary series, 'Hospital' is the story of the health service in unprecedented times. Edited and broadcast within weeks of filming early in 2018, this six-part series captured the day-to-day realities of patient care at NUH.

We worked closely with the producers of the series, Label1 TV to provide exceptional access to the patients and staff at QMC and City Hospital, in order to bring viewers closer to the issues and challenges in the NHS and to show the caring, determination and dedication of Team NUH.

Each episode showed the story of NUH from different perspectives – patients, families, clinical staff and managers. Filmed over eight weeks in January and February 18, 'Hospital' included the extraordinary work of some of NUH's 15,000 staff as they pushed the boundaries of what is possible with cutting-edge treatments, clinical research, innovations and life-saving operations.

The impact of 'Hospital' was huge – over 2m people watched it each week and NUH received thousands of comments via email, social media and in person from people who wanted to express their pride and admiration for the work we do.

Non-operational performance

Research and Innovation

Our Research for All strategy is the five-year strategy for delivering clinical research excellence in Nottingham. The intention is to make a real and enduring difference to the quality of clinical care provided by NUH, building on existing strengths and exploiting new opportunities, in partnership with key partners from industry, universities, from the NHS and working with our local communities.

We want to empower and invest in our staff to enable them to participate in research, draw on the best available research findings, and developing innovative approaches to clinical practice to improve outcomes. Our priorities and goals reflect these intentions.

NUH is highly active in clinical research, with ongoing clinical research studies in all Divisions. The Trust has a close partnership with the University of Nottingham in clinical research, exemplified by the combined £26m award for the NIHR Nottingham Biomedical Research Centre (BRC) and NIHR Nottingham Clinical Research Facilities (CRF).

NUH hosts more than 400 clinical research studies, including approximately 250 complex clinical trials. In 17/18 our key performance achievements were:

Key performance indicator	17/18	
	Target	Actual
Minimum % of patients offered the opportunity to participate in research	20%	22%
Number of patients recruited in NIHR studies	7,000	11,360
Total research and innovation income	£20m	£24.3m

NUH is one of the best performing NHS Trusts in the country measured against a national benchmark of setting up and recruiting into new trials within a maximum of 70 days.

Maintaining a vibrant and growing research environment within NUH is central to our strategy and to securing a leading position in the region. Moreover, the scale of our activities attracts world-class clinicians, scientists and other clinical and non-clinical staff to Nottingham and contributes significantly to retention and career development.

Nottingham is Research

Patients are at the very heart of what we do in reaching across from science to improving people's health and wellbeing. We need and value the insight from patients and the public about their experiences of health care and their involvement with research. The enthusiasm and support of our patient partners together with the experience of the team will help to drive forward the ambition set out in the Research For All strategy. We have called it, Nottingham is Research, to reflect the depth of knowledge, expertise and commitment to involving people in our research here. We want to build on the high quality of our biomedical science and improve the way we engage with and actively involve patients and the public in all aspects of our work. In 17/18, we delivered a public consultation programme of activities led by a patient activist, Derek Stewart, OBE, to develop our new involvement and engagement strategy. In 18/19 we will proceed with implementing our ambitious plans and delivering a citizenship model for meaningful involvement in clinical research.

Pro-Vice-Chancellor and Dean of the Faculty of Medicine and Health Sciences, Professor John Atherton, said: "Over the past 40 years, QMC has improved healthcare in the region beyond measure. In fact the collaborative medical research between the university and the hospital trust has had major impact on healthcare globally. We look forward to continuing our work together, not least through our new Biomedical Research Centre, a joint venture between NUH and the University that has recently secured £23.6m of funding for new medical research."

Priorities for 18/19

In 18/19 we will be focusing on developing a Joint Clinical Research Management Service with the University of Nottingham, strengthening our partnerships with the Life Sciences and Medical Technologies industry in addition to other research organisations regionally, nationally and internationally. Our updated research and innovation plans will be published in October 18.

NIHR Nottingham Biomedical Research Centre (BRC)

The partnership between NUH and the University of Nottingham was successful in securing a substantial National Institute for Health Research (NIHR) funding award, £23.6m for the period 2017-22. This represents an unprecedented opportunity for Nottingham to host the biggest BRC in the Midlands and one of the two significant centres (in addition to Manchester) outside the London-Oxford-Cambridge "golden triangle" area. The main aim of the Nottingham BRC is to produce internationally recognised research in our chosen research themes and to provide added value through the overarching BRC structure. In the first year of its operation, the BRC focused on establishing a core structure with new appointments; developing our Patient and Public Involvement Strategy; and fostering partnerships with other BRCs in the Midlands and the North West.

NIHR Nottingham Clinical Research Facilities (CRF)

The multi-site Nottingham Clinical Research Facilities aims to expand Nottingham's substantial portfolio of research from childhood to old age focusing on patient engagement and delivering excellence in experimental medicine, particularly in the areas of gastrointestinal and liver disorders, respiratory, musculoskeletal and hearing. The CRF operates a 2000m2 hub and spoke model, maximising efficiency and access to medical expertise across NUH. The Hub is located at QMC in close proximity to the new University of Nottingham MRI research facility, ED and the East Midlands Major Trauma Centre. The gastro-intestinal and liver; respiratory, hearing and paediatric spokes provide state-of-the-art facilities for early phase studies. In the first year of its operation the Nottingham CRF has significantly expanded with the addition of cancer (oncology) experimental studies.

Environmental performance

Staff travel

Our Travel to Work scheme, aims to make access to NUH via public transport more attractive and more practical. In 17/18 we:

- Increased membership of the scheme by around 25%
- Promoted cycling through the Dr Bike scheme which includes bike maintenance classes and staff roadshows describing the benefits to health and wellbeing of active travel
- Continued access for staff to the Medilink bus service and the associated Park and Ride facilities; this is estimated to have made a reduction of 700 tCO2 emissions (compared to using other transport)
- The completion of the Tram Bridge at QMC has made travel even easier for staff, patients and visitors (see page 9 for more infomation)
- Promoted car-sharing via an online platform which helps staff to find car-sharing partners

Developments in 18/19

Our focus for next year includes:

- Continue to support Clean Air Day and promote sustainable travel options for staff, visitors and patients
- Explore opportunities to reduce car journeys by working with partners to develop Park and Ride facilities which serve the City Hospital. The provision of a Park and Ride site on the A60 connected to the City Hospital via the Medilink bus service would significantly reduce traffic

Future infrastructure projects

We are working on a business case to replace the heating infrastructure at City Hospital with a sustainable solution. This will see NUH completely moving away from coal, and producing on-site electricity. At least 5% of energy produced on campus will come from renewable sources including photovoltaic panels, air source heat pumps and biogas.

We are continuing to work in partnership with Nottingham City Council to install cycle hubs at City Hospital and QMC.

Emergency Planning

In the last year we have been awarded the status of "Substantial Compliance" following a confirm and challenge exercise in partnership with the NHS England Regional Emergency Preparedness Resilience and Response (EPRR) Director, NHS England North Midlands Area EPRR Team and Nottinghamshire Clinical Commissioning Groups. This status is an indicator of the quality of our emergency plans including our plans for the East Midlands Major Trauma Centre.

NHS England said "We would like to thank your team for their time at the confirm and challenge session which demonstrated a Trust wide commitment to EPRR and as a result meeting the core standards."

Nationally, 17 saw a number of incidents that identified key lessons for hospitals to consider and implement – these included terrorist attacks.

The Trust Incident Response Procedure (TIRP) needed significant amendments due to changes in clinical practice and incorporating the East Midlands Major Trauma Centre. To help facilitate this, a clinical steering group was established to consider the impacts and strategies to manage a mass casualty incident if this was ever to occur in Nottingham and the surrounding areas. In September 2017 we carried out an exercise to assess the content, suitability and capability of our plan. This provided an assurance that if the plan was to be activated, it would meet the requirements for managing the aftermath of a major incident.

During the course of the year, the Trust has responded to a wide range of other incidents, ranging from cyber security to power outages to heatwave and heating issues, all of which required the mobilisation of our emergency plans.

NUH has also continued to participate in a wide range of internal and external exercises designed to test our plans and processes. Lessons learned from these incidents and exercises provide invaluable feedback, which we can use to improve our response plans, policies, procedures and training programmes.

Summary of financial performance

17/18 was the second financial year of the three-year plan to return the Trust to financial surplus. 18/19 will be the third year of this plan, to deliver a surplus, which will be vital to ensuring the Trust's services remain financially sustainable and allow us to invest in our facilities and infrastructure, in line with our 10-year strategy.

For the second successive year, the Trust has achieved its financial control total of £10.7m set by our regulator, NHS Improvement (NHSI), ending the year with a deficit of £2.3m. In delivering our own financial control total, we contributed to the Nottinghamshire Integrated Care System (ICS) meeting its overall financial control total in 17/18.

We achieved this financial performance despite the backdrop of significant operational pressures, most notably we fell short of meeting the four-hour emergency access standard combined with winter pressures, such were the consistently high volumes of patients presenting at ED, often with complex medical conditions. The number of patients exceeded the capacity of the department, which was built to cope with much lower levels of patients, to treat, admit or discharge within the standard, with a consequent impact on patient flow and discharge throughout the hospital and on subsequent level of income received. This is recognised as a being health system wide pressures and the local position is reflective of national health services picture in this regard.

This financial position was achieved despite not earning all of the core national sustainability and transformation (STF) funds available, as a result of not meeting the four-hour emergency access standard. The Trust financial position was supported by financial efficiency savings of £40m against a target of £41m. NUH has now achieved savings of £40m or more for the last five consecutive years. In 17/18, this was built around the success of the Getting It Right First Time (GIRFT) and Wave programmes. We also delivered our activity and income plans agreed with commissioners for the year, despite the cancellation of operations.

We also achieved all of our other statutory financial duties, other than our break-even duty (along with the majority of acute provider organisations), including maintaining capital spending, cash and borrowing within the limits set by the Department of Health and Social Care. We invested more than £44m in our capital infrastructure in 17/18, to meet growth in demand, improve quality standards, drive us towards achieving performance targets and ensure patients are treated in best possible clinical environments.

NUH built on the progress achieved in the previous year, by further reducing reliance on temporary staffing sourced from an outside provider or third party. This was achieved by running our own internal bank of employees to cover vacancies and to provide short term or fixed term cover. In doing so, we complied with a national spending cap on agency staffing.

The overall size of our workforce increased by over 1,000 staff in 17/18, as a result of the repatriation of Estates and Facilities staff from Carillion on 1 April 2017.

NUH is on a path to financial recovery, demonstrated by the fact that it plans to achieve a financial surplus in 18/19 for the first time since 14/15. The delivery of this position is not without risk and is reliant on delivering a savings programme of in excess of £40m (5%) again. The Board has assessed the level of efficiencies required which represent a challenging but attainable target while not undermining the quality and safety of the services NUH provides. All efficiency plans are subject to a full quality impact assessment where they have a potential quality impact on a clinical service or where they require a workforce reduction, to ensure there is no detrimental impact of the quality of services provided.

The efficiency programme draws heavily on Carter Model Hospital data and the Getting it Right First Time (GIRFT) approach, to generate ideas to support the level of transformation required.

Dr Peter Lanyon, Consultant Rheumatologist, was appointed to work as part of Getting It Right First Time, the national programme designed to improve clinical care, in 17. He said: "I'm looking forward to working with colleagues across the country to gain insight into how to improve outcomes and variations in care, with a view to developing national solutions that will work for all. The inclusion of rheumatology within the GIRFT programme marks an important phase in the ongoing development of our specialty."

NUH plays a key role in the integrated care system (ICS), with both commissioners and acute and social care providers committed to developing a fully integrated and effective care system (which will be set up in shadow form in 18/19) to ensure that patients are treated in the most appropriate clinical environment across Nottinghamshire, whilst bringing it into financial balance.

NUH made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 18 and remains committed to making best use of resources, in delivering its own efficiency plans and working with its partners across the health and care system.

Patient experience

4Cs (Compliments, Complaints, Concerns and Comments)

17/18 is the eighth year that NUH has been using the 4Cs (complaints, concerns, compliments and comments) approach to capture feedback from patients, carers and families. The Quality Assurance Committee receives patient experience quarterly reports on complaint themes and examples of learning. 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 14/15 to 17/18.

Number of local complaints and PHSO referrals

	14/15	15/16	16/17	17/18
Complaints	694	598	656	637
Complaints upheld	149 fully	136 fully	122 fully	87 fully
	223 partially	231 partially	177 partially	129 partially
PHSO contacts	80	85	76	69 (as at 26.2.18)
Investigations taken up by the PHSO	19	30	16	14 (as at 26.2.18)
Upheld PHSO referrals (in-year)	4 fully/ 5 partially	4 fully/ 6 partially	0 fully/ 12 partially	0 fully/3 partially

Most frequent complaint themes

14/15	15/16*	16/17	17/18
Standards of care (medical)	Standards of care (treatment)	Standards of care (treatment)	Standards of care (treatment)
Manner and attitude	Standards of care (diagnosis)	Standards of care (diagnosis)	Standards of care (assessment)
Complications	Complications during/ after surgery	Complications during/ after surgery	Standards of care (diagnosis)
Standards of care (nursing and midwifery)	Verbal communication	Lack of communications regarding discharge	Complications during/ after surgery
Delays	Lack of communications regarding discharge	Standards of care (assessment)	Verbal communication

* Datix reasons for complaints changed to mirror PHSO subjects for greater clarity.

Compliments

14/15	15/16	16/17	17/18
5,853	5,335	5,892	6,415

Re-opened complaints

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

Quarter One – 17/18			Quarter Two – 17/18		
Re-opened	Total complaints	% resolved at first response	Re-opened	Total complaints	% resolved at first response
27	143	82%	23	170	87%
Quarter Three – 17/18			**Quarter Four – 17/18**		
Re-opened	Total complaints	% resolved at first response	Re-opened	Total complaints	% resolved at first response
33	155	79%	23	169	87%

Examples of learning from complaints taken from most frequent complaint themes

Reason for complaint	Quality objective	Action taken
Standards of care – treatment	Improve treatment for patients and promote best practice	A Standard Operating Procedure (SOP) for enrolment into research studies has been written and shared with complainants for comments. All immunotherapy patients are now coordinated from oncology day case and not chemotherapy suite, thereby releasing additional capacity to ensure treatments are organised in a more timely way.
Standards of care – assessment	Improve the assessment process and communications in relation to this	Reviewed our nursing procedure: guideline for completing the Nottingham Paediatric Early Warning System (PEWS) chart, PEWS Tool and eObservation system in the Children's Hospital and Children's Emergency Department. Amendments were made which included a narrative on the way Nervecentre is used. A SOP has been written to ensure information provided to women attending the Healthy Lifestyle Clinic is clear and standardised. Changes to the NUH maternity website pages are in progress to reflect this information.
Standards of care – diagnosis	Improve early diagnosis and communication of this to patients and their families	The consultant discussed the importance of the quality and timeliness of discharge summaries with the whole junior doctor cohort and included this as an item within the induction programme for future Junior Doctors. This was also highlighted at the specialty governance meeting. Up to date printed cards have been produced to give to patients following enrolment in research studies, to ensure all patients and their families have a number to contact with any queries that they may have regarding the study and potential diagnoses.

Reason for complaint	Quality objective	Action taken
Complications during/ after surgery	Improve care provided during/after surgery and promote best practice	Regular drug rounds of orthopaedic patients to ensure all patients are offered analgesia whilst waiting for their surgery. Trauma co-ordinators visit Queen's Day Case Unit at QMC every four hours to review patients, including their pain levels. Critical care teams have implemented the ABCDEF (awake, breathing, choice of sedation, delirium, early mobilisation and family) critical care bundle. This tool has fundamentally changed the way we nurse patients. We focus our care on reducing ventilation and sedation, recognising and treating delirium, promoting sleep and earlier mobilisation and rehabilitation.
Verbal communication	Ensure robust communication between ward staff, family, carers and also between departments regarding the discharge of patients	Implemented the 'Dear Doctor' initiative in order to encourage improved communication. Each day a pre-printed card is left for all patients and carers who are encouraged to note down any questions or concerns they have. The consultant refers to the card on their next ward round to ensure they have specifically addressed the patient's concerns. 'Dear Doctor' – improved the communication between medical staff and their patients. Puts the patients 'right at the centre of the ward round process.' Patient information booklet has been updated to include information regarding the role of the Dialysis Outreach Team with contact details included.

Improving complaint handling:

In 17/18:

- NUH has continued to participate in the Peer Review process on a bi-monthly basis, reviewing the complaint process in a minimum of 25 redacted complaint files. This year we reviewed 37 complaint files
- The Complaints service, in line with the Patient Advice and Liaison Service (PALS), has become paper-light
- NUH has undertaken an annual external Peer Review process 'buddying up' with the Nottingham Treatment Centre. Representatives from both organisations reviewed redacted complaint files from the other's organisation, including one complaint from each organisation which has been led by them as a co-ordinated complaint
- Patient stories, taken from complaints which have demonstrated learning within the organisation are presented monthly at Trust Board. Divisions usually present two patient stories each annually
- The Complaints and PALS and Patient Safety Teams now meet weekly to identify any joint cases and trends from incidents, complaints and claims at the earliest opportunity
- The Complaint and Incident investigations will run alongside each other to streamline and speed up the processes for the patient/complainant
- Following work with one of the Trust's Clinical Psychologists, the 'Complaints with Compassion' training package has been developed to inform and support staff who investigate complaints and those staff who are involved in the wider complaints process. This is currently being rolled out across Divisions and the programme will continue to increase throughout 18/19. Training can be tailored to be more specific and to relate to wards/departments/attendees
- Compliments can be recorded directly onto Datix by ward and departmental staff which gives a greater representation of the compliments that are received by the Trust

Patient surveys

NUH participated in two national patient surveys during 17/18 – Inpatient and Maternity.

Annual inpatient survey

Between August 2017 and January 2018, the Care Quality Commission invited 1,250 recent inpatients at NUH to give their feedback on their experiences. At NUH, 492 patients completed the survey, a response rate of 40%.

The survey had 79 questions, including areas such as the Emergency Department, waiting lists and planned admissions, operations and procedures, discharge process, emotional and wellbeing support and overall experience. In each domain, NUH scored 'about the same' in comparison to other hospitals and overall 81% of people reported they had had a 'good experience' during their stay.

There were several areas highlighted where Nottingham's hospitals had done well, which included: 94% of patients saying that their admission date was not changed by the hospital and 91% of patients said they did not share a sleeping area with patients of the opposite sex.

In relation to hydration and nutrition, 94% of patients said they did get enough to drink whilst in hospital and 91% of patients agreed that they felt well looked after by the non-clinical hospital staff.

95% of patients said 'Yes always' to the question: 'Were you given enough privacy when being examined or treated?' and 91% of patients said they felt overall that they were treated with 'respect' and 'dignity' while in hospital.

In comparison with the 2016 Inpatient Survey results, Nottingham's hospitals have improved across the following areas including; cleanliness of room or ward and communications with staff about the operation or procedure they had undergone.

Areas for improvement highlighted by patients were more information on how to complain about their care, and other recurring themes included: noise created from other patients at night, delayed discharge from hospital and receiving medications.

Ann-Marie Riley, Deputy Chief Nurse at NUH, said: "We are pleased that the results show we are providing a positive experience for patients who are admitted and stay overnight in our hospitals. Eight out of 10 patients said they were overall happy with their experience which is similar to other trusts nationally, however, there is more for us to do in Nottingham to improve the experience for all patients. However, there are still clearly areas we need to act on in response to this important feedback from our patients. The annual Inpatient Survey results are an important measure of how patients feel about their experience in our care and along with feedback we receive via other channels such as complaints, concerns and social media help us to further improve the experience of our patients and our services."

Maternity survey

NUH's scores were 'about the same' as other hospitals in the areas of antenatal care and labour and birth.

There was a statistically significant improvement in the areas of skin-to-skin contact, staff responding quickly if attention was needed after birth and cleanliness standards compared with our 2015 scores.

Post-natal care was identified as an area for improvement, specifically in areas such as frequency of midwife visits and the information provided during these appointments.

Patient 'Friends and Family' Test (FFT)

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

NUH received 47,150 inpatient and day case patient FFT responses in 17/18 with an overall recommend rate of 97.3%. Similarly, NUH received 22,236 Emergency Department FFT responses with an overall recommend rate of 94.3%. Examples of changes prompted by feedback comments include:

- Focused cleaning resources to the areas of greatest need
- Addressed temperature issues on the Labour Suite and transitional care rooms
- Provided information and picture boards in maternity clinical areas in response to positive feedback
- Promoted awareness of privacy issues across teams (Surgery Division)
- Introduced 'Dear Doctor' cards for patients to write down any questions they would like answering (Surgery Division)
- Introduced new 'sleep packs' for patients with an eye mask and earplugs

Staff experience

NHS staff survey

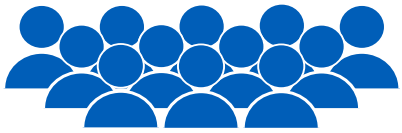
The staff survey is the biggest single opportunity each year for NUH staff to give feedback and is an important part of our commitment to listening to all of our people. The staff survey helps us to identify what makes working for NUH a positive experience and also the areas where we need to improve.

The NHS staff survey includes 88 questions across nine themes:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

National Staff Survey results

We're listening.



5,251 people completed the survey

88 questions in the survey

43%

We're better than last year on reducing unpaid overtime

NUH staff say that not working additional unpaid overtime was better in 2017 than 2016.

3.84 out of 5

Staff recomment NUH as a place to work or recieve treatment.

Compared to other NHS organisations NUH results are:

- above average on **28 questions**
- about the same on **50 questions**
- below average on **10 questions**

Compared to the 2016 Staff Survey NUH results are:

- the same as last year on **58 questions**
- worse on **29 questions**
- better on **1 question**

Where we're below average:

84% of staff say there are equal opportunities for career progression

12% of staff say they experience discrimination at work

Staff confidence in the quality of appraisals is 3.02/5.0

Where we're doing better than average:

76% of staff say if a friend or relative needed treatment, they would be happy with the standard of care provided by NUH

79% of staff say care of patients is our top priority

We're reducing the number of staff who say they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months to 24%

Areas we are working to improve in 2018:

- Team working
- Appraisals and development
- Training
- Involvement in decision-making
- Staff health and wellbeing

New, shorter staff FFT now open!

#NUHislistening

Staff experience is also measured on a rolling basis through the staff 'Friends and Family' Test. The most recent survey was taken in March 18 and the results for the three surveys during 17/18 are in the table below.

Nicky Hill, Director of HR, said: "In the last 12 months we have agreed plans to address the feedback we have received from our people, by directly involving them in developing the solutions that will improve their experience at work. We will take the same approach to these results.Together we will be looking in detail at how we can improve areas such as staff motivation and development, which were two aspects of the survey where our staff feel we need to improve."

Factor	Quarter One June 17	Quarter Two September 17	Quarter Four March 18
% of respondents would be extremely likely or likely to recommend NUH services to friends and family if they needed care or treatment	87%	86%	89%
% of respondents would be extremely likely or likely to recommend NUH as a place to work	64%	62%	63%

Taking the actions forward

The Staff Experience Group (SEG) was launched in September 17, based on the feedback from the 2016 Staff Survey, with volunteers from across the all staff groups and Divisions agreeing to take part.

Equality and Diversity

Highlights for 17/18 included:

- A continuation of our equality partnership work with other statutory organisations including a health and wellbeing conference on 1 December 17 in recognition of Disability History Month. Over 100 members of the public attended
- Securing additional funding to provide staff with autism awareness and autism champion training over a two-year period, delivered by Autism East Midlands
- Selected to be an NHS Employers Equality and Diversity Partner – the first time a combined Acute Trust and Clinical Commission Groups partnership had been selected
- A successful completion of the second 'Future Leaders' programme, Future Leaders aims to address under representation and increase diversity at board and senior level across Nottingham City
- Improvements made to the Disabled Go hospital access guides on the NUH website to enable better accessibility – an invaluable resource for people who identify as disabled and need advance information on disability access when visiting us. The online access guides are here: **www.disabledgo.com** (search Nottingham University Hospitals)
- In April, a delegation of clinical staff undertook the annual visit to Jimma Hospital Ethiopia. The visits continue to serve as excellent developmental opportunities for NUH staff in honing skills in very challenging resource poor circumstances
- A continued commitment to address the wider determinents of health inequalities through the provision of work opportunities for young people not in education, employment or training (NEET's) through hosting The Prince's Trust 'Get Into Hospitals' programme and 'Project Search'
- We were successful in gaining accreditation for the 'Disability Confident Employer' Government Scheme
- We reaccredited with the 'Mindful Employer' programme, promoting and supporting positive attitudes to mental health in the workplace

- NUH actively promoted the 'Time to Talk' Day on 1 February, encouraging staff to have conversations about mental health to challenge prejudice and stigma
- We have continued to pledge our support to the Equality and Human Rights Commission Initiative 'Working Forward', to make our workplace the best it can be for pregnant women and new parents
- Interpreting and Translation Services (ITS) continue to deliver efficiencies amid increasing demand
- Interpreting and Translation Services (ITS) continue to deliver efficiencies amid increasing demand. The closing financial account 17/18 is £370,000 with NUH increasing its business by 50%

Consultation and engagement

At the end of 16/17, NUH and Carillion mutually agreed to a managed exit from the core aspects of the estates and facilities contract, which had been in place since 2014. The process to transfer core Estates and Facilities services back under NUH's management took place with effect from 1 April 2017.

Early in January 2018, when the financial problems and then ultimately the liquidation of Carillion became apparent, the Trust formally terminated its contract with the company to provide car parking services, one of the residual services left with Carillion following the reintegration of core estates and facilities services.

All parking services transferred back to NUH with the former Carillion staff joining Team NUH under TUPE arrangements. This was managed to ensure there was no disruption to parking services, patrols and enforcement.

Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came in to force on 1 April 2017. The regulations require the Trust to publish information regarding trade union facility time in accordance with Schedule 2 of the regulations. The Trust will publish this information on our website prior to the required deadline of 31 July 18.

Freedom to Speak Up

In 2017, we strengthened our approach to developing an open and honest culture for staff with the appointment of a network of Freedom to Speak Up champions to support colleagues who may have concerns.

Freedom to Speak Up Guardians were first appointed in NHS Trusts across England following the publication of Sir Robert Francis' inquiry in to the failings in care at Mid-Staffordshire NHS Foundation Trust. They are designed to give independent support and advice to staff who want to speak up, and hold the Board to account if it fails to focus on patient safety.

The NUH champions are all members of staff who will help to advise their colleagues on the most appropriate channels to use to raise their concerns and ensure they are properly supported.

Olivia Hay, one of the Champions, is a Research Practitioner, she said: "I wanted to get involved because I think it is crucial that people know where to turn if they are unhappy and have concerns about anything that impacts on patient care. It can be daunting for people to raise concerns, particularly if it is about someone they work closely with, but we are there to help advise and support, and show that they will be taken seriously."

Kirstie MacDonald, the Trust's Freedom to Speak Up Guardian, said: "Patient safety and the patient's experience is at the heart of all we do at NUH, but we know there may be times when we fall short of this and it's important that people feel they can speak up if they see something happening which they feel is wrong. We aim to foster an open and honest culture at NUH and we hope that the appointment of these new champions will only serve to strengthen that, and help reassure people that their concerns will be taken seriously."

MBE for contribution to stroke care in Nottingham

A nurse who has dedicated her professional life to helping to improve the quality of care for stroke survivors received royal recognition for her work.

Dawn Good, previously Head of Service for Stroke Services and Lead Stroke Nurse was made an MBE in HM Queen's Birthday Honours, in June 17. She said: "I am absolutely thrilled to receive this honour. It is just fantastic that the work over the last 30 years, with the support of very many colleagues from NUH, the University of Nottingham and other partners across Nottinghamshire and further afield, to improve stroke care, treatments and outcomes and quality of life of stroke patients has been recognised. The work we have done together, with the support of stroke survivors and their families, over many years, has led to Nottingham becoming a national leader for stroke care, with the best outcomes in the country."

Nurse of the Year follows in her mother's footsteps

Nottingham's Nurse of the Year for 2017 was student nurse Christina O'Loughlin, whose mum inspired her to pursue her nursing dream. She is following in the footsteps of her mother Wendy who works as a Discharge Co-ordinator at QMC who she says inspired her to pursue a career in nursing.

Christina, 24, was nominated by the grateful parents of a child she cared for at Nottingham Children's Hospital who were impressed and inspired by her care. She said: "I'm so happy but really shocked at the same time. Hopefully I'll carry on the way I am and continue to learn from those around me, and I hope to be a great nurse in the future."

Christina was one of eight winners at the Nurse and Midwife of the Year Awards, which recognise the outstanding contributions of our nurses and midwives.

The 2017 winners were:

- **Adult Nurse of the Year:** Laura Hardwick
- **Children's Nurse of the Year:** Claire Pothecary
- **Healthcare Assistant of the Year:** John Marriott
- **International Nurse of the Year:** Andreia Almeida
- **Midwife of the Year:** Heather Bartram
- **Nurse Leader of the Year:** Lucy Gillespie
- **Student Nurse of the Year:** Christina O'Loughlin
- **QMC 40 Anniversary Award:** Mary Palframan

Nottingham Hospitals Charity

During the last year more people than ever have wanted to support their local NHS here in Nottingham. The official charity for NUH is proud to be able to ensure that donations go directly to help those areas within our hospitals that are close to people's hearts.

Highlights:

- The #Here4Nottingham campaign told the stories of patients, researchers and consultants who have benefitted from £4.2m invested during 17/18 in innovation, research, new technology and enhancing the environment for patients
- Celebrated our support for the incredible teams at our Hayward House end of life centre, our Zephyr's child and baby loss bereavement project and the amazing Nottingham Breast Institute
- Launched the next phases of our four-year Big Appeal for Nottingham Children's Hospital. First with our Big Neonatal Appeal and then with our Big iMRI Appeal for children undergoing surgery for brain cancer
- Supporting service excellence has continued to be a key focus for the Charity including the first year of a three year £650,000 programme supporting the Trust's journey to achieve the internationally-recognised Magnet nursing and midwifery excellence status

Nottingham Hospitals Charity
At the heart of your care

Nottingham Children's Hospital
THE BIG APPEAL
#RobinsBigWorldRecord

Trust Members and Volunteers

Trust membership

Our Trust Members continue to take an active and supportive role in the life on NUH, including for the first time in 17/18 sitting on the judging panels for NUHonours Awards 2017 and Nurse and Midwife of the Year 2018 Awards.

In addition they were an integral part of our celebrations for the QMC's 40th anniversary, the development of our EndPJParalysis initiative and the Annual Public Meeting.

Volunteers

By the end of March 18, NUH had 1,610 registered and guest volunteers currently all working to enhance patient care and promote our values.

Volunteering continues to be an integral part of our hospital fabric with an army of easily recognised polo-shirted volunteers contributing to every aspect of life at NUH. Their activities in 17/18 included:

- Distributing Leaflets – volunteers distributed leaflets on both the City and QMC for the 'REBOOT' research study for people suffering with anxiety and/or low mood. The leaflets are in conjunction with the NUH Occupational Health and Staff wellbeing teams, who are also promoting the study
- Bed replacement project – two volunteers helped with this project as PPI representatives
- Nurse and Midwife of the Year Awards – volunteers helped to promote the awards by handing out flyers to tram passengers leading up to the judging date
- EndPJParalysis – volunteers were involved in promoting and signposting carers to End PJ Paralysis as part of national carer's week
- QMC Bereavement Centre requested trolley dash volunteers – volunteers have now started a trolley collection service for the Bereavement Centre collecting files, patient property and undertaking other small tasks
- City Hospital volunteers assisted the Critical Care Unit for 11 weeks in August escorting families to the recovery area in theatres whilst they had a short-term decanting of beds and patients
- Promoting research – volunteers at both hospitals distributed posters/information about a research study around hospitals. The study invites healthy males and females (family and friends who are visiting patients in hospital) between the ages of 18-55 to take part in a MRI brain imaging study called SPRING
- Support for carers and patients families – volunteers on both campuses have been distributing posters/ information about how families and careers can seek support themselves around hospitals
- GU Medicine – in conjunction with Judith Green Outreach and Health Promotion Lead for NUH Sexual Health, a volunteer has been recruited to assist promoting sexual health services and helps at their roadshows
- Volunteers joined the PLACE assessments team as assessors – the assessments looks at cleanliness, the condition of the buildings, how well the buildings meet the needs of those who use it e.g. signage, car parking, the availability and quality of food and drink and how well privacy and dignity is supported by the environment, including dementia-friendly organisation and disability
- Volunteers within the Emergency Department – volunteers have participated in a 3 week trial in the green area of the Emergency Department offering a buddy system whilst frail patients await treatment. Currently we now have two volunteers undertaking this duty on a regular basis since the trial

NUH Volunteer Youth Group

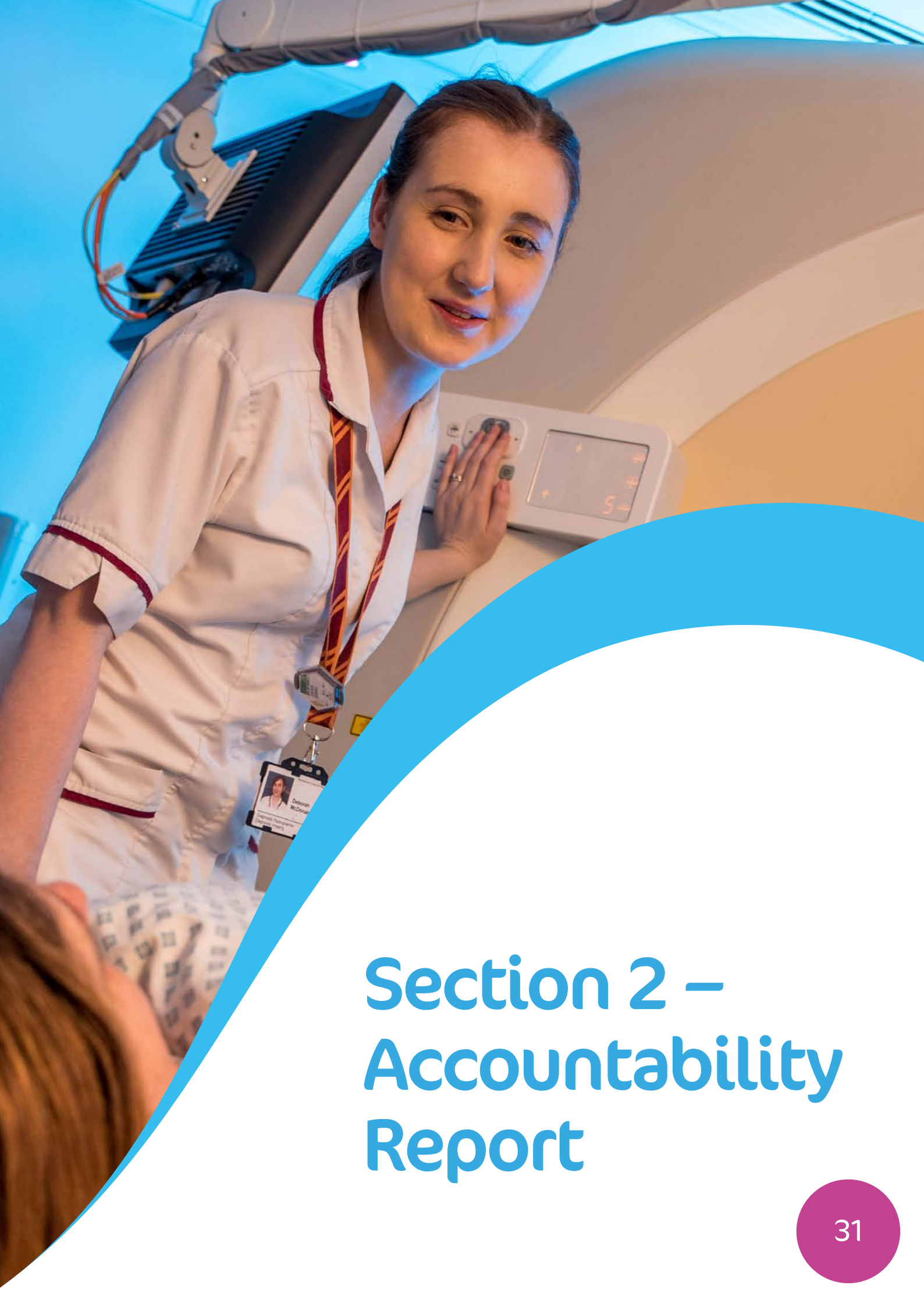
The NUH Youth Service has a committed team of volunteers who are vital in enabling and meeting the needs of young people. Volunteers provide many opportunities which include daily drop-in sessions where young people can have a break from the medical environment.

Volunteers are involved with day trips and residential sleepovers, giving up their time to provide others with opportunities.

Though the NUH Youth Group volunteers are able to develop their skills including qualifications such as the Level Two Certificate in Youth Work Practice qualification.

Tracy Taylor
Chief Executive

24 May 2018



Section 2 – Accountability Report

Summary of Governance Statement

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

Accountability

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

All substantive executive directors and advisors to the Board are appointed through national advertisement, on permanent contracts. The contract may be terminated by their retirement, resignation or dismissal. Performance of the Chief Executive is evaluated by the Chair and is reported to the Remuneration and Terms of Service Committee. The performance of other executive directors and senior managers is evaluated by the Chief Executive and is reported to the Remuneration and Terms of Service Committee. Any changes in remuneration for executive directors or advisors to the Board are agreed by the Remuneration and Terms of Service Committee.

Board meetings

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

It is also available from:

Michelle Rogan
Director of Corporate Governance

Trust Headquarters
Nottingham City Hospital
Nottingham, NG5 1PB

Tel: **0115 969 1169**

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

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

Annual Public Meeting

The Trust's annual public meeting for the year ending 31 March 17 was held on 20 July 17 in the Postgraduate Education Centre at City Hospital. We shared with our patients, members and partners our responsibilities and good stewardship of public funds in the previous financial year.

We celebrated a number of our achievements and recognised the hard work of our staff.

Executive colleagues asked a range of questions about the way we run the Trust and our plans for the future. There were presentations on:

- Research and Innovation
- EndPJParalysis
- Nursing and Midwifery
- Creating "Tomorrow's NUH"

The Board and its Committees

The Board discharges its responsibilities through monthly Board meetings, an annual public meeting and a number of formal committees. For details of attendance at Board and committee meetings, please refer to the Annual Governance Statement on page 122.

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

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

- Audit
- Remuneration & Terms of Service
- Finance and Investment
- Quality Assurance
- People
- Appointment of CEO
- Appointment of Other Executive Directors
- Advisory Appointments (medical consultant appointments)
- Ethics of Clinical Practice
- Organ Donation

All Board committees are led by Non-Executive directors with the exception of the Ethics of Clinical Practice Committee which has a clinical chair. Scrutiny of the reports and information take place in executive led operational committees prior to submission to the Board. For further details, please refer to the Annual Governance Statement on page 122.

Board membership

The Board comprises a Chair, five non-executive directors and five executive directors. The following changes were made in 17/18:

- Ms Louise Scull stepped down and was replaced by Mr Eric Morton as Chair on 1 May 17
- Dr Peter Homa retired and was replaced by Mrs Tracy Taylor as Chief Executive on 30 October 17
- Dr Stephen Fowlie retired and was replaced by Dr Keith Girling as Medical Director on 1 June 17
- Dr Sheila Newport and Mrs Christine Reed were appointed as Associate Non-Executive Directors (non-voting) on 31 August 17
- Mr Mark Chivers was appointed as Associate Non-Executive Director (non-voting) on 13 December 17
- Mr Alec McKee's term of office as Associate Non-Executive Director (non-voting) ended on 31 March 18

Fit and Proper Person Test

In 17/18, the directors individually updated their declarations to confirm continuing compliance with the Fit and Proper Person Test.

Staff report

Health and wellbeing

At NUH our health and wellbeing programme for staff supports everyone to lead healthier lives through a variety of information, resources and activities.

Highlights of 17/18 include:

- In the run-up to winter we ensured that 66% of our staff were vaccinated against the flu as part of our Flu Fighters campaign

Steph Knowles, Health and Wellbeing Lead for NUH, said: "Our health and wellbeing programme for staff has been going since 2005 and is always developing to provide the things that help our colleagues to feel healthier and happier. We are also helping to shape the programmes that will hopefully be available to all NHS staff."

Mandatory training attendance

87% of staff attended their mandatory training in 17/18. Staff currently do their training during the month of their birthday, which works well, but operational pressures have had an impact on attendance.

Appraisal rate (medical and non-medical)

87% of non-medical and dental staff had an annual appraisal during 17/18. Whilst the uptake of appraisal is positive, more work is required to ensure the quality of appraisals is maximised. Medical and dental appraisal consistently performs well 96% of medical and dental staff (excluding Junior Doctors) had an appraisal within the last 12 months. Appraisal of medical and dental staff is linked to revalidation.

Turnover

The Trust performance on turnover is currently 11.1%. It should be noted that a level of turnover should be expected and encouraged, however, there are some staff groups and some areas where rates are higher than we feel is appropriate. We have recently launched a leavers survey which will provide more detailed analysis and here is now an established recruitment and retention group, with an increased focus on retention.

Workforce summary

At the end of March 2018, the workforce at NUH was 15,446 (13,372 Full-Time Equivalents). On 1 April 17, 1,149 Estates and Facilities staff transferred from Carillion to NUH.

DIVISION	HEADCOUNT	FTE
Cancer and Specialties	2,031	1772.8
Clinical Support	3,625	3130.5
Corporate Departments	1,238	1083.3
Estates & Facilities	1,258	1040.6
Family Health	2,233	1858.5
Medicine	2,657	2371.3
Surgery	2,404	2115.6
Total	**15446**	**13372.6**

STAFF GROUP	HEADCOUNT	FTE
Add Prof Scientific and Technic	727	627.9
Additional Clinical Services	2,535	2136.5
Administrative and Clerical	3,054	2638.6
Allied Health Professionals	817	678.2
Estates and Ancillary	1,285	1059.3
Healthcare Scientists	554	497.0
Medical and Dental	1,860	1674.4
Nursing and Midwifery Registered	4,614	4060.7
Total	**15446**	**13372.6**

March 2017	FTE
Medical and Dental	1670.0
NHS Infrastructure	2085.2
Nursing and Midwifery	4071.0
Other	10.4
Qualified Scientific, Therapeutic and Technical Staff	1840.3
Support to Clinical Staff	3695.7
Total	**13372.6**

	Total 17/18	Permanently employed	Other	Total 16/17	Permanently employed	Other
Average staff numbers	**No.**	**No.**	**No.**	**No.**	**No.**	**No.**
Medical and dental	1,775	1,635	140	1,737	1,574	163
Administration and estates	2,896	2,838	58	2,627	2,497	130
Healthcare assistants and other support staff	1,419	1,322	97	812	516	296
Nursing, midwifery and health visiting staff	5,366	5,345	21	5,611	5,307	304
Scientific, therapeutic and technical staff	1,784	1,702	82	1,736	1,653	83
Other	360	264	96	84	33	51
Total	**13,600**	**13,106**	**494**	**12,607**	**11,580**	**1,027**

Gender pay gap

We published our statutory Gender Pay Gap report in March 17.

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

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	21.89	17.16
Female	15.27	14.05
Difference	6.62	3.10
Pay Gap %	30.24	18.11

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

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

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

- Consultants earning the highest salary within this staff group are at the moment predominantly male (65.2%). Historically the medical profession has attracted more male than female candidates although this is changing as years progress. However the dominance within this staff group currently gives some indication as to the difference in pay rates. Those consultants who have a higher annual salary and therefore hourly rate are also more likely to be male given they have been in post for longer
- Only Consultants can receive pay that is classified as bonus pay. Bonus pay elements are awarded as a result of recognition of excellent practice over and above contractual requirements and have no gender bias. However, it is important to consider that the opportunity to develop excellent practice over and above contractual requirement is linked to the amount of time the consultant has been in post. Again, this makes the awarding of bonus pay more likely for male employees in this staff group
- For non-medical staff there is a predominantly female workforce (83%) which has a direct impact on our profile

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

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

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

Sickness absence

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

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

	16/17	17/18
Total days lost	93,662	108,470
Total staff days per year	11,743	12,737
Average working days lost	7.98	8.52

The staff sickness absence data is stated for the calendar year as being the latest available data at the time of preparation of the annual report and accounts. The Department of Health (DH) considers these as a reasonable proxy for the financial year.

Total days lost through sickness increased slightly in 17/18 compared with 16/17, resulting in an average working days lost per whole time equivalent of 8.52 (7.98 in 16/17).

Consultancy

NUH spent £1m on consultancy costs in 17/18, significantly lower than £8.1m committed in 16/17 which were as a result of costs incurred in relation the proposed merger with Sherwood Forest Hospitals NHS Foundation Trust.

Remuneration report

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

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

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

Salary and pension entitlements of senior managers

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

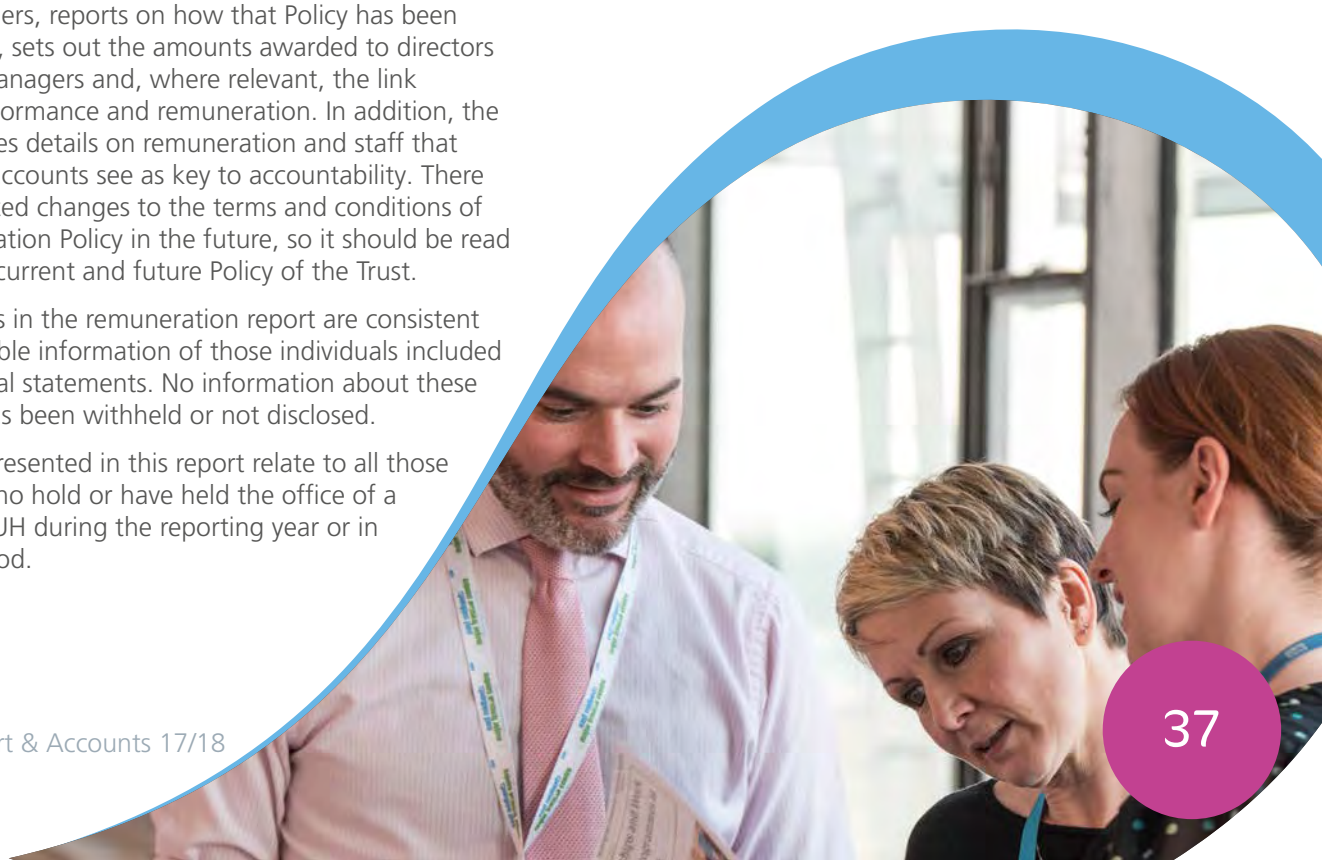
The 17/18 remuneration and pension entitlement for these Senior Managers is disclosed in the tables below.

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. However in 17/18 the Director of Finance, Information & Procurement was paid a one-off bonus of £7,500 which was approved by the Renumeration Committee on 25 January 18.

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

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

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



Remuneration

Name and Title	17/18					16/17				Notes
	Salary	Expense payments (taxable)	Performance pay and bonuses	All pension-related benefits *	TOTAL	Salary	Expense payments (taxable)	All pension-related benefits *	TOTAL	
	Bands of £5k	Total to nearest £100	Bands of £5k	Bands of £2.5k	Bands of £5k	Bands of £5k	total to nearest £100	Bands of £2.5k	Bands of £5k	
	£000	£00		£000	£000	£000	£00	£000	£000	
Executives										
Dr P Homa, Chief Executive	130-135	0	0	10.0-12.5	140-145	220-225	0	72.5-75	295-300	1
Mrs T Taylor, Chief Executive	95-100	0	0	102.5-105	195-200	0	0	0	0	2
Ms M Sunderland, Chief Nurse	155-160	0	0	27.5-30	185-190	150-155	0	20-22.5	175-180	
Dr S Fowlie, Medical Director	35-40	0	0	0	35-40	280-285	0	705-707.5	990-995	3
Dr K Girling, Medical Director	160-165	0	0	22.5-25	185-190	0	0	0	0	4
Mr R Egginton, Director of Finance, Information and Procurement	170-175	0	5-10	2.5-5	185-190	170-175	0	35-37.5	205-210	
Ms C Shaw, Chief Operating Officer	180-185	0	0	27.5-30	205-210	175-180	0	0	175-180	
Non-Executives										
Ms L Scull (Chair)	0-5	0	0	0	0-5	20-25	0	0	20-25	5
Mr E Morton (Chair)	35-40	0	0	0	35-40	0	0	0	0	6
Mrs J Pomeroy	5-10	0	0	0	5-10	5-10	0	0	5-10	
Professor H Sewell	5-10	0	0	0	5-10	5-10	0	0	5-10	
Mr S Thomas	5-10	0	0	0	5-10	5-10	0	0	5-10	
Mr D Cartwright	5-10	0	0	0	5-10	5-10	0	0	5-10	
Mrs E Grant	5-10	0	0	0	5-10	5-10	0	0	5-10	

Notes

1. Dr Peter Homa retired on 3.11.17
2. Mrs Tracy Taylor was appointed Chief Executive on 30.10.17
3. Dr Stephen Fowlie retired on 31.05.17
4. Dr Keith Girling was appointed Medical Director on 1.06.17
5. Ms Louise Scull stepped down as Chair on 30.04.17
6. Mr Eric Morton was appointed a Non-Executive Director and Chair on 1.05.17

There are no performance pay, long term performance pay or bonuses for the directors in 16/17

*** 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 DH in 13/14.**

Pension entitlements

Name and Title	Real increase in pension at pension age (£2,500)	Real increase in pension lump sum at pension age (£2,500)	Total accrued pension at pension age at 31 March 2018 (£5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (£5,000)	Cash Equivalent Transfer Value at 1 April 2017	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Mrs T Taylor, Chief Executive	2.5-5.0	12.5-15.0	80-85	240-245	1,173	1,469	119
Ms M Sunderland, Chief Nurse	0.0-2.5	5.0-7.5	60-65	185-190	1,129	1,260	120
Dr K Girling, Medical Director	0.0-2.5	0	50-55	140-145	920	981	43
Mr R Egginton, Director of Finance and Procurement	0.0-2.5	0.0-2.5	65-70	190-195	1,192	1,284	80
Mrs C Shaw, Chief Operating Officer	2.5-5.0	0	70-75	185-190	1,152	1,261	97

Note

The Trust has no employer contributions for Partnership pension accounts

Pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at **www.nhsbsa.nhs.uk/pensions**. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The scheme is subject to a full actuarial valuation every four years (until 04, every five years) and an accounting valuation every year.

Cash Equivalent Transfer Values

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

Pay multiples

The reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid Director of the Trust in the financial year 17/18 was £225,000-£230,000 (16/17, £280,000-£285,000). This was 8.3 times (16/17, 10.1 times) the median remuneration of the workforce, which was £27,308 (16/17, £28,113). In 17/18, one (16/17, 0) employee received remuneration in excess of the highest paid director. Remuneration ranged from £6,091 to £309,334 (16/17 £6,064 to £284,823). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the CETV of pensions. Where there is a sharing arrangement, the cost of an individual to the Trust is shown and not the total of that individual's remuneration. Termination benefits have been excluded from the calculation of the highest paid director's/member's salary to avoid distorting the ratio.


Patient Escort
NUH
Theatres

On 1 April 17 there was a transfer of 1,149 staff from the external Estates and Facilities service provider Carillion plc back to the NUH Trust, which had a significant impact on the composition of the workforce.

The Chief Executive was the highest paid Director and a Consultant was the highest paid member of staff in 17/18. The median rate of pay has fallen due to repatriation of 1,149 Estates and facilities staff, which are generally lower paid jobs.

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

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

The Trust has developed and is implementing a tax policy to ensure compliance with DH and HMRC guidelines. During 17/18 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.

The Trust does 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). The Trust is required to disclose:

This is for all off-payroll engagements as of 31 March 18, 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 17 and 31 March 18, 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 17 and 31 March 18.

Summary of off-payroll engagements

Off-payroll engagements Table 1

Number of engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:	NUH TOTAL
Number of existing engagements as of 31 March 2018	19
Of which, the number that have existed:	
• **For less than one year at the time of reporting**	6
• **For between one and two years at the time of reporting**	7
• **For between two and three years at the time of reporting**	4
• **For between three and four years at the time of reporting**	1
• **For four or more years at the time of reporting**	1

Off-payroll engagements Table 2

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 17 and 31 March 18, for more than £245 per day and that last for longer than six months	NUH TOTAL
No. of new engagements, or those that reached six months in duration, between 1 April 17 and 31 March 18	9
No. assessed as caught by IR35	4
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	3
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements Table 3

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 17 and 31 March 18	NUH TOTAL
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements (2)	11

Severance and exit packages

Actual redundancy and other departure payments in the year were £226,000.

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

Exit package cost band (incl. any special payment element)	No of compulsory redundancies	Cost of compulsory redundancies	No. of other departures agreed	Cost of other departures agreed	Total no. of exit packages		No. of departures where special payments have been made	Cost of special payment element incl. in exit pakages
	No.	£000	No.	£000	No.	£000	No.	£000
16/17								
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	0	0	3	69	3	69	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001-£150,000	0	0	1	116	1	116	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**4**	**185**	**4**	**185**	**0**	**0**

Other exit packages	17/18 no. of exit package agreements	17/18 total value of agreements	16/17 no. of exit package agreements	16/17 total value of agreements
	No.	£000	No.	£000
Voluntary redundancies incl. early retirement contractual costs	0	0	3	162
Mutually agreed resignations (MARS) contractual costs	0	0	1	10
Early retirements in the efficiency of service contractual costs	0	0		
Contractual payments in lieu of notice	4	226	1	13
Exit payments following employment tribunals or court orders	0	0		
Non contractual payments requiring HMT approval*	0	0		
Total	**4**	**226**	**5**	**185**
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Note
*This includes any non-contractual severance payment following judicial mediation and amounts relating to non-contractual payments in lieu of notice.

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

Modern Slavery Act Statement

All staff at NUH, in clinical or non-clinical roles, have a responsibility to consider issues regarding modern slavery and to incorporate their understanding of these issues into their day-to-day activities.

Frontline NHS staff are well-placed to be able to identify and report any concerns they may have about individual patients who present for treatment and modern slavery is part of the safeguarding agenda for children and adults.

The Trust is fully aware of the responsibilities towards patients, employees and the local community and, as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 15, the Procurement Department within NUH reviews its supply chains with a view to confirming that such actions are not taking place.

We have introduced a 'Supplier Code of Conduct' and ask all existing and new suppliers to confirm their compliance, as well as adding evidence gathering questions into our tendering procedures.

Advice and training about slavery and human trafficking is available to staff through the Safeguarding Team. Further information on Modern Day Slavery can be found by visiting:

www.gov.uk/government/ collections/modern-slavery-bill

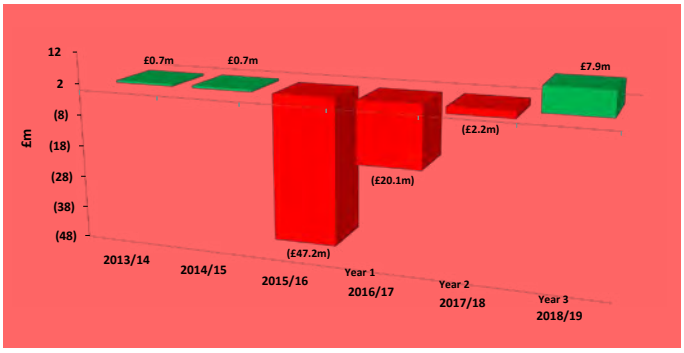
Tracy Taylor
Chief Executive

24 May 2018

Section 3 – Financial performance

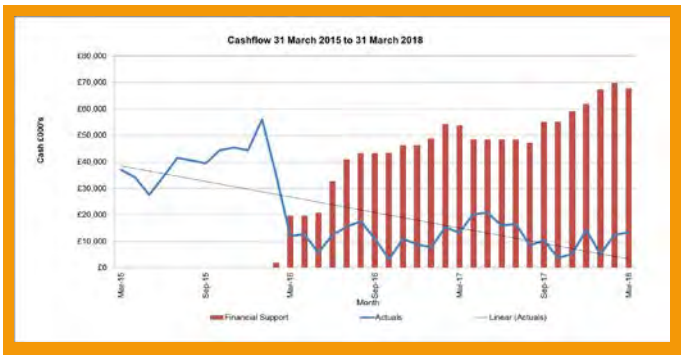
17/18 Financial performance scorecard

BREAK EVEN DUTY



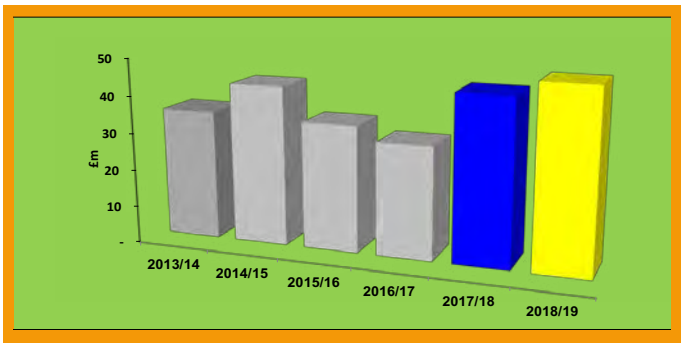
NUH reported a deficit of £2.2m. The Trust did not achieve its break even duty, but met its financial control total. The Trust is planning to return to surplus in 17/18.

CASH



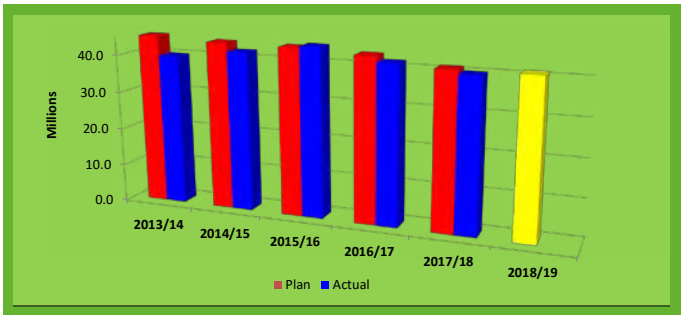
The Trust had a cash balance of £13.4m at 31 March 2018. The Trust remained within its cash limit set by the Department of Health and Social Care (DHSC)

CAPITAL INVESTMENT



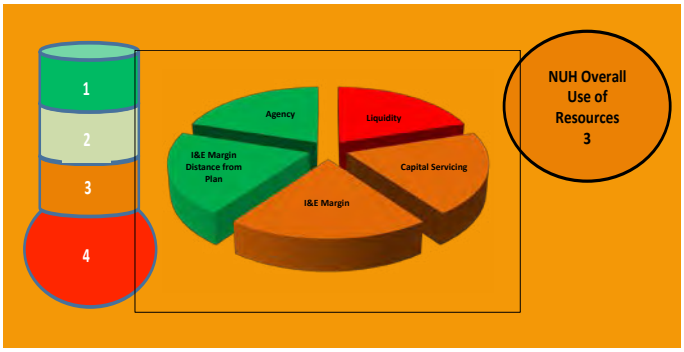
The Trust invested £44m in capital infrastructure and equipment in 17/18 and remained within the limit set by the DHSC

FINANCIAL EFFICIENCY



The Trust delivered cost improvements of £40m (5% of operating expenditure)

USE OF RESOURCES



17/18 financial headlines

The Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 18.

The Trust is required to meet certain financial duties in order to ensure appropriate management of public funds. The performance of these is shown in the table below:

Statutory duty	Notes	Target	Performance	Variance	Duty
Breakeven	Expenditure does not exceed income	(£10.7m)	(£2.3m)	£8.4m better than plan	Not met
External Finance Limit (EFL)	Limit on net external cash	£27.8m	£15.4m	£12.4m better than plan	Met
Capital Absorption Rate	The Trust pays a dividend of 3.5% of the relevant net assets	3.5%	3.5%		Met
Capital Resource Limit (CRL)	Capital expenditure is not allowed to exceed the limit set	£44.2m	£43.8m	£0.4m underspent	Met

- 17/18 was the second financial year of the Trust's three-year plan to return the Trust to financial balance. The Trust achieved a better position that it's planned financial control total, in delivering a deficit of £2.3m (against a plan of £10.7m). This included securing sustainability and transformation funding of £28.5m, as a result of meeting its financial performance targets
- The Trust generated financial efficiency savings of £40m against a target of £41m. This is consistent with delivering cost improvement plans in excess of £40m (5%) for the last five years
- NHSI measures use of resources through the Single Oversight Framework (SOF). The Trust achieved a score of 3, which represents the best possible score that we could have achieved, given the failure to achieve financial balance triggers an override to the calculation. The Trust delivered the highest possible score of 1 for hitting its financial plan and spending less on agency staffing than its cap
- NHSI required the Trust to reduce agency spend and set a cap for 17/18 of £20.4m (£2m lower than 16/17). The Trust managed to reduce agency expenditure to £18.2m, £2.2m lower than cap and £4.2m lower than the previous year
- The Trust managed its cash resources and stayed within its interim revenue support facility, linked to the I&E control total. A closing cash balance of £13.4m was achieved at 31 March 18, which was £11.4m better than the minimum daily cash requirement, as a condition of loan support
- The Trust's consolidated financial position includes the operating surplus of its private subsidiary, Hospital Pharmacy Services (Nottingham) Ltd (£0.5m), in accordance with the Group accounting standards
- The Trust invested £44.4m in its capital infrastructure in 17/18, which was £0.4m lower than its available capital resource limit, having adjusted for asset write offs and donated capital funding

Income

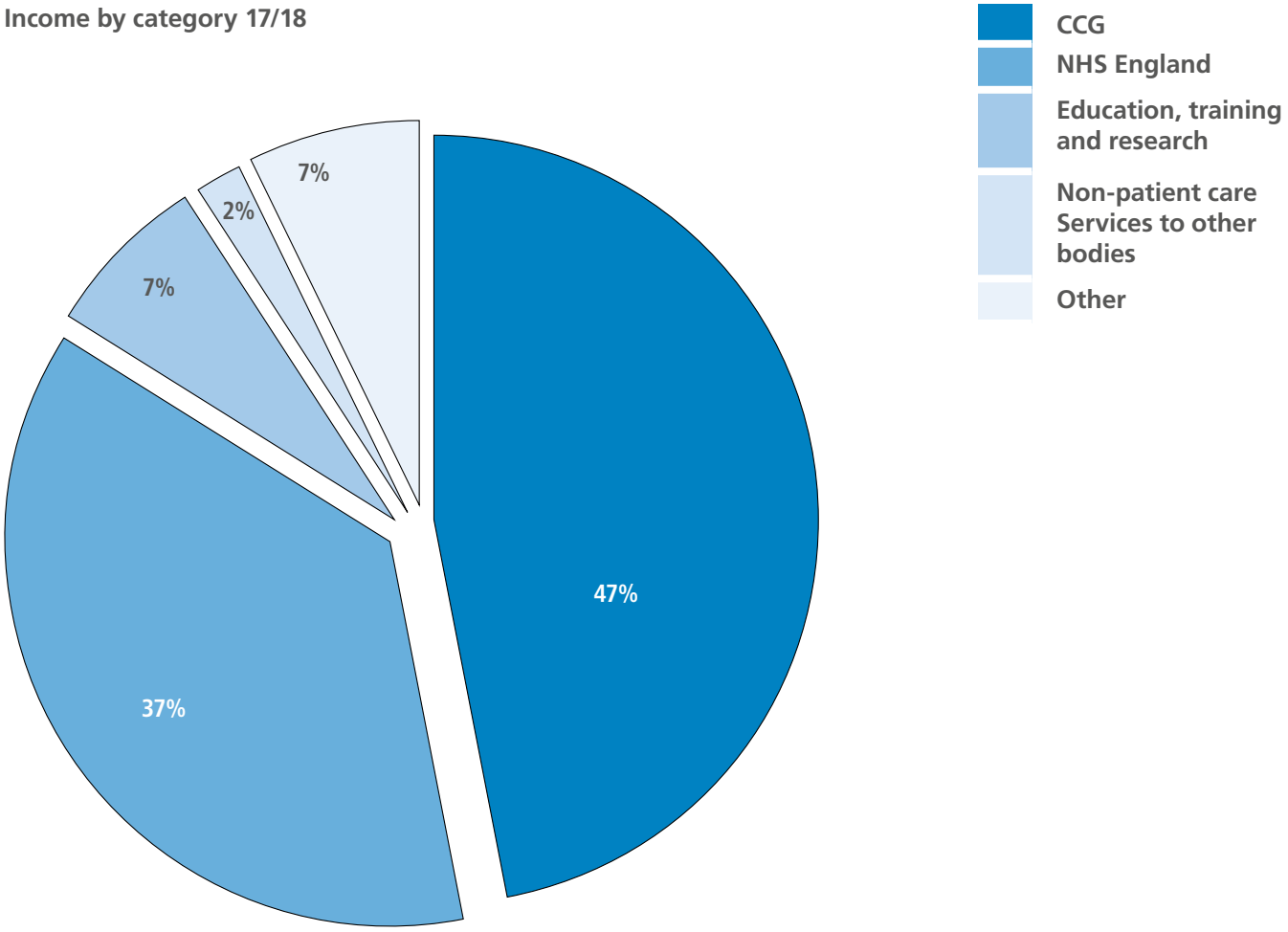
The Trust earned income of £987.5m (compared with £934.8m in 16/17) – an overall increase of £52.7m (6%), of which 85% (£840.3m) (£777.6m in 16/17) came from the delivery of acute and specialised patient care activities. The largest component of the Trust's clinical activity related income was received from the CCG Commissioning Consortia (£459.0m) and local authorities (£5.7m) for acute services, and NHS England (£363.7m) for specialised services. The increase in patient care income resulted from changes to national and local tariff pricing that aims to improve income allocation and reward more complex case mix, increased growth in activity from 16/17, increase in pass through high cost drugs and devices and additional winter pressures funding. The component relating to increased activity growth accounted for £24.7m, which equated to an increase of 3.2% year on year growth funded by our commissioners.

Other operating income for the period was £147.2m, which is received to fund education, training and research activities and generated from trading and commercial activities. As a Teaching Hospital and centre of excellence for teaching, education and research, the Trust receives significant investment for these services.

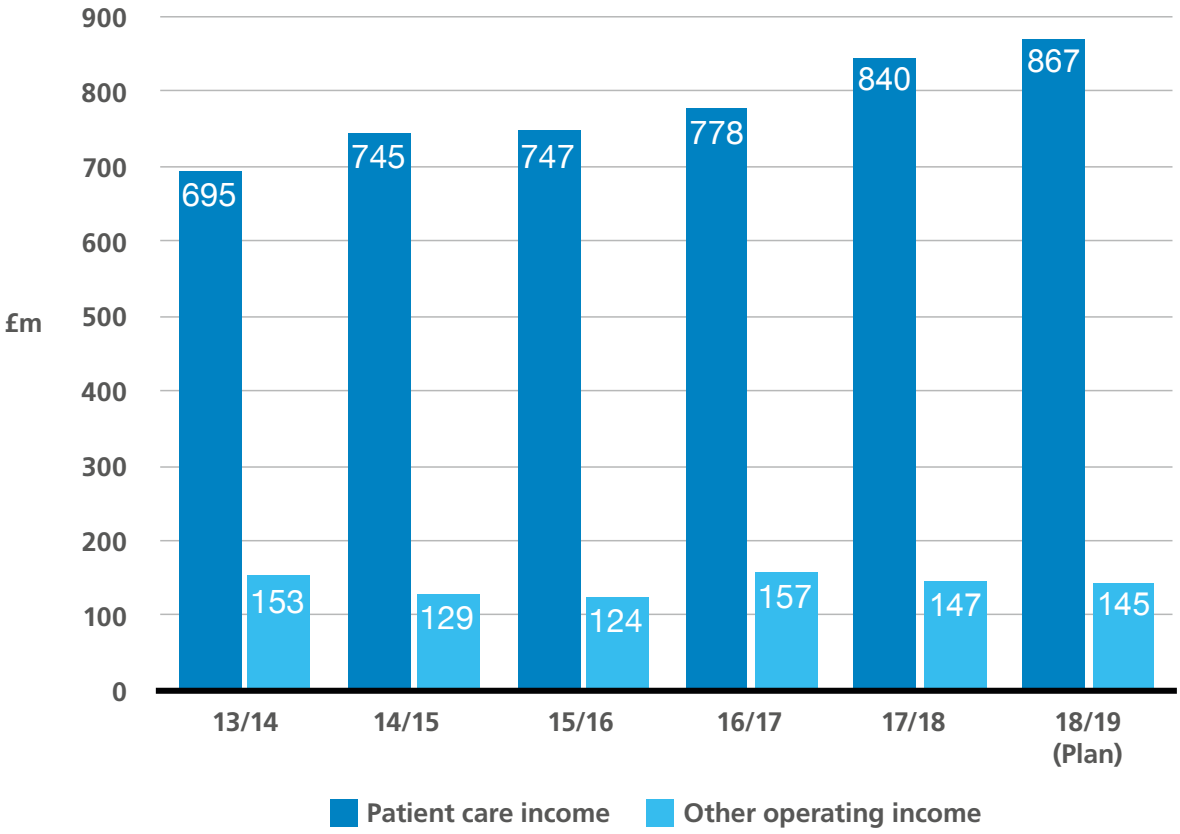
Other operating income actually reduced by £10m in 17/18, mainly due to the receipt in 16/17 of in excess of £14m long term partnership income associated with the Sherwood Forest NHS Foundation Trust collaboration (offset by expenditure) and reduction in the value of the core medical teaching and education contracts (£2.9m) in 17/18. This reduction was mitigated by an increase in funding for Sustainability and Transformation Funding (£3m), biomedical research and academic health sciences programmes (£2.4m) (offset by expenditure) and other R&D funding sources and increase in central network funding (£2m).

An analysis of the sources of income by type and trend analysis in 17/18 is shown in the graph overleaf:

Income by category 17/18



Trust income (13/14 – 18/19)

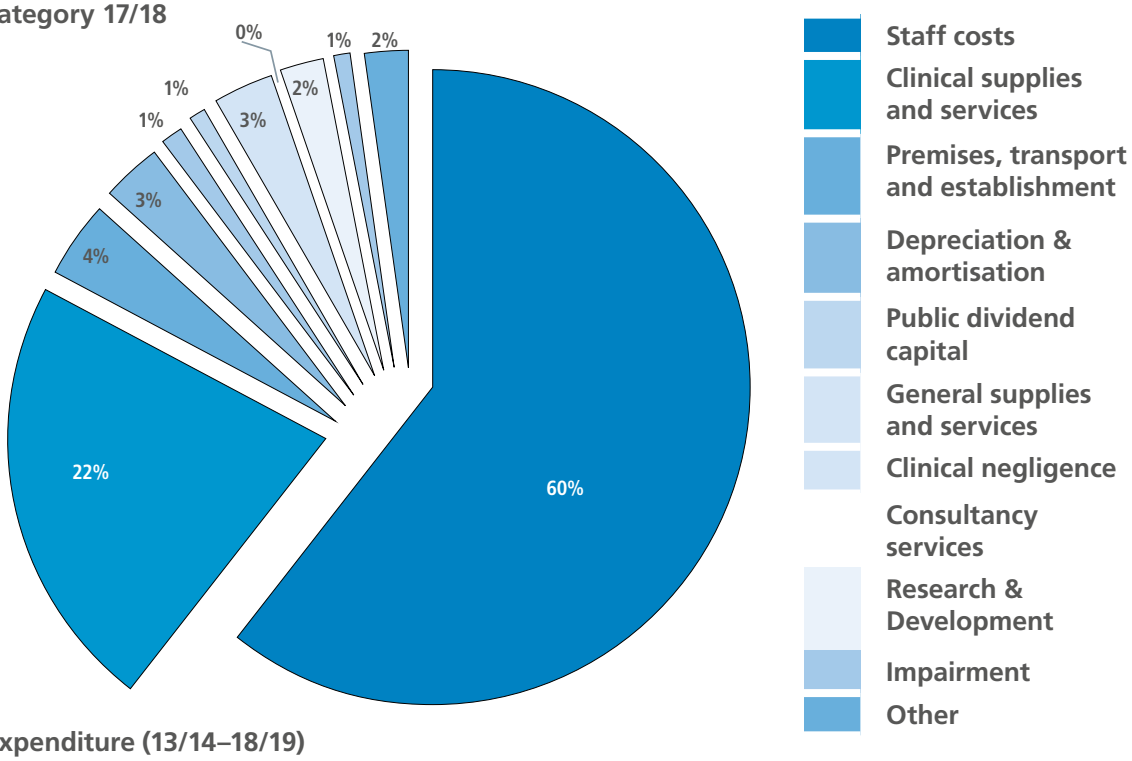


Expenditure

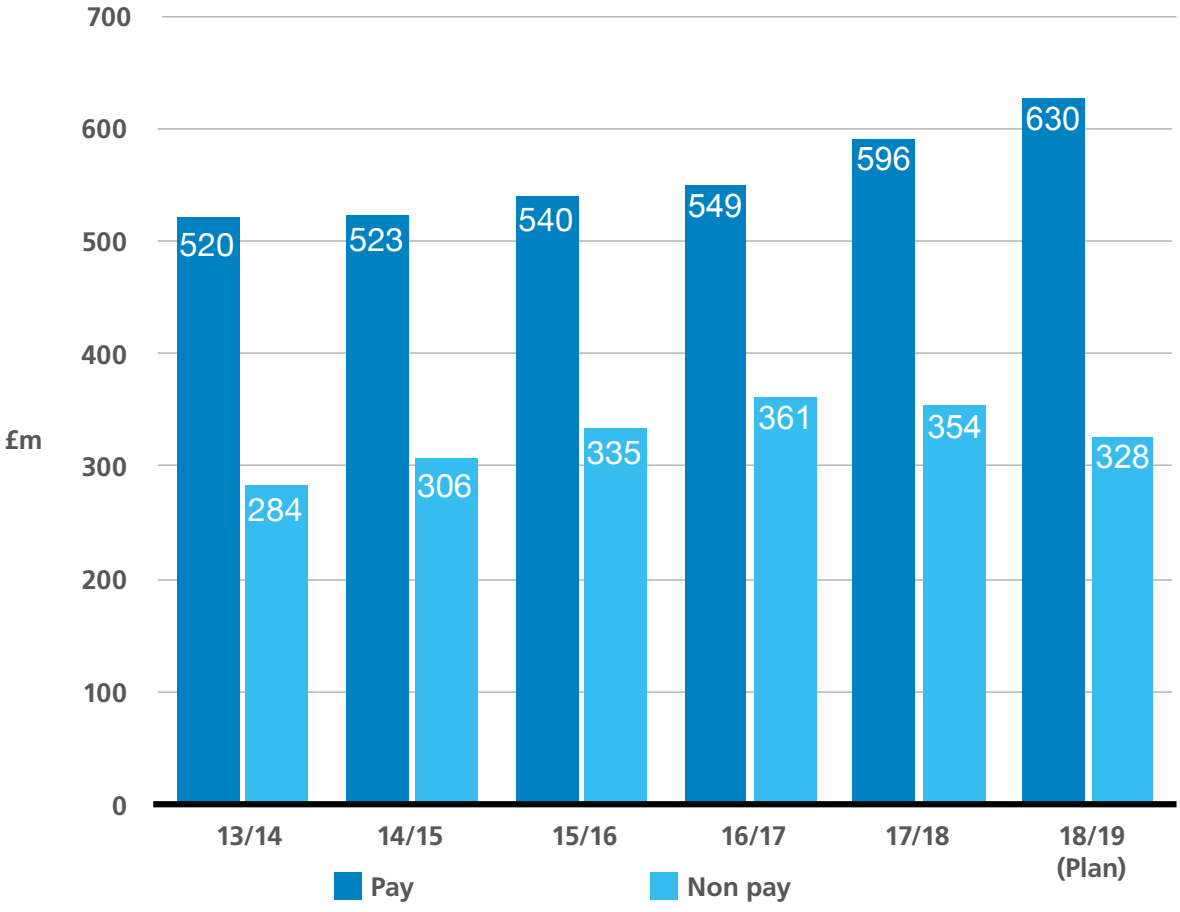
Expenditure (including non operating items) of £983.3m was incurred in delivering Trust services in 17/18 compared with £959.1m in 16/17; an increase of £24.5m (2.5%). Staff costs absorbed the largest amount of resources, equating to £595.8m (£549.4m in 16/17) (representing 60% of total expenditure).

An analysis of operating expenses by type and trend analysis in 17/18 is shown in the graph below:

Expenditure by category 17/18



Trust operating expenditure (13/14–18/19)



The Trust built on the progress achieved in the previous year, by further reducing reliance on agency, bank and locum staff in 17/18, sourced from outside providers or third parties.

The Trust is required to comply with a national spending cap on agency staffing, which it did successfully again in 17/18. In fact there was a significant shift from temporary staff 'recharged' into the organisation and those substantially employed, as the Trust successfully managed its own internal bank of employees to cover vacancies and to provide short term or fixed term cover. This was supported by other measures introduced last year, most notably the effective use of nursing and midwifery recruitment campaigns and applying restrictions and controls on the use of agency through the use of procurement and expenditure controls .

The overall size of the Trust's workforce increased by over 1,000 to just over 13,600 FTEs in 17/18, as a result of the transfer of staff equating to £27m to the Trust on 1 April 17 from the external Estates and Facilities service provider Carillion, following the termination of this contract.

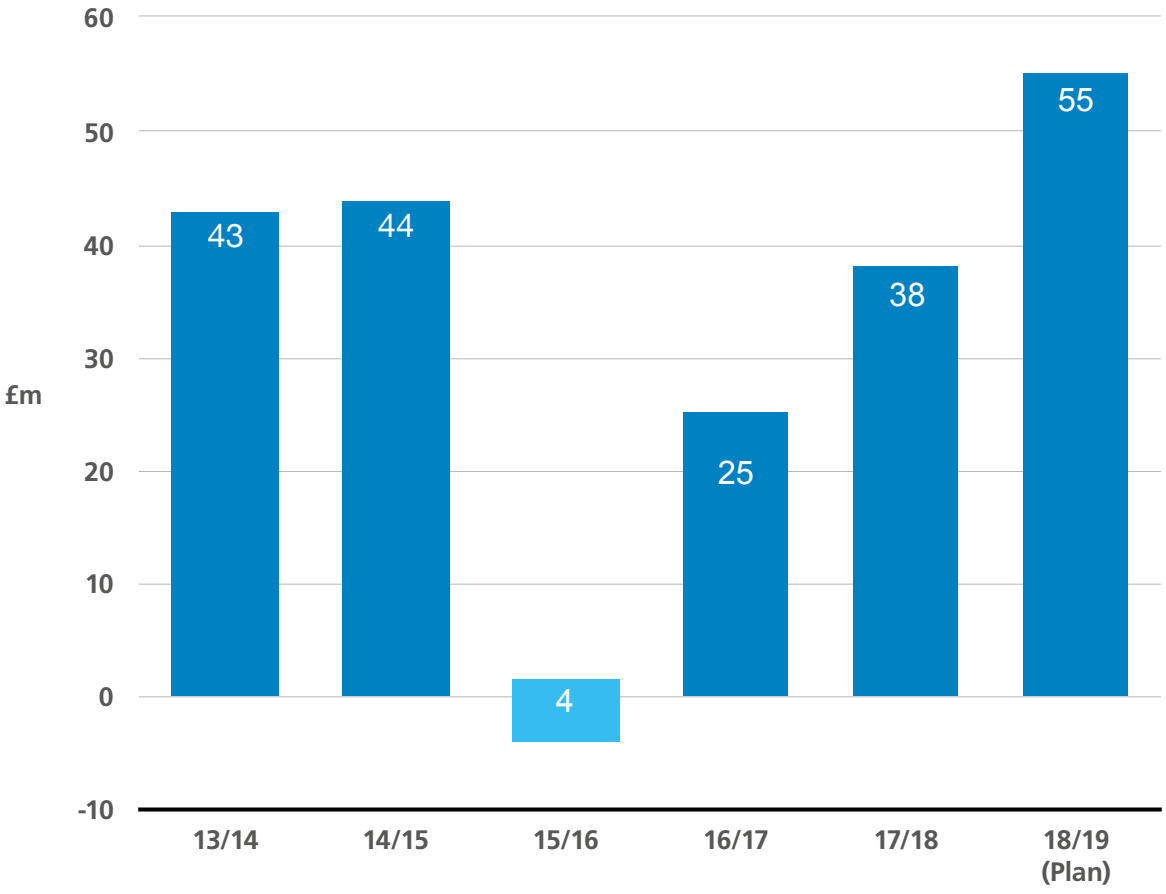
The Trust's underlying non-pay expenditure position (excluding non-operating items) reduced by £8.4m (2.3% year on year). This is mainly explained by the repatriation of the Estates and Facilities service to the Trust (£20.4m), which removed this element of contractual non pay spend (substituted by increased pay costs reported in the previous section) and a reduction in consultancy costs compared with 16/17 (£7.1m), which were incurred in supporting the Sherwood Forest merger/long term partnership .

These non pay cost reductions were offset by increased in expenditure in relation high cost drugs (£6.2m), clinical negligence scheme for trusts (CNST) insurance premium (£3.0m), academic health sciences network expenditure hosted by the Trust and research related expenditure (£1.9m).

EBITDA

EBITDA is defined as earnings before interest, tax and dividend. The Trust returned to a surplus EBITDA of £22m in 16/17, which increased to £38.1m in 17/18 and is planned to grow to £55m in 18/19 demonstrating that the Trust is successfully transitioning through a period of financial recovery,

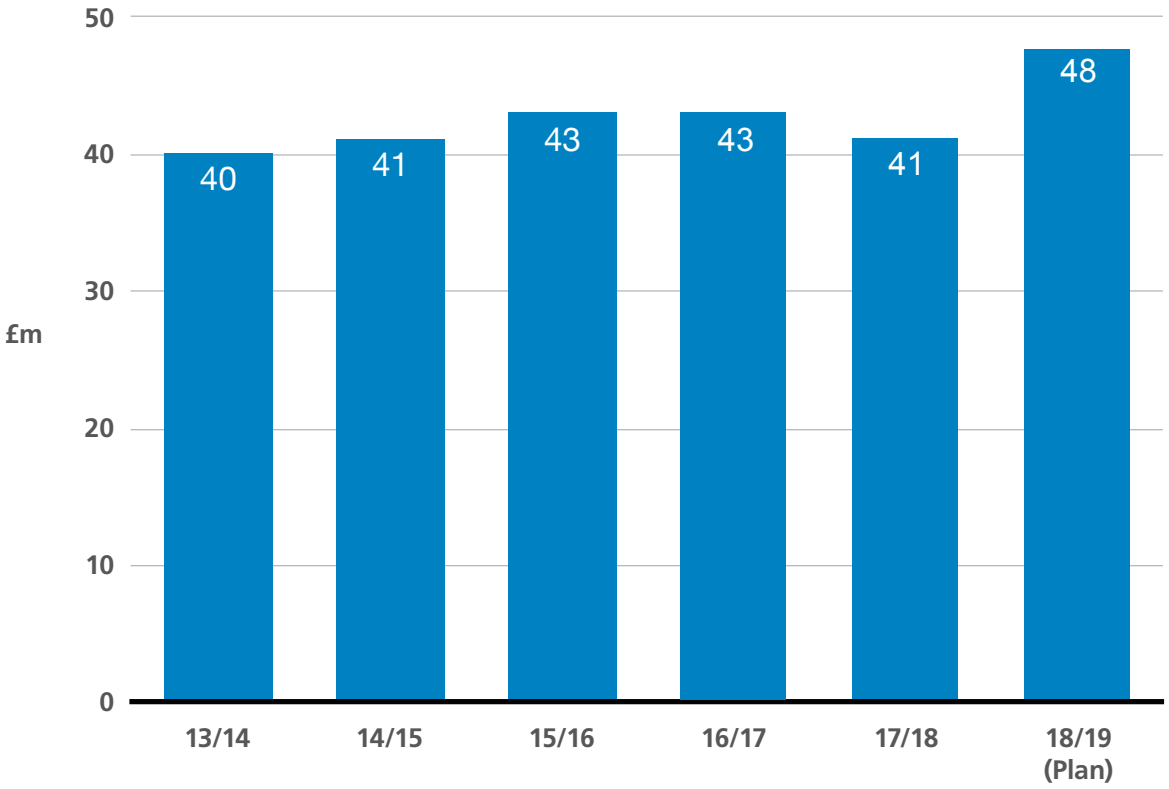
EBITDA (13/14–18/19)



Non-operating items

As its name suggests, non operating items is 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. The forecast increase in non-operating costs in 18/19 reflects the full year impact of depreciation and amortisation on IT and equipment capitalised in 17/18. The capital programme has been weighted heavily towards 'shorter life' assets of between five to seven years, resulting in a higher annual charge. Depreciation provides a fund for asset replacement when they reach the end of their economic life.

Trust non-operating items (13/14–18/19)



Efficiency and effectiveness

The Trust achieved £40m savings against a £41m target. The Trust has now achieved annual savings targets in excess of £40m (5%) for the last five years.

The table below sets out where the savings were delivered across the Trust, in terms of workstreams and Divisions.

The Trust uses the reference cost benchmarking tool alongside other operational information to highlight areas where there may be financial efficiency opportunities. The Trust makes active use of the Model Hospital benchmarking tool to target performance improvement in support of the financial efficiency programme and has an established performance management process to maintain divisional financial accountability, supported by high quality service line reporting.

The Model Hospital has been key driver behind the Trust's financial efficiency. This can be seen in both schemes developed independently by divisions, as well as the savings identified through the Trust's Wave process. The Model Hospital has proved to be a key data source in the planning stages. In 17/18, Carter efficiency savings initiatives contributed £27.4m of the £40m level of savings achieved.

Although £10.3m of actual savings delivered were non-recurrent, plans started in 17/18 that continue with a recurrent, full year effect into 18/19 will be worth £11.9m in the 18/19 year.

Service line reporting

The table below presents a summary of the margins achieved by each of the Trust's service lines in 17/18. All frontline clinical service lines, delivered financial deficits in 17/18, although in the case of the emergency pathway, on a much reduced scale, reflective of the investment and redesign that has taken place within the service. The key challenge for the integrated care system is to address the patient flow issues associated with urgent and emergency care and in particular the number of patients identified as 'medically safe for transfer' that remain in hospital due to lack of community beds. This impacts upon the Trust's ability to effectively and appropriately use its bed stock and to ensure that specialties have an appropriate bed-base to meet demand.

Service line	17/18 Margin – Surplus (Loss) £m	16/17 Margin – Surplus (Loss) £m	15/16 Margin – Surplus (Loss) £m	14/15 Margin – Surplus (Loss) £m
Emergency Pathway	(14.1)	(25.0)	(29.1)	(22.7)
Cancer	(2.6)	4.5	(1.6)	(2.1)
Planned Care	(13.8)	(11.4)	(10.2)	(2.4)
Family Health	(8.2)	(11.5)	(12.5)	(1.7)
Support Services (Diagnostics, Theatres and Critical Care)	2.5	0.6	3.8	2.0
Central and Corporate (includes STP funding)	33.5	22.3	1.6	26.9
Pharmacy Company (HPSN)	0.5	0.4	0.8	0.8
Total	**(2.2)**	**(20.1)**	**(47.2)**	**0.8**

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

Property Valuation

An interim revaluation of Trust property was been completed by its Valuers, Gerald Eve, which resulted in land and building values increasing by 6.9% after making adjustments for physical, functional and economic depreciation and 17/18 capital works, in 17/18 which was consistent with the national picture in most NHS organisations.

Capital investment programme

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

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

The size and scale of capital expenditure in the next five years will remain dependent upon the extent to which the Trust is able to sustain financial recovery and deliver annual financial surpluses. Work progresses on 'Tomorrow's NUH,' which involves developing a strategic estate vision transformation plan to ensure we address our ageing estate and infrastructure to complement our long terms service strategy, to ensure the best possible care is delivered to our patients.

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

Capital investment scheme	Benefits	Value in 17/18 (£m)
Minor medical equipment replacement	Replacement of medical equipment that has reached the end of its useful life to modernise services	6.1
Major medical equipment schemes	X-ray rooms, Linear Accelerator replacement, Gamma Camera, MRI	4.2
Digitising health records and e-observations	Replacement of paper-based records and processes via electroniccapture to eliminate inefficiencies such as accessibility, security, manual processing and the costs of storage and transportation of physical documents	2.4
IT network	Modernisation of voice and data infrastructure	9.0
Other IT investment	Hardware and software additions improving clinical and corporate information and services	3.9
Estates regulatory compliance	Improvements to buildings and infrastructure, patient environments and health and safety compliance	11.7
South tram entrance, QMC	Provide patient and visitor access to QMC South block adjacent to tram stop	0.4
Seedcom developments	Capital investment to improve servioces and save revenue monies	0.4
Modular theatres	Decant theatres used for theatre modernisation programme, including Theatres 18-19 to incorporate the inter-operative MRI and the upgrade of the ventilation to Theatres 1-17 over the next 24 months	2.0
ED, capacity and patient flow	Range of schemes to support streaming of ED and improve capacity and patient flow through the hospital	1.0
Other developments	Small schemes, including those funded from charitable donations	3.3
Total capital expenditure		**44.4**
Book value of assets disposed of		(0.2)
Charitable income		(0.4)
Total capital expenditure		**43.8**
Capital Resource Limit (CRL)		**44.2**
CRL underspend		**0.4**

Better payments performance (BPPC)

All providers are required to pay their suppliers promptly, by ensuring that payments are made within 30 days of receipt of each invoice for 95% of invoices. NUH achieved 92% of the value of invoices processed, which benchmarks in the upper quartile of all providers.

Balance sheet events

There are no post balance sheet events to report.

Financial outlook

Since being established, NUH has demonstrated a history of strong financial performance, delivering annual surpluses up to 14/15. Over the course of the last 3 years, like most acute providers, nationally, the Trust has been exposed to unprecedented operational and financial pressures, such that the Trust incurred losses in 15/16 (£47.2m), 16/17 (£20.1m) and 17/18 (£2.2m). However, in each of these years, the Trust has delivered its financial control total agreed with NHSI and the magnitude of the losses have reduced year on year, as the Trust has undergone a period of financial recovery. 17/18 marked the second year of our 3 year challenge to return NUH back to financial balance.

The Trust has developed financial plans that will support delivery of an agreed 'control total,' in 18/19 of a financial surplus of £7.9m. This will require that the Trust delivers a savings target of £41m. The 18/19 plan assumes that the full Provider Sustainability Fund (PSF) of £32.7m will received in order to meet the control total after PSF, although 30% of this will be dependent upon the financial performance of the 'shadow' integrated care system.

The Trust's financial planning process is driven from a clinically led activity planning exercise. This is undertaken jointly between the Trust and local commissioners and sets an agreed activity baseline assumption for 18/19.

Redthread ED Team

The quality and workforce requirements to deliver the changes of activity in a safe and efficient manner are then assessed. This is set against the financial impact of the planning assumptions and other changes in cost profile to develop an estimate of the financial gap to the control total. Following recommendations from the Director of Financial Recovery, the Trust Board then assesses the level of efficiencies that represents an ambitious but attainable target while not undermining the quality and safety of the services we provide.

Activity and income

The NHS planning guidance issued on 2 February 18 outlined a requirement to refresh 18/19 plans already prepared under the two-year (2017 to 2019) contract agreed with commissioners in December 16. The overall activity model has been compared to national assumptions and also to the Trust's strategic activity projections and is broadly in line with expectations and where there are differences these can be explained by local initiatives. The Trust is anticipating future years' activity growth of circa 2.5% which is in line with the Sustainability and Transformation Partnership (STP).

Nottinghamshire's Sustainability and Transformation Partnership (STP)

Although the Trust did not meet its four-hour access target in 17/18, this was the context of unprecedented national health services pressures in this regard and is recognised as a being a health system wide pressure. To this end, the Trust plays a key role in the integrated care system (ICS). The commissioners and providers are committed to developing a fully integrated and effective care system (which will be shadowed in 18/19) across the Nottinghamshire area whilst bringing it into financial balance to achieve this aim.

NUH is reviewing and redesigning the way that planned and emergency care, is currently delivered, both within and outside of hospital and will implement new ways of working to achieve better results for patients. The successful achievement of this system transformation will deliver new service models which result in patients staying healthier for longer, receiving care in or closer to their home wherever possible and only being in hospital when this is the best place for their care.

Miriam Duffy, Director of Operations at NUH, said: "Sadly, our Emergency Department regularly sees young people who have been victims of crime, including those seriously hurt by knives or other weapons. Our priority is always helping them in the moment by providing care and treatment to help and, often, save their life. By partnering with Redthread we can work together, using their skills and experience, to do our best to help change these young lives for the better, and hopefully reduce the risk of them becoming victims of crime again and needing our help again."

Financial efficiency programme

The Trust achieved £40m against a savings target of £41m in 17/18.

The 18/19 NUH plan includes an ambitious programme of efficiency improvement designed to also deliver £41m of savings for the organisation. Plans have been identified to achieve this target, although there are delivery risks associated with a proportion of this programme, which the Trust is addressing. The delivery of the Financial Efficiency Programme and achievement of the associated financial savings will be a critical component of the Trust achieving its financial plan in 18/19.

Within the Trust, each clinically led division has an associate General Manager who takes the lead on financial efficiency for their division. The programme is supported by the Better for You Team that take responsibility for leading the Wave Programme which supports specialties in the Clinical Divisions through a structured process of change and improvement including the scoping and implementation of changes that significantly improve the financial performance of the specialties. The efficiency programme and the Wave programme in particular make extensive use of the Trust's Service Line Reporting (SLR) information, Patient Level Costing (PLICS) information and of the Carter Model Hospital and the Getting it Right First Time (GIRFT) recommendations.

Capital planning

The Trust occupies an estate which is in need of major investment, both to address critical backlog maintenance issues, significant fire risks and also to provide facilities that support contemporary service delivery. There is a pressing need to upgrade theatre and critical care capacity at QMC, as well as to reconfigure the emergency department and assessment facilities, which are strongly aligned with the Nottinghamshire STP objective of transforming urgent and emergency care. We are continuing to develop an organisational Strategic Outline Business Case (SOC), aligned to the STP Acute Clinical Service Strategy for Nottingham and Nottinghamshire, which will enable us to secure a sustainable future for healthcare services across the Nottinghamshire Health Care system.

The capital plan in 18/19 is £48.2m, which includes £7.9m generated through our planned surplus in 18/19 focuses on addressing significant Trust risks which are associated with estates and ICT infrastructure, clinical safety and the replacement of ageing medical equipment. The major medical equipment priorities include the installation of a NUH charity funded inter-operative MRI scanner, replacement ventilation works in Theatres, the replacement of an MRI scanner at QMC, along with the upgrading two X Ray Rooms. The procurement of new cardiac catheterisation laboratory (Cath Lab) imaging equipment and refurbishment of a Cath Lab (£1.4m) environment will improve the imaging quality during 18/19, building on work over the last three years to replace and upgrade other end-of-life Cath Labs.

During 18/19 the Trust will undertake the reconfiguration of our Fertility Service, upgrading the fertility andrology laboratory and fertility clinic (£487K), to enable the service to meet regulatory requirements and expand the cryopreservation service to meet demand. In addition to this, a refurbishment of the Acute Medical Receiving Unit (AMRU) will be undertaken to make it fit for purpose, increasing trolley spaces, introducing an isolation room and making improvements to the observable sick patients' area and waiting area (£500K). Reconfigurations in AMRU will support a simplified acute reconfiguration care pathway ensuring patients receive the right advice or service at the right time, supporting the delivery of the Nottinghamshire STP.

The Trust intends to also support the Endoscopy JAG accreditation process through the refurbishment of the QMC Endoscopy unit (£1.2m) ensuring clinical safety, continuous improvement in processes and patient outcomes.

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 assume the continuation of provision of clinical services in the future by NUH as sufficient evidence of going concern. The Trust is also planning to return to financial surplus in 18/19, providing assurance as to the financial stranding of the organisation. Key components of the 18/19 plan are in place that create going concern, in so far as the Trust has agreed commissioning contracts and a control total with NHSI. The plan also provides cash support to the Trust, as required in line with the phasing of the control total. The Trust has assessed its financial efficiency requirement and has plans in place to deliver this target.

The Trust will have adequate resources to continue as a going concern for at least 12 months from the date of preparation of the 17/18 accounts from a cash perspective. This is through a combination of its existing internal working capital and financial support offered by the Department of Health. Emergency cash loans are also available from NHSI, should they be required.

NUH remains a going concern and has taken steps to ensure that this remains the case. The Trust also remains committed to making best use of resources, working with its partners across the health and care system.

In conclusion

The delivery of safe and high quality care to patients in the most appropriate clinical setting is NUH's overriding strategic objective and priority.

Although we delivered a deficit in and failed to meet our break-even duty in 17/18, we delivered a much improved financial position and achieved our financial control total

agreed with our regulator. 17/18 was recognised as being the second year of a three-year plan to return to financial surplus. 18/19 will be the third of that plan, which will be vital to ensuring the Trust's services remain financially sustainable and allow the Trust to invest in its facilities and infrastructure.

The environment of public finances remains austere, such that the efficiency challenge remains the same – to deliver more activity and better outcomes for patients with fewer resources, in real terms. NUH made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 18 and remains committed to making best use of resources, in delivering its own efficiency plans and working with its partners across the health and care system.

The level of transformation required to meet the financial challenge in 18/19 and subsequent years remains very challenging. The Trust is continuing on its path to financial recovery in 18/19. NUH and the wider integrated care system is committed to developing a fully integrated and effective care system across the Nottinghamshire area whilst bringing it into financial balance to achieve this end.

Rupert Egginton

Rupert Egginton
Director of Finance and Procurement

24 May 2018

4 – Financial Statements

Accounting policies

The Annual Accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) and accounting policies. Their preparation has been guided by the 17/18 NHS Group Accounting Manual issued by the Department of Health and Social Care. They represent a "true and fair view" of the Trust's activities in 17/18, are materially accurate and contain no misstatements or errors of such magnitude that they would mislead the reader with regard to the financial standing of the Trust.

The Trust is required to disclose related undertakings as required by the section 409 of the Companies Act 2006. Hospital Pharmacy Services Nottingham (HPSN) Limited is a wholly owned subsidiary of Nottingham University Hospitals. The Accounts are presented for both the "Group" and "Trust", in accordance with the Group accounting standards (IFRS 10). The Trust has invoked Section 408 of the Companies Act 2006 and is therefore exempt from the requirements to present its own income statement and statement of comprehensive income.

External auditors

The Trust employed the services of KPMG as the external auditor for the Trust. The auditors perform their work in accordance with the Audit Commission's Code of Practice. The Codes of Audit Practice define the scope, nature and extent of local audit work. The main areas of work included the audit of financial statements, Quality Accounts and review of the Trust arrangements for securing economy, efficiency and effectiveness in our use of resources (value for money). KPMG charged a fee of £105K (excluding VAT) for the statutory audit and £19K (excluding VAT) for the Quality Accounts in 17/18.

The Trust has not received any non-audit services from KPMG in 17/18.

Annual Governance Assurance Statement

The Annual Governance Assurance Statement is printed in full in the Trust's 17/18 Annual Accounts (see pages 122-131).

Fraud awareness

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

5 – Foreword to the accounts

The Accounts for the year ended 31 March 2018 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
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year

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

Signed

Tracy Taylor
Chief Executive

24 May 2018

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 the 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, directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts

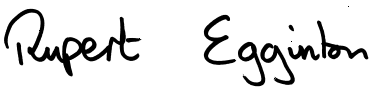
The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Tracy Taylor
Chief Executive

24 May 2018



Rupert Egginton
Director of Finance and Procurement

24 May 2018

Annual Accounts 17/18

Statement of comprehensive income for year ended 31 March 2018

	17/18	16/17	
	£000	£000	Note
Operating income from patient care activities	840,299	777,577	3
Other operating income	147,200	157,194	4
Operating expenses	(968,584)	(944,310)	6, 8
Operating surplus / (deficit) from continuing operations	**18,915**	**(9,539)**	
Finance income	79	91	11
Finance expenses	(3,155)	(3,235)	12
PDC dividends payable	(11,314)	(11,448)	
Net finance costs	**(14,390)**	**(14,592)**	
Other gains / (losses)	(126)	25	13
Corporation tax expense	(122)	(94)	
Surplus / (deficit) for the year from continuing operations	**4,277**	**(24,200)**	
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	0	0	15
Surplus / (deficit) for the year	**4,277**	**(24,200)**	
Other Comprehensive Income			
Not reclassified to income and expenditure:			
Impairments	(240)	(2,822)	7
Revaluations	19,506	1,901	21
Total comprehensive income / (expense) for the period	**23,543**	**(25,121)**	
Financial performance for the year			
Retained surplus / (deficit) for the year	4,277	(24,200)	
Impairments	(7,296)	3,255*	7
Adjustments in respect of donated government grant asset reserve elimination	759	837	
Adjusted retained surplus / (deficit)	**(2,260)**	**(20,108)**	

The notes on pages 67 to 113 form part of the accounts

*Prior Year includes IFRIC 12 adjustment which no longer applicable in the current year.

Statement of Financial Position

		Group		Trust	
		31 March 2018	31 March 2017	31 March 2018	31 March 2017
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	16-17	16,307	7,895	16,307	7,895
Property, plant and equipment	18-19	498,313	462,451	498,313	462,451
Trade and other receivables	28	4,698	4,394	4,698	1,333
Total non-current assets		**519,318**	**474,740**	**519,318**	**474,740**
Current assets					
Inventories	27	21,690	20,800	19,736	19,463
Trade and other receivables	28	70,517	54,365	72,256	56,154
Cash and cash equivalents	31	13,360	13,281	13,238	12,527
Total current assets		**105,567**	**88,446**	**105,230**	**88,144**
Current liabilities					
Trade and other payables	32	(97,117)	(82,219)	(99,758)	(84,378)
Borrowings	35	(20,931)	(1,878)	(20,931)	(1,878)
Provisions	37	(1,913)	(3,011)	(1,913)	(3,011)
Other liabilities	34	(14,503)	(14,581)	(14,503)	(14,581)
Total current liabilities		**(134,464)**	**(101,689)**	**(137,105)**	**(103,848)**
Total assets less current liabilities		**490,421**	**461,497**	**487,443**	**459,036**
Non-current liabilities					
Borrowings	35	(81,369)	(79,185)	(81,369)	(79,185)
Provisions	37	(3,050)	(3,222)	(3,050)	(3,222)
Total non-current liabilities		**(84,419)**	**(82,407)**	**(84,419)**	**(82,407)**
Total assets employed		**406,002**	**379,090**	**403,024**	**376,629**
Financed by					
Public dividend capital		414,423	411,054	414,423	411,054
Revaluation reserve		75,471	59,019	75,471	59,019
Income and expenditure reserve		(83,892)	(90,983)	(86,870)	(93,444)
Total taxpayers' equity		**406,002**	**379,090**	**403,024**	**376,629**

The notes on pages 67 to 113 form part of these accounts.

Mrs Tracy Taylor
Chief Executive

24 May 2018

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

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

Statement of Changes in Equity for the year ended 31 March 2017

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**408,896**	**62,764**	**(69,607)**	**402,053**
Surplus / (deficit) for the year	-	-	(24,200)	(24,200)
Other transfers between reserves	-	(2,824)	2,824	-
Impairments	-	(2,822)	-	(2,822)
Revaluations	-	1,901	-	1,901
Public dividend capital received	6,393	-	-	6,393
Public dividend capital repaid	(4,235)	-	-	(4,235)
Taxpayers' and others' equity at 31 March 2017	**411,054**	**59,019**	**(90,983)**	**379,090**

Statement of changes in equity for the year ended 31 March 2018

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

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 – brought forward	**408,896**	**62,764**	**(71,692)**	**399,968**
Surplus / (deficit) for the year	-	-	(24,576)	(24,576)
Other transfers between reserves	-	(2,824)	2,824	-
Impairments	-	(2,822)	-	(2,822)
Revaluations	-	1,901	-	1,901
Public dividend capital received	6,393	-	-	6,393
Public dividend capital repaid	(4,235)	-	-	(4,235)
Taxpayers' and others' equity at 31 March 2017	**411,054**	**59,019**	**(93,444)**	**376,629**

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.

Other reserves

The Trust has no other reserves.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	Group 17/18 £000	Group 16/17 £000	Trust 17/18 £000	Trust 16/17 £000
Cash flows from operating activities					
Operating surplus / (deficit)		18,915	(9,539)	18,408	(10,007)
Non-cash income and expense:					
Depreciation and amortisation	6.1	26,426	28,629	26,426	28,629
Net impairments	7	(7,204)	2,473	(7,204)	2,473
Income recognised in respect of capital donations	4	(383)	(388)	(383)	(388)
(Increase) / decrease in receivables and other assets		(17,002)	(4,560)	(17,022)	(3,107)
(Increase) / decrease in inventories		(890)	(38)	(273)	(360)
Increase / (decrease) in payables and other liabilities		14,660	(1,422)	15,108	(1,230)
Increase / (decrease) in provisions		(1,277)	(6,476)	(1,277)	(6,476)
Corporation Tax (paid) / received		(94)	(200)	-	-
Net cash flows from operating activities		**33,151**	**8,479**	**33,783**	**9,534**
Cash flows from investing activities					
Interest received		79	91	79	90
Purchase of intangible assets		(6,177)	(3,505)	(6,177)	(3,505)
Purchase of PPE		(29,034)	(24,054)	(29,034)	(24,054)
Sales of PPE		169	711	169	711
Receipt of cash donations to purchase assets		276	128	276	128
Net cash flows (used in) investing activities		**(34,687)**	**(26,629)**	**(34,687)**	**(26,630)**
Cash flows from financing activities					
Public dividend capital received		3,369	6,393	3,369	6,393
Public dividend capital repaid		0	(4,235)	-	(4,235)
Movement on loans from DHSC		12,829	32,748	12,829	32,748
Capital element of finance lease rental payments		(122)	(119)	(122)	(119)
Capital element of PFI and other service concession payments		(483)	(473)	(483)	(473)
Interest paid on finance lease liabilities		(12)	(21)	(12)	(21)
Interest paid on PFI and other service concession obligations		(1,804)	(1,777)	(1,804)	(1,777)
Other interest paid		(1,302)	(1,332)	(1,302)	(1,332)
PDC dividend paid		(10,860)	(11,888)	(10,860)	(11,888)
Net cash flows from financing activities		**1,615**	**19,296**	**1,615**	**19,296**
Increase in cash and cash equivalents		**79**	**1,146**	**711**	**2,200**
Cash and cash equivalents at 1 April 2017		**13,281**	**12,135**	**12,527**	**10,327**
Cash and cash equivalents at 31 March 2018	**31**	**13,360**	**13,281**	**13,238**	**12,527**

NOTES TO THE ACCOUNTS

Note 1: Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 17/18 issued by the Department of Health. 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 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 1.1.2 Going concern

These accounts have been prepared on a going concern basis which applies to both the Trust and its subsidiary. The Trust has no intention to dispose of or liquidate its subsidiary.

Note 1.2 Critical judgements in applying accounting policies

In the course of preparing the financial statements, no judgements have been made in the process of applying the Trust's accounting policies, other than those involving estimation (noted below), that have had a significant effect on the amounts recognised in the financial statements.

Note 1.2.1 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 2017 was £6,233,000. The liability provided for at 31 March 2018 is £4,963,000.

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

Note 1.3 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 Nottingham University Hospitals NHS 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.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust derives from contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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.

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 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 for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is 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. The scheme is accounted for as though it is a defined contribution schemes.

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.

Note 1.6 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 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 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.

Land and buildings used for the NHS Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

- Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings – depreciated replacement cost

The freehold property known as Nottingham University Hospitals NHS Trust was valued as at 31 March 18 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuations were prepared in accordance with the requirements of the RICS Valuation – Global Standards (July 17 edition), the international Valuation Standards and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM). The valuations of specialised properties were derived using the Depreciated Replacement Cost (DRC) method, with other in – use properties reported on an Existing Use Value basis.

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.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income. All assets are measured subsequently at fair value.

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 economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating 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 1.7.3 De-recognition

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

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

Note 1.7.4

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 1.7.5

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC12 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. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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

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

Note 1.7.6

Useful Economic lives of property, plant and equipment

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

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

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

Note 1.8 Intangible assets

Note 1.8.1 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.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

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

Software

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

Note 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.8.3 Useful economic life of intangible assets

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

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

Note 1.9 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 1.10 Investment properties

The Trust does not have any investment properties.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory "cap" and trade scheme for non-transport CO2 emissions. The Trust has opted out of this scheme by participating in the European Union Emissions Trading Scheme (EUETS) which operates on similar principles. The Trust is operating within the "cap" set by EUETS and is therefore not required to contribute to the scheme this year.

Note 1.13 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent

which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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 described above/below.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade/Settlement date.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

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

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from [quoted market prices/independent appraisals/discounted cash flow analysis/other (describe)].

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those

held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced - delete as appropriate: directly or through the use of an allowance account / bad debt provision.

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

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

Note 1.14 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 1.14.1 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 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 1.14.2 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 1.15 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 37.3 but is not recognised in the trust's accounts.

Non-clinical risk pooling

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

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 38 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 38, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

Note 1.17 Public dividend capital

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

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

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

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 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 1.19 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% (20% – 16/17) throughout the financial year to which these accounts relate.

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

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into sterling at the spot exchange rate on the date of the transaction.

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.

Note 1.21 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 note 31.2 to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, 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 1.23 Gifts

The Trust has made no gifts during the year.

Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies

The Trust has had no transfers from or made any transfer to any other NHS body or local government body.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 17/18.

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

IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM.

IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 18, but not yet adopted by the FReM.

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 19, but not yet adopted by the FReM.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 21, but not yet adopted by the FReM.

IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 18.

IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 19.

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	
	17/18	16/17	17/18	16/17	17/18	16/17
	£000	£000	£000	£000	£000	£000
Income	987,304	934,607	195	164	987,499	934,771
Surplus / (Deficit)	3,758	(24,575)	519	375	4,277	(24,200)
Net Assets:						
Segment net assets	403,024	376,629	2,978	2,460	406,002	379,090

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

The income of HPSN Ltd in 17/18 is £29.562m, of which £29.368m is from NUH (99.3%).

The comparative figures for 16/17 are £23.162m of which £25.999m (99.3%) is from NUH.

Note 3 Operating income from patient care activities (group)

Note 3.1 Income from patient care activities (by point of delivery)

	17/18	16/17
	£000	£000
Acute services		
Elective income	132,582	130,887
Non elective income	242,358	205,053
First outpatient income	28,148	26,126
Follow up outpatient income	80,617	65,938
A & E income	25,725	23,492
High cost drugs income from commissioners (excluding pass-through costs)	78,731	72,271
Other NHS clinical income	222,041	240,779
Income from other sources (e.g. local authorities)	5,698	6,831
All services		
Private patient income	2,512	1,991
Other clinical income	21,887	4,209
Total income from activities	**840,299**	**777,577**

Note 3.2 Income from patient care activities (by source)

	17/18	16/17
Income from patient care activities received from:	**£000**	**£000**
NHS England	363,714	312,999
Clinical commissioning groups	458,976	448,965
Department of Health and Social Care	7	2
Other NHS providers	4,563	3,430
NHS other	197	219
Local authorities	5,698	5,660
Non-NHS: private patients	1,914	1,987
Non-NHS: overseas patients (chargeable to patient)	598	401
NHS injury scheme	4,170	3,630
Non NHS: other	462	284
Total income from activities	**840,299**	**777,577**
of which:		
Related to continuing operations	840,299	777,577
Related to discontinued operations	-	-

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

	17/18	16/17
	£000	£000
Income recognised this year	598	401
Cash payments received in-year	116	211
Amounts added to provision for impairment of receivables	118	299
Amounts written off in-year	177	5

Note 4 Other operating income (group)

	17/18	16/17
	£000	£000
Research and development	27,350	21,364
Education and training	42,419	45,358
Receipt of capital grants and donations	383	388
Charitable and other contributions to expenditure	3,373	3,238
Non-patient care services to other bodies	20,950	35,754
Sustainability and transformation fund income	28,505	25,554
Rental revenue from operating leases (note 10.1)	806	1,268
Rental revenue from finance leases	1,644	1,742
Income in respect of staff costs where accounted on gross basis	6,636	5,829
Other income	15,134	16,699
Total other operating income	**147,200**	**157,194**
of which:		
Related to continuing operations	147,200	157,194
Related to discontinued operations	-	-

Note 5 Fees and charges (group)

	17/18	16/17
	£000	£000
Income	3,483	-
Full cost	(3,634)	-
Surplus / (deficit)	**(151)**	**-**

Note 6

Note 6.1 Operating expenses (group)

	17/18	16/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,203	3,954
Purchase of healthcare from non-NHS and non-DHSC bodies	1,478	1,430
Staff and executive directors costs	595,826	549,439
Remuneration of non-executive directors	71	56
Supplies and services - clinical (excluding drugs costs)	118,627	122,461
Supplies and services - general	9,145	29,630
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	103,180	90,510
Inventories written down (note 44)	345	243
Consultancy costs	991	8,060
Establishment	8,446	9,002
Premises	27,587	25,153
Transport (including patient travel)	4,562	4,794
Depreciation on property, plant and equipment (note 18)	20,761	26,018
Amortisation on intangible assets (note 16)	5,665	2,611
Net impairments (note 7)	(7,204)	2,473
Increase / (decrease) in provision for impairment of receivables	750	689
Change in provisions discount rate(s)	45	356
Audit fees payable to the external auditor		
audit services - statutory audit (including VAT)	126	154
other auditor remuneration (external auditor only)	37	85
Internal audit costs	185	149
Clinical negligence	32,739	29,763
Legal fees	274	592
Insurance	698	642
Research and development	24,665	22,751
Education and training	2,669	1,764
Rentals under operating leases (note 10.2)	1,500	1,174
Redundancy	226	185
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI) on IFRS basis	4,474	4,388
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	4,995	3,902
Car parking & security	125	988
Hospitality	149	102
Losses, ex gratia & special payments (note 44)	449	233
Other	795	559
Total	**968,584**	**944,310**
of which:		
Related to continuing operations	968,584	944,310
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration (group)

	17/18	16/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	12
2. Audit-related assurance services	37	15
3. Taxation compliance services	-	58
Total	**37**	**85**

Note 7 Impairment of assets (group)

	17/18	16/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	92	-
Changes in market price	(7,296)	2,473
Total net impairments charged to operating surplus / deficit	**(7,204)**	**2,473**
Impairments charged to the revaluation reserve	240	2,822
Total net impairments	**(6,964)**	**5,295**

The loss of £92k relates to the C11 Medical Records building at the City Hopspital campus which is due to be demolished

The gain of £7.296m relates to the revaluation of the Trust's estate:

- £7.6m due to the reversal of previous impairments offseting
- £0.4m of impairments

Note 8 Employee benefits (group)

	17/18 Total	16/17 Total
	£000	£000
Salaries and wages	474,926	438,266
Social security costs	43,255	40,218
Apprenticeship levy	2,266	-
Employer's contributions to NHS pensions	55,981	51,120
Pension cost – other	100	48
Termination benefits	226	185
Temporary staff (including agency)	36,780	34,445
Total gross staff costs	**613,534**	**564,282**
Recoveries in respect of seconded staff	-	-
Total staff costs	**613,534**	**564,282**
of which		
Costs capitalised as part of assets	1,566	470

Note 8.1 Retirements due to ill-health (group)

During 17/18 there were 7 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 17). The estimated additional pension liabilities of these ill-health retirements is £410k (£425k in 16/17).

The cost of these ill-health retirements 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 18, is based on valuation data as 31 March 17, updated to 31 March 18 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.

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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 12. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

With effect from 1 April 13 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 majority of the Trust's leasing arrangements are for plant and equipment supplied under normal commercial terms by non-NHS suppliers. There is no contingent rent associated with the arrangements.

In addition, the Trust leases two satellite dialysis facilities from neighbouring NHS bodies under typical intra-NHS arrangements. There are no contingent rents associated with the arrangements.

	17/18	16/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	722	1,196
Contingent rent	84	72
Other	-	-
Total	**806**	**1,268**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	188	195
- later than one year and not later than five years;	545	628
- later than five years.	3,828	3,932
Total	**4,561**	**4,755**

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.

	17/18	16/17
	£000	£000
Operating lease expense		
Minimum lease payments	1,500	1,174
Contingent rents	-	-
Less sublease payments received	-	-
Total	**1,500**	**1,174**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,435	1,360
- later than one year and not later than five years;	4,113	4,255
- later than five years.	575	798
Total	**6,123**	**6,413**
Future minimum sublease payments to be received	-	-

Note 11 Finance income (group)

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

	17/18	16/17
	£000	£000
Interest on bank accounts	79	91
Total	**79**	**91**

Note 12

Note 12.1 Finance expenditure (group)

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

	17/18	16/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,327	1,401
Finance leases	12	21
Interest on late payment of commercial debt	5	-
Main finance costs on PFI schemes obligations	1,028	1,060
Contingent finance costs on PFI scheme obligations	776	717
Total interest expense	**3,148**	**3,199**
Unwinding of discount on provisions	7	36
Other finance costs	-	-
Total finance costs	**3,155**	**3,235**

Note 12.2 The late payment of commercial debts (interest) Act 1998/ Public Contract Regulations 2015

	17/18	16/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	5	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains/(losses) (group)

	17/18	16/17
	£000	£000
Gains on disposal of assets	-	25
Losses on disposal of assets	(126)	-
Total gains / (losses) on disposal of assets	**(126)**	**25**
Total other gains / (losses)	**(126)**	**25**

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 £2.8million (16/17: (£24.7million)). The Trust's total comprehensive income / (expense) for the period was £23.0million (16/17: (£25.5million)).

Note 15 Discontinued operations (Group)

The Group has no discontinued operations.

Note 16

Note 16.1 Intangible assets – 17/18

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

Note 16.2 Intangible assets – 16/17

Group and Trust	Software licences	Development expenditure	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 – as previously stated	**11,733**	**4,860**	**16,593**
Additions	3,504	-	3,504
Reclassifications	435	(435)	-
Valuation / gross cost at 31 March 2017	**15,672**	**4,425**	**20,097**
Amortisation at 1 April 2016 – as previously stated	**7,610**	**1,981**	**9,591**
Provided during the year	1,722	889	2,611
Amortisation at 31 March 2017	**9,332**	**2,870**	**12,202**
Net book value at 31 March 2017	**6,340**	**1,555**	**7,895**
Net book value at 1 April 2016	**4,123**	**2,879**	**7,002**

The above Group and Trust Intangible Assets relate solely to the Trust as HPSN Ltd has no Intangible Assets.

Reclassifications relate to the Digitalised Health Records project

Note 17

Note 17.1 Intangible assets – 17/18

Group and Trust

The Trust Intangible Assets are as stated in notes 16.1 for the Group and Trust. HPSN Ltd has no intangible assets.

Note 17.2 Intangible assets – 16/17

Group and Trust

The Trust Intangible Assets are as stated in notes 16.2 for the Group and Trust. HPSN Ltd has no intangible assets.

Note 18

Note 18.1 Property, plant and equipment – 17/18

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

The above Group and Trust Property, plant and equipment (PPE) Assets relate solely to the Trust as HPSN Ltd has no PPE Assets.

Reclassifications relate to Digitalised Health Records

Note 18.2 Property, plant and equipment – 16/17

Group and Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 – as previously stated	**27,189**	**366,522**	**25,158**	**121,590**	**1,233**	**36,666**	**2,994**	**581,352**
Additions	-	7,087	12,621	6,122	-	892	49	26,771
Impairments/reversals charged to operating expenses	31	(18,401)	-	-	-	-	-	(18,370)
Revaluations	550	1,351	-	-	-	-	-	1,901
Reclassifications	-	5,107	(16,845)	1,724	71	9,862	81	-
Disposals/derecognition	(804)	-	-	(6,426)	-	(317)	(40)	(7,587)
Valuation/gross cost at 31 March 2017	**26,966**	**361,666**	**20,934**	**123,010**	**1,304**	**47,103**	**3,084**	**584,067**
Accumulated depreciation at 1 April 2016 – as previously stated	**-**	**-**	**-**	**89,444**	**937**	**23,353**	**1,677**	**115,411**
Provided during the year	-	13,075	-	5,941	93	6,681	228	26,018
Impairments/reversals charged to reserves	-	2,822	-	-	-	-	-	2,822
Impairments/reversals charged to operating expenses	-	(15,897)	-	-	-	-	-	(15,897)
Disposals/derecognition	-	-	-	(6,381)	-	(317)	(40)	(6,738)
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**89,004**	**1,030**	**29,717**	**1,865**	**121,616**
Net book value at 31 March 2017	**26,966**	**361,666**	**20,934**	**34,006**	**274**	**17,386**	**1,219**	**462,451**
Net book value at 1 April 2016	**27,189**	**366,522**	**25,158**	**32,146**	**296**	**13,313**	**1,317**	**465,941**

The above Group and Trust Property, plant and equipment (PPE) Assets relate solely to the Trust as HPSN Ltd has no PPE Assets.

Note 18.3 Property, plant and equipment financing – 17/18

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

Note 18.4 Property, plant and equipment financing – 16/17

Group and Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned – purchased	26,966	331,539	20,934	30,518	274	17,386	924	428,541
Finance leased	-	-	-	-	-	-	295	295
On-SoFP PFI contracts and other service concession arrangements	-	9,581	-	-	-	-	-	9,581
Owned – donated	-	20,546	-	3,488	-	-	-	24,034
NBV total at 31 March 2017	**26,966**	**361,666**	**20,934**	**34,006**	**274**	**17,386**	**1,219**	**462,451**

Note 19

Note 19.1 – 19.2 Property, plant and equipment – 17/18 and prior year

Trust

The Trust Property, plant and equipment assets are stated in notes 18.1, and 18.2

Note 19.3 – 19.4 Property, plant and equipment financing – 17/18 and prior year

Trust

The Trust Property, plant and equipment financing is as stated in notes 18.3 and 18.4


No parking ahead
NHS
Entrances

Note 20 Donations of property, plant and equipment

Trust received £0.3m of donations of property, plant and equipment received during the year.

Note 21 Revaluations of property, plant and equipment

Summary Explanation of Revaluation 17/18

Assets are no longer routinely subject to annual indexation. Property is valued at fair value based on a modern equivalent basis (MEAV) basis as required by HM Treasury. As a minimum, a full revaluation is required to be undertaken every five years with an interim valuation every three years, with an assessment of changes in property values undertaken during the intervening years. The Trust engaged an independent firm of professional valuers to undertake its 14/15 Full Valuation and assess the continuing changes in property values of the NUH Estate. The 17/18 valuation resulted in an impairment on some Trust properties and upward revaluations on other buildings, with an overall net increase of £26.5m in the value of the Trust asset base (including in year 17/18 capital additions).

This impairment reflects changes in value of the Trust's property arising both from economic use and market conditions during the course of the year.

The financial impact of the revaluation on each campus, including the impairment is summarised below:

	£000	£000
Upward Valuation to Revaluation Reserve	19,506	
Upward Valuation Reversal of Previous Impairments	7,621	27,127
Downward Valuation / Impairment transferred to revaluation reserve	(240)	
Downward Valuation / Impairment transferred to SoCI	(417)	(657)
Total Impact of Valuation		**26,470**

Note 22

Note 22.1 and 22.2 Investment Property

The Group and Trust have no investment properties.

Note 23 Investments in associates and joint ventures

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

Note 24 Other investments / financial assets (non-current)

The Group and Trust have no other investments or financial assets.

Note 25 Disclosure of interests in other entities

Hospital Pharmacy Services (Nottingham) Limited, trading as Trust Pharmacy, is a wholly owned subsidiary of Nottingham University Hospitals NHS Trust which was incorporated on 4 April 12.

Note 26 Analysis of charitable fund reserves

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 NUH Trust. NUH have therefore chosen not to consolidate the NUH Charity accounts with the Trust Accounts.

Note 27 Inventories

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Drugs	7,507	6,520	5,553	5,183
Consumables	13,937	14,011	13,937	14,011
Energy	246	269	246	269
Total inventories	**21,690**	**20,800**	**19,736**	**19,463**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £204,626K (16/17: £184,845K). Write-down of inventories recognised as expenses (note 6.1) for the year were £345K (16/17: £243K).

Note 28

Note 28.1 Trade and other receivables

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Trade receivables	55,883	40,470	59,106	42,572
Capital receivables (including accrued capital related income)	71	163	71	163
Accrued income	5,016	3,388	5,016	3,388
Provision for impaired receivables	(3,591)	(2,958)	(3,591)	(2,958)
Prepayments (non-PFI)	4,128	3,697	4,128	3,697
PFI lifecycle prepayments	555	814	555	814
Finance lease receivables	356	322	356	322
PDC dividend receivable	17	471	17	471
VAT receivable	906	1,117	(578)	804
Other receivables	7,176	6,881	7,176	6,881
Total current trade and other receivables	**70,517**	**54,365**	**72,256**	**56,154**
Non-current				
Prepayments (non-PFI)	715	975	715	975
Finance lease receivables	358	358	358	358
Other receivables	3,625	3,061	3,625	3,061
Total non-current trade and other receivables	**4,698**	**4,394**	**4,698**	**4,394**
of which receivables from NHS and DHSC group bodies:				
Current	49,298	36,124	49,294	36,101
Non-current	715	975	715	975

Note 28.2 Provision for impairment of receivables

	Group		Trust	
	17/18	16/17	17/18	16/17
	£000	£000	£000	£000
At 1 April as previously stated	**2,958**	**2,283**	**2,958**	**2,283**
Increase in provision	819	675	819	675
Amounts utilised	(117)	(14)	(117)	(14)
Unused amounts reversed	(69)	14	(69)	14
At 31 March	**3,591**	**2,958**	**3,591**	**2,958**

Note 28.3 Credit quality of financial assets

Group	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0-30 days	0	0	-	-
30-60 Days	0	0	-	-
60-90 days	0	0	-	-
90-180 days	0	0	-	-
Over 180 days	1,199	0	739	-
Total	**1,199**	**-**	**739**	**-**
Ageing of non-impaired financial assets past their due date				
0-30 days	4,235	0	2,645	-
30-60 Days	1,559	0	746	-
60-90 days	1,035	0	772	-
90-180 days	2,013	0	501	-
Over 180 days	2,994	0	1,728	-
Total	**11,836**	**-**	**6,392**	**-**

Trust	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & other financial assets	Trade and other receivables	Investments & other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0-30 days	0	0	-	-
30-60 Days	0	0	-	-
60-90 days	0	0	-	-
90-180 days	0	0	-	-
Over 180 days	1,199	0	739	-
Total	**1,199**	**-**	**739**	**-**
Ageing of non-impaired financial assets past their due date				
0-30 days	4,235	0	2,645	-
30-60 Days	1,559	0	746	-
60-90 days	1,035	0	772	-
90-180 days	2,013	0	501	-
Over 180 days	2,994	0	1,728	-
Total	**11,836**	**-**	**6,392**	**-**

Note 28.4 Credit quality of financial assets

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

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

Note 29 Other assets

The Group and Trust have no other financial assets

Note 30

Note 30.1 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 30.2 Liabilities in disposal groups

The Group and Trust have no liabilities in disposal groups

Note 31

Note 31.1 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	
	17/18	16/17	17/18	16/17
	£000	£000	£000	£000
At 1 April 2017	**13,281**	**20,465**	**12,527**	**20,465**
Net change in year	79	(7,184)	711	(7,184)
At 31 March 2018	**13,360**	**13,281**	**13,238**	**13,281**
Broken down into:				
Cash at commercial banks and in hand	148	781	26	27
Cash with the Government Banking Service	13,212	12,500	13,212	12,500
Deposits with the National Loan Fund	0	-	-	-
Total cash and cash equivalents as in SoFP	**13,360**	**13,281**	**13,238**	**12,527**
Total cash and cash equivalents as in SoCF	**13,360**	**13,281**	**13,238**	**12,527**

Note 31.2 Third party assets held by the trust

NUH held cash and cash equivalents which relate to monies held by the the foundation 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 2018	31 March 2017
	£000	£000
Bank balances	-	-
Monies on deposit	-	-
Total third party assets	**-**	**-**

Note 32

Note 32.1 Trade and other payables

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current and Non-Current				
Trade payables	19,884	19,151	22,787	21,487
Capital payables	9,667	9,566	9,667	9,566
Accruals	54,984	41,996	54,869	41,932
Receipts in advance (including payments on account)	285	109	285	109
Social security costs	11,967	11,017	11,942	10,998
Other taxes payable (corporation tax)	122	94	-	-
Accrued interest on loans	192	133	192	133
Other payables	16	153	16	153
Total current trade and other payables	**97,117**	**82,219**	**99,758**	**84,378**
of which payables from NHS and DHSC group bodies:				
Current	6,138	14,978	6,138	14,978
Non-current	-	-	-	-

Note 32.2 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 2018	31 March 2018	31 March 2017	31 March 2017
	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	-	-	-	-
- number of cases involved		-		-
- outstanding pension contributions	8,039	7,217	8,039	7,217

Note 33 Other financial liabilities

The Group and Trust have no Other financial liabilities.

Note 34 Other liabilities

	Group and Trust	
	31 March 2018	31 March 2017
	£000	£000
Current		
Deferred income	14,503	14,581
Total other current liabilities	**14,503**	**14,581**
Non-current		
Deferred income	-	-
Total other non-current liabilities	**-**	**-**

Note 35 Borrowings

	Group and Trust	
	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from DHSC	18,995	1,252
Obligations under finance leases	1,420	143
Obligations under PFI or other service concession contracts (excl. lifecycle)	516	483
Total current borrowings	**20,931**	**1,878**
Non-current		
Loans from DHSC	61,657	66,571
Obligations under finance leases	7,745	152
Obligations under PFI or other service concession contracts	11,967	12,462
Total non-current borrowings	**81,369**	**79,185**

Note 36 Finance leases

Note 36.1 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 Initaitive 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 2018	31 March 2017
	£000	£000
Gross lease receivables	**714**	**680**
of which those receivable:		
- not later than one year;	356	322
- later than one year and not later than five years;	358	358
Net lease receivables	**714**	**680**
of which those receivable:		
- not later than one year;	356	322
- later than one year and not later than five years;	358	358
- later than five years.	-	-
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

Note 36.2 Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

Group and Trust	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	**9,902**	**324**
of which liabilities are due:		
- not later than one year;	1,623	162
- later than one year and not later than five years;	7,792	162
- later than five years.	487	-
Finance charges allocated to future periods	(737)	(29)
Net lease liabilities	**9,165**	**295**
of which payable:		
- not later than one year;	1,420	143
- later than one year and not later than five years;	7,262	152
- later than five years.	483	-
Total of future minimum sublease payments to be received at the reporting date	**9,165**	**295**
Contingent rent recognised as an expense in the period	-	-

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

- Existing lease for hospital beds, which entered its secondary lease term of seven years in 2012/13 and terminates on 29/06/2019.
- The Trust entered into a new agreement with Cisco on 23/03/2018 for the supply of communication equipment and support services over 60 months

Note 37

Note 37.1 and 37.2 Provisions for liabilities and charges analysis

Group and Trust	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,026**	**467**	**4,740**	**6,233**
Change in the discount rate	9	-	36	45
Arising during the year	-	244	100	344
Utilised during the year	(68)	(221)	(423)	(712)
Reversed unused	(36)	-	(918)	(954)
Unwinding of discount	2	-	5	7
At 31 March 2018	**933**	**490**	**3,540**	**4,963**
Expected timing of cash flows:				
- not later than one year;	68	490	1,355	1,913
- later than one year and not later than five years;	273	-	609	882
- later than five years.	592	-	1,576	2,168
Total	**933**	**490**	**3,540**	**4,963**

Note Provisions for liabilities and charges analysis (Group)

Note 37.3 Clinical negligence liabilities

At 31 March 18, £536,313,000 was included in provisions of NHS Resolution in respect of clinical negligence liabilities of NUH (31 March 17: £379,177,000).

Note 38 Contingent assets and liabilities

The Group and Trust have no contingent assets or liabilities

Note 39 Contractual capital commitments

	Group and Trust	
	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	1,461	4,770
Intangible assets	-	-
Total	**1,461**	**4,770**

Note 40

Note 40.1 Other financial commitments

The Group and Trust have no other financial liabilities

Note 40.2 Defined benefit pension schemes

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

Note 41 On-SoFP PFI, LIFT or other service concession arrangements

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

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

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

The estimated capital cost of the scheme was £3,600,000 and commenced on 2 December 04 for a term of 15 years.

The Trust has no LIFT arrangements.

Note 41.1 Imputed finance lease obligations

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

	Group and Trust	
	31 March 2018	31 March 2017
	£000	£000
Gross PFI and other service concession liabilities	**23,537**	**25,027**
of which liabilities are due:		
- not later than one year;	1,511	1,511
- later than one year and not later than five years;	5,423	5,589
- later than five years.	16,603	17,927
Finance charges allocated to future periods	(11,054)	(12,082)
Net PFI and other service concession arrangement obligation	**12,483**	**12,945**
- not later than one year;	516	483
- later than one year and not later than five years;	1,785	1,824
- later than five years.	10,182	10,638

Note 41.2 Total on-SoFP PFI and other service concession arrangement commitments

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

	Group and Trust	
	31 March 2018	31 March 2017
	£000	£000
Total future payments committed in respect of the PFI or other service concession arrangements	**83,604**	**89,264**
of which liabilities are due:		
- not later than one year;	6,542	6,244
- later than one year and not later than five years;	19,939	22,159
- later than five years.	57,123	60,861

Note 41.3 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	
	17/18	16/17
	£000	£000
Unitary payment payable to service concession operator	**6,761**	**6,617**
Consisting of:		
- Interest charge	1,028	1,060
- Repayment of finance lease liability	483	452
- Service element and other charges to operating expenditure	4,474	4,388
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	-	-
- Contingent rent	776	717
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**6,761**	**6,617**

Note 42

Note 42 Off-SoFP PFI and other service concession arrangements

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

The Combined Heat and Power (CHP) scheme provides CHP plant at QMC 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 2018	31 March 2017
	£000	£000
Charge in respect of the off SoFP PFI or other service concession arrangement for the period	4,995	3,902
Commitments in respect of off-SoFP PFI or other service concession arrangements:		
- not later than one year;	4,995	3,902
- later than one year and not later than five years;	19,536	15,608
- later than five years.	28,083	26,339
Total	**52,614**	**45,849**

Note 43 Financial instruments

Note 43.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that Nottingham University Hospitals NHS Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

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

Credit risk

NUH is principally a domestic organisation with the great 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.

Liquidity risk

NUH'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 43.2 Carrying values of financial assets

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non-financial assets	68,479	-	-	-	68,479
Other investments/financial assets	714	-	-	-	714
Cash and cash equivalents	13,360	-	-	-	13,360
Total at 31 March 2018	**82,553**	**-**	**-**	**-**	**82,553**

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non-financial assets	52,593	-	-	-	52,593
Other investments/financial assets	680	-	-	-	680
Cash and cash equivalents	13,281	-	-	-	13,281
Total at 31 March 2017	**66,554**	**-**	**-**	**-**	**66,554**

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

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non-financial assets	54,382	-	-	-	54,382
Other investments/financial assets	680	-	-	-	680
Cash and cash equivalents	12,527	-	-	-	12,527
Total at 31 March 2017	**67,589**	**-**	**-**	**-**	**67,589**

Note 43.3 Carrying values of financial liabilities

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	80,652	-	80,652
Obligations under finance leases	9,165	-	9,165
Obligations under PFI and other service concession contracts	12,483	-	12,483
Trade and other payables excluding non financial liabilities	84,403	-	84,403
Total at 31 March 2018	**186,703**	**-**	**186,703**

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	67,823	-	67,823
Obligations under finance leases	295	-	295
Obligations under PFI and other service concession contracts	12,945	-	12,945
Trade and other payables excluding non financial liabilities	71,108	-	71,108
Total at 31 March 2017	**152,171**	**-**	**152,171**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	80,652	-	80,652
Obligations under finance leases	9,165	-	9,165
Obligations under PFI and other service concession contracts	12,483	-	12,483
Trade and other payables excluding non financial liabilities	87,262	-	87,262
Total at 31 March 2018	**189,562**	**-**	**189,562**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	67,823	-	67,823
Obligations under finance leases	295	-	295
Obligations under PFI and other service concession contracts	12,945	-	12,945
Trade and other payables excluding non financial liabilities	73,679	-	73,679
Total at 31 March 2017	**154,742**	**-**	**154,742**

Note 43.4 Fair values of financial assets and liabilities

The book value (carrying value) is a reasonable approximation of fair value.

Note 43.5 Maturity of financial liabilities

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
In one year or less	105,335	72,976	102,686	75,547
In more than one year but not more than two years	28,571	1,252	28,571	1,252
In more than two years but not more than five years	34,122	31,075	34,122	31,075
In more than five years	18,675	46,868	18,675	46,868
Total	**186,703**	**152,171**	**184,054**	**154,742**

Note 44 Losses and special payments

Group and trust	17/18		16/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	160	199	117	18
Inventories written down (note 6.1)	3,686	345	3,417	243
Total losses	**3,846**	**544**	**3,534**	**261**
Special payments				
Ex-gratia payments and legal fees	87	243	91	223
Total special payments	**87**	**243**	**91**	**223**
Total losses and special payments	**3,933**	**787**	**3,625**	**484**
Compensation payments received		-		-

Note 45 Gifts

The Trust has made no gifts during the year.

Note 46 Related parties

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

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

Name of Counter Party NHS Commissioned Patient Care Activity				
Nottinghamshire Commissioning Consortia, comprised of:	£000 Income	£000 Expenditure	£000 Debtors	£000 Creditors
NHS Commissioning Board (Specialised)	344,533	0	9,686	0
NHS Commissioning Board – N&D at (Dental / Public Health)	15,933	0	2,086	0
NHS England (Military)	393	0	10	0
Nottingham City CCG	175,189	80	3,178	2,054
Nottingham North & East CCG	79,704	0	190	590
Rushcliffe CCG	59,853	0	41	450
Nottingham West CCG	46,379	0	0	415
Erewash CCG	23,203	0	321	0
Newark & Sherwood CCG	13,945	0	268	97
Mansfield & Ashfield CCG	13,025	0	835	125
Southern Derbyshire CCG	9,339	0	1,015	0
South West Lincolnshire CCG	7,829	0	632	0
Lincolnshire West CCG	4,409	0	391	342
Lincolnshire East CCG	4,500	0	380	0
West Leicestershire CCG	4,431	3	209	3
East Leicestershire & Rutland CCG	4,026	0	129	0
Hardwick CCG	1,667	0	55	41
South Lincolnshire CCG	1,219	0	80	0
North Derbyshire CCG	657	0	9	39
Bassetlaw CCG	680	0	123	0
East Staffordshire CCG	518	0	79	0
Leicester City CCG	561	0	3	0
Nene CCG	414	0	51	0
Sheffield CCG	184	0	8	56
Doncaster CCG	140	0	46	0
South East Staffordshire & Seisdon CCG	157	0	17	187
Nottingham City Council	3,636	0	3	0
Nottinghamshire County Council	1,596	16	0	0

Non Patient Care activity	£000 Income	£000 Expenditure	£000 Debtors	£000 Creditors
NHS England	44,932	0	19,551	62
Health Education England	44,912	13	446	4
Department of Health – Incoming Resources	8,504	0	721	0
Department of Health – Outgoing Resources	0	63	0	0
Her Majesty's Revenue and Customs	0	45,904	1,167	12,089
Sherwood Forest Hospitals NHS Foundation Trust – Outgoing Expenditure	0	3,734	0	480
Sherwood Forest Hospitals NHS Foundation Trust – Incoming Resources	2,983	0	1,731	0
Nottinghamshire Healthcare NHS Foundation Trust – Outgoing Expenditure	0	3,484	0	632
Nottinghamshire Healthcare NHS Foundation Trust – Incoming Resources	3,218	0	313	0
Derby Teaching Hospitals NHS Foundation Trust – Outgoing Expenditure	0	506	0	214
Derby Teaching Hospitals NHS Foundation Trust – Incoming Resources	2,514	0	990	0
University Hospitals of Leicester NHS Trust – Outgoing Expenditure	0	1,793	0	817
University Hospitals of Leicester NHS Trust – Incoming Resources	7,851	0	3,646	0
NHS Resolution (formerly NHS Litigation Authority)	0	33,350	0	15
NHS Blood and Transplant Authority	73	5,630	16	160
University of Nottingham – Incoming Resources	3,286	0	0	0
University of Nottingham – Outgoing Resources	0	17,863	0	2,752
Nottingham City Council	487	5,426	0	3
Nottinghamshire County Council	254	0	0	0

Nottingham Hospitals Charity

NUH also received income (£0.4m) from Nottingham Hospitals Charity during 17/18 (£0.4m in 16/17). During this time, Mrs Amanda Sunderland held posts as an Executive Director of NUH and a Trustee of Nottingham Hospitals Charity.

Hospital Pharmacy Services (Nottingham) Limited (Trust Pharmacy)

Trust Pharmacy is a wholly owned private subsidiary of NUH. In 17/18, the income and expenditure for NUH in relation to Trust Pharmacy activity was £27.8m (£20.9m in 16/17) and £29.4m (£22.9m in 16/17) respectively. In 17/18, Dr Peter Homa and Mr Rupert Egginton served as Directors of both NUH and Trust Pharmacy. Caroline Shaw replaced Dr Peter Homa on the Trust Pharmacy board on 27 October 17. Caroline Shaw is the Chief Operating Officer of the Trust.

Note 47 Transfers by absorption

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

Note 48 Prior period adjustments

There are no prior period adjustments

Note 49 Events after the reporting date

There are no post Balance Sheet events to report.

Note 50 Final period of operation as a trust providing NHS healthcare

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

Note 51 Better Payment Practice code

	17/18	17/18	16/17	16/17
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	177,997	498,321	165,679	448,117
Total non-NHS trade invoices paid within target	155,046	453,840	154,981	415,729
Percentage of non-NHS trade invoices paid within target	**87.11%**	**91.07%**	**93.54%**	**92.77%**
NHS Payables				
Total NHS trade invoices paid in the year	4,772	177,714	5,522	92,541
Total NHS trade invoices paid within target	3,029	167,318	4,607	88,160
Percentage of NHS trade invoices paid within target	**63.47%**	**94.15%**	**83.43%**	**95.27%**

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 52 External financing

The trust is given an external financing limit against which it is permitted to underspend

	17/18	16/17
	£000	£000
Cash flow financing	15,514	33,168
Finance leases taken out in year	9,017	-
Other capital receipts	-	-
External financing requirement	**24,531**	**33,168**
External financing limit (EFL)	**27,815**	**39,432**
Under spend against EFL	**3,284**	**6,264**

Note 53 Capital Resource Limit

	17/18	16/17
	£000	£000
Gross capital expenditure	44,432	30,276
Less: Disposals	(202)	(849)
Less: Donated and granted capital additions	(383)	(388)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	**43,847**	**29,039**
Capital Resource Limit	44,187	31,109
Under spend against CRL	**340**	**2,070**

Note 54 Breakeven duty financial performance

	17/18
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(2,260)
Remove impairments scoring to Departmental Expenditure Limit	92
Add back income for impact of 16/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**(2,168)**

Note 55 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13
	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		7,256	5,010	4,764	9,133
Breakeven duty cumulative position	26,288	33,544	38,554	43,318	52,451
Operating income		722,169	742,215	784,605	812,969
Cumulative breakeven position as a percentage of operating income		**4.64%**	**5.19%**	**5.52%**	**6.45%**

	13/14	14/15	15/16	16/17	17/18
	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	701	750	(47,154)	(20,108)	(2,168)
Breakeven duty cumulative position	53,152	53,902	6,748	(13,360)	(15,528)
Operating income	847,938	874,090	870,621	934,771	987,499
Cumulative breakeven position as a percentage of operating income	**6.27%**	**6.17%**	**0.78%**	**-1.43%**	**-1.57%**

Mrs Tracy Taylor
Chief Executive

24 May 2018

6 – Independant auditor's report

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

Report on the audit of the financial statements

Opinion

We have audited the financial statements of Nottingham University Hospitals NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its 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 Group Accounting Manual 17/18.

Basis for opinion

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

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 17/18. 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 Group Accounting Manual 17/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 89, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 88 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at
wwwirc.org.uk/auditorsresporisibilities

Report on other legal and regulatory matters

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

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

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Nottingham University Hospital NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial sustainability, we identified that:

- the Trust reported a pre-STF deficit of £30.7m and a Breakeven Performance Deficit of £2.168m. This has increased the Trust's cumulative deficit to £15.528 million as at 31 March 2018;
- to support cash flow, the Trust obtained £14.1m interim revenue support loans from the Department of Health and Social Care; and
- the Trust is forecasting a surplus of £7.884m for 18/19 which is underpinned by the delivering of a £41 m financial efficiency programme.

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 88, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

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

Statutory reporting matters

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

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

We have nothing to report in these respects.

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

On 25 May 2018 a referral was made to the Secretary of State under section 30(1)(b) of the Local Audit and Accountability Act 2014 in respect of the Trust's failure to achieve its statutory break even duty

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

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

Certificate of completion of the audit

We certify that we have completed the audit of the accounts of Nottingham University Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

John Cornett

for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
31 Park Row Nottingham NG1 6FQ

25 May 2017

7 – Appendices & Glossary

Sustanability Report 17/18

Overall Trust Performance

In alignment to the Trust's sustainability commitments, NUH has continued to progress efficiencies and improvements in its operations.

Carbon and energy

17/18 was a great year in the Trust's climate action agenda. The Trust achieved a reduction of 18% of its carbon footprint. This was largely by the switching from coal to gas as the main way to heat the City Hospital. However a reduction in the carbon footprint of imported electricity resulted in an additional contribution. NUH continued working on the business case to replace the heating infrastructure at City Hospital with a sustainable solution. This will see NUH completely moving away from coal, and producing on-site electricity in 2020. The project specifies that at least 5% of energy produced on campus comes from renewable sources which will be delivered via photovoltaic panels, air source heat pumps and biogas.

Sustainable food

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

Sustainable commuting

The NUH sustainable commute agenda was also very busy during 17/18. In regards to public transport, NUH continues promoting its Travel to Work scheme, which aims to make access to NUH via public transport more attractive for NUH staff. In 17/18 membership of the scheme grew by 25% to 1100 staff now using the scheme to commute by bus to NUH. In the same line, NUH maintained its support to the Medilink bus service which displaces circa 700 tCO2 from road emissions. NUH also promotes actively the use of park & ride sites linked to the Medilink bus service to reduce vehicles circulating within the City, and keeps supporting its car-sharing platform to help staff find a car-sharing partner.

The access by tram to QMC was also improved in 17/18.

In the area of active travel, NUH also continues promoting a number of initiatives including Dr Bike, Cycle to Work scheme, bike maintenance classes and roadshows aiming to promote health, wellbeing and active travel. The Cycle2Work scheme continues to be a successful scheme which helps promote sustainable travel choice but also provides many health and wellbeing benefits. During 17/18, 290 members of staff applied for the scheme. 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 300 staff subscribed to this initiative.

In partnership with Nottingham City Council, NUH installed two cycle compounds at QMC and City Hospital to allow safer parking of bicycles for staff, visitors and patients.

Air quality

The shift from coal to gas as main means to heat City Hospital. Since August 17, NUH has made its gas boiler house the leading heating infrastructure, making its coal-fired boiler house the backup heating infrastructure. This has reduced the emission of particulates and has reduced the Trust's carbon footprint by circa 8,000 tCO2. This has had a positive impact on the local air quality.

NUH was an active partner and collaborator during the promotion of the Clean Air Day in June 17, organising a roadshow to promote sustainable travel. These were well attended by members of the public and NUH staff.

Social agenda

The Trust continues working in partnership with Nottingham City Council in a common vision of health. The ethos of this vision is the "Happier Healthier Lives: Nottingham City Joint Health and Wellbeing Strategic Framework 2016–2020". This strategy aims to increase healthy life expectancy and close the gap between the most affluent and poorest areas of the City.

Waste and Finite Resources Consumption

The Trust continues pushing its waste and water agendas. In line with Department of Health and Social Care guidance during 17/18 NUH increased the segregation of "offensive waste", by reducing the amount of waste classed as clinical. NUH continues working to reduce the impact of its waste to the environment. By recycling an ever-increasing proportion of its waste, NUH contributes to minimise the impact to the environment.

In 17/18, NUH increased its consumption of water by 3.5%, however this followed a reduction of 15% from the previous year.

AREA	2015-16	2016-17	2017-18
GREEN HOUSE GASES REPORT			
Total Energy Consumption (GJ)	**869,073**	**1,001,082**	**968,114**
Coal	209,863	246,010	73,686
Natural Gas	458,185	551,658	701,568
Electricity (Imported)	137,591	116,746	103,083
Electricity (Produced)	61,557	77,659	85,646
Gasoil	1,878	9,009	4,131
Energy expenditure (£)	**7,956,340**	**9,644,390**	**9,644,391**
Total Business Travel (miles)	**1,377,107**	**1,361,808**	**1,137,391**
Car	1,036,574	1,009,172	784,932
Train	315,618	280,590	314,322
Airplane (domestic)	24,915	72,046	38,138
Carbon Emissions (TCO2eq)	**61,333**	**65,457**	**53,620**
Scope 1			
Coal	19,672	22,604	6,827
Natural Gas	23,476	28,195	35,890
Gasoil (GJ)	149	728	332
Scope 2			
Electricity Imported	17,665	13,363	10,067
Scope 3			
Business Travel Miles	371	567	504

WASTE MINIMISATION & MANAGEMENT

Total Waste Produced (tonnes)	**5,464**	**5,472**	**5,112**
Waste recycled/reused	1,341	2,018	1,125
Waste to energy	966	468	1,055
Waste to recovery treatment*	2,193	1,901	2,276
Waste for alternative treatment	687	385	307
Waste to Landfill	276	700	348
Total Waste disposal expenditure (£)	**£1,203,637**	**£902,255**	**£1,353,906**

FINITE RESOURCE CONSUMPTION

Total Water consumed (m3)	**779,363**	**662,837**	**686,462**
Water Imported	187,508	173,344	171,849
Waster Abstracted	591,855	489,493	514,613
Total Water Expenditure (£)	**£890,569**	**£900,795**	**£947,039**

Annual Governance Statement 17/18

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively.

I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Nottingham University Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Nottingham University Hospitals NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Chief Executive has overall accountability for ensuring that robust and effective risk management systems are in place to deliver safe and effective services and to ensure the Trust operates its activities in compliance with all relevant statutory requirements and Department of Health guidance. During 17/18 the Medical Director had delegated responsibility for operational management of the risk management strategy and processes. In 18/19 this responsibility will transfer to the Director of Corporate Governance.

The majority of risk management training is provided to staff in order that they are able to undertake their specific roles and responsibilities. The training provided includes:

- An introduction to risk management as part of the Trust's compulsory induction for new staff
- Structured training sessions with the Trust Board and Senior Management Team and with Divisional teams where specifically requested
- Role-related risk management training for specific disciplines such as Health and Safety, Patient Safety and Complaints as evidenced by the relevant annual reports
- Work to formalise a training needs Analysis is planned for progression and implementation in early 18/19

The objectives of the training are to ensure:

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

In addition, a range of risk management resources

are accessible via the Trust's intranet along with the contact details for the specialist advisors within the Trust who can support managers and staff with specific risk management issues.

4. The risk and control framework

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

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

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

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

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

The Trust acknowledges that in order to achieve its objectives some risk is acceptable whereas in other scenarios it must be rigorously avoided. By defining its risk appetite the Trust arrives at an appropriate balance between uncontrolled innovation and excessive caution. It guides decision makers on the level of risk permitted and encourages consistency of approach across the organisation.

The Trust uses the risk appetite classification below in considering its decision making and assurance processes for individual risks or clusters of risk:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty or ultra safe options required (linked to key organisational objectives)
Cautious	Preference for safe options that have a low degree of residual risk
Open	Willing to consider all potential options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward
Hungry	Eager to be innovative and to choose options offering potentially higher rewards, despite greater inherent and residual risk

In setting the level of risk appetite the Trust Board considers its risk tolerance based upon the risk impact on the organisation, the proposed duration that the substandard performance will exist and the assurances and mitigations in place to manage the risk in the intervening period.

4.1 Quality governance arrangements

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

The Trust has a quality strategy which was informed by a three year dialogue with patients to establish what was most important to them in their experience of the Trust's

services. The strategy covers the domains of:

- Safe care
- Thoughtful and effective care
- Caring staff
- Staff development
- Research and development
- Value for money
- Health and safety

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

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

- Board patient safety conversations (3-4 per month)
- Chair and Chief Nurse walkabouts (monthly)
- Executive Director quality visits to clinical areas (periodic)
- Board Directors' visits to wards and departments on Board meeting days to learn about staff and patient experience

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

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

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

4.2 Clinical governance

The Senior Management Team reports to the Trust Board through the Chief Executive on the operational delivery and effectiveness of the Trust's arrangements for clinical governance and risk management, thus ensuring there is an integrated approach to the management of clinical and organisational risk. A new operational Quality, Risk and Safety Committee, reporting to the Senior Management Team, was established during the year to which four principal quality committees have reported – Clinical Risk Committee, Clinical Effectiveness Committee, Organisational Risk Committee and Health and Safety Committee. Divisions provide more detailed reviews to the Quality, Risk and Safety Committee on a quarterly basis of:

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

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

In addition to the work of these committees, the Trust has monthly divisional performance management meetings with each of the five divisional leadership teams. 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.

Further changes to the Trust's quality governance arrangements have been agreed which will start in 18/19.

4.3 CQC registration

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

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

The Trust's overall self-assessment of compliance with the five key domains in 17/18 was:

SAFE	GOOD
EFFECTIVE	GOOD
CARING	GOOD
RESPONSIVE	GOOD
WELL LED	GOOD

4.4 CQC inspection status

The Trust last underwent a comprehensive Chief Inspector of Hospitals CQC inspection in September 2015. The results of this inspection were published in March 2016 when the Trust was rated 'Good' overall by the CQC for the quality of its services, including a rating of 'Outstanding' for the well led domain.

The CQC undertook an unannounced inspection of the urgent and emergency core service in December 2016, focusing on the adult emergency department. The CQC's reassessment of this core service was 'Good' in the effective, caring and well-led domains, but 'Requires Improvement' in the safe and responsive domains. There were no compliance actions arising from this inspection but ten recommendations for improvement were made. The action plan in response to these recommendations has been monitored closely by the Board Quality Assurance Committee. The CQC visited the emergency

department in April 2018 and commented that whilst the service was clearly very busy, both patient care and flow were being well managed.

The Trust's overall rating of 'Good' was not impacted by this core service inspection.

4.5 Quality of performance information

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

The Trust undertakes six monthly reviews of data quality against a number of data sets relating to both corporate data and patient data. The actions that have been taken in the previous six months to improve data quality and actions that are proposed for the following six months are reported to both the Information Governance and Audit Committees.

5. Significant risks

Trust Risk Profile

The profile below reflects the Trust risk register as at 31 March 2018. It is important to note that NUH's approach is to capture all risks, from a range of systems, in one single risk register, which includes, for example, all health a safety risk assessments and cleaning audit risks, as well as the traditional clinical, financial and operational risks. This makes all risks transparent and accounts for the large number of risks which are visible on the DATIX risk management system.

Risk Scoring Bands	1-9	10-12	15/16	20/25	Total Live	Total Archived
No of Risks	2825	464	198	14	3501	463

Out of the 2,825 risks scoring between one and 9, 924 score between one and three and as such are deemed to be managed to an acceptable level.

Current significant risk register

There are currently 14 risks scoring 20 or more on the Trust's significant risk register. These are:

1 Poor standards of cleanliness in clinical areas – being mitigated by increase in

2 Numbers of cleaning staff; purchase and training in new cleaning equipment; joint environmental oversight by estates and facilities and infection, prevention and control and assessed through programme of cleaning audits

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

4 Failure of critical non-clinical or clinical systems due to failure of IT infrastructure (network) – being mitigated by procurement of new systems for which contracts have been exchanged and signed following tender process. Trusts paperless hospital board overseeing system changes and monitoring performance.

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

6 Significant business continuity impact due to failure of EFM infrastructure/systems

7 Risk of harm due to failure to provide safe healthcare premises

8 Risks 4, 5 and 6 are being mitigated by capital investment in key infrastructure projects; appointment of approved persons, including training and familiarisation with Trust maintenance systems and processes and will be assessed through audit and completion of projects

9 Lack of manufacturer support for voice and data infrastructure

10 Cybersecurity risk

11 Risks 7 & 8 being mitigated by procurement of new systems for which contracts have been exchanged and signed following tender process. Trusts paperless hospital board overseeing system changes and monitoring performance

12 Risk to theatre service due to infrastructure failure – risk being mitigated by theatre maintenance schedule, additional checks and design of modular ventilation upgrade plan

13 Failure to deliver the Board approved annual plan for 17/18 – risk being mitigated through financial efficiency programme; achievement of STF funding and tight controls on expenditure. Ongoing assessment through financial management processes with oversight by the finance and investment committee.

Future risks relating to integrated care system (ICS)

14 Unclear financial impact of ICS project (deficit increases)

15 The available workforce does not meet the volume or skills required for the scale of transformation required or future NUH needs.

16 NUH does not achieve sufficient access to STP capital funds.

17 Reputational risk to NUH if there is failure in delivering the planned system transformation

The mitigation plans for these last four risks include the programme of work led by the strategic workforce transformation delivery group to model workforce requirements; the development of the future contract model, delivery of system control totals and establishment of deliverable ICS plans; and oversight of delivery by the ICS Leadership Board/ The Greater Nottingham Transformation Partnership Board, comprising the accountable officers from key organisations including NUH.

Newly identified Significant Risks in 17/18

ED resuscitation capacity – mitigations described in 2 above.

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

2. Well-led assessment

As part of its 2016-2021 strategy the Trust maintained a clear focus on working with partners on the sustainability and transformation plan (STP) for Nottingham City and Nottinghamshire County health and social care services. Under the leadership of the new Chief Executive, the Board has developed and consulted upon a new strategy which will be launched early in 2018.

The Board conducted a self-assessment against the key lines of enquiry in the well led framework in December 2017. This was reviewed at a Board development day in February 2018. Against a backdrop of an outstanding award against well led in 2015 and a positive self-assessment, the Board identified further areas for improvement, in particular in relation to updating the Board Assurance Framework in line with the newly agreed Trust strategy and the programme of activity needed to engage staff with the new strategy. An action plan has been formulated and a further assessment of progress will be made in July 2018. At the same time the Board also reviewed the findings from the clinical divisions who had conducted a review against the well led framework and a desktop review was undertaken to identify evidence that would be relevant to the key lines of enquiry.

3. The Board and its committees

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

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

- Audit
- Remuneration & Terms of Service
- Finance and Investment
- Quality Assurance
- People
- Appointment of CEO
- Appointment of Other Executive Directors
- Advisory Appointments (medical consultant appointments)
- Ethics of Clinical Practice
- Organ Donation

All Board committees are led by non-executive directors with the exception of the Ethics of Clinical Practice Committee which has a clinical chair. Scrutiny of the reports and information take place in executive led operational committees prior to submission to the Board.

7.1 Board membership

The Board comprises a Chair, five non-executive directors and five executive directors. The following changes were made in 17/18:

- Ms Louise Scull stepped down and was replaced by Mr Eric Morton as Chair on 1 May 17
- Dr Peter Homa retired and was replaced by Mrs Tracy Taylor as Chief Executive on 30 October 17
- Dr Stephen Fowlie retired and was replaced by Dr Keith Girling as Medical Director on 1 June 17
- Dr Sheila Newport and Mrs Christine Reed were appointed as Associate Non-Executive Directors (non-voting) on 31 August 17
- Mr Mark Chivers was appointed as Associate Non-Executive Director (non-voting) on 13 December 17
- Mr Alec McKee's term of office as Associate Non-Executive Director (non-voting) ended on 31 March 18

7.2 Board meetings

The Board met each month in 17/18. Meetings were open to the public (except for those matters which the Board resolved to consider in confidential session).

Information about Board meetings, including agendas and papers, is posted on the Trust's website - **www.nuh.nhs.uk**.

7.3 Principal Board committee responsibilities

7.3.1 Audit Committee

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

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

7.3.3 Finance & Investment Committee

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

7.3.4 People Committee

The People Committee was established in 17/18 as a new committee of the Board and meets monthly. Its purpose is to provide assurance to the Board on the effectiveness of the trust's arrangements for the leadership, engagement, training, development and education of staff at NUH.

7.3.5 Quality Assurance Committee

The Quality Assurance Committee meets monthly. It monitors, reviews and reports on the quality of services provided by the Trust in each of the quality domains: safety, outcome and experience, and on the quality of the Trust's risk management processes and arrangements.

7.3.6 Remuneration and Terms of Service Committee

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

7.4 Performance management

To ensure that the Board is aware to a sufficient degree of granularity about what is happening in the hospitals, a comprehensive integrated performance report is reviewed at each public Board meeting.

The monthly report:

- Is structured across several domains: quality, safety and patient experience, operational standards, research and development, finance and workforce.
- Includes information on our performance against the NHS Improvement outcome and quality governance measures.
- Includes performance indicators rated red or green and future forecasts.
- Is complemented by exception reports and commentaries from the accountable Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

Importantly, the performance report includes information on 'never events' and other significant incidents, and the Board's Quality Assurance Committee (QUAC) receives information on follow-up action. The QUAC also receives quarterly reports on the emergency, elective and cancer pathways addressing any patient safety, experience and outcome issues.

This formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- Patient stories, which are presented in public at each Board meeting. These shine a light on individual experiences of care provided by the Trust and act as a catalyst for improvement; and
- Board members carry out patient safety conversations and ward/department visits regularly.

These arrangements allow Board members to help

model our values through direct engagement, as well as ensuring that Board members take back to the boardroom an enriched understanding of the lived reality for staff, public and patients.

The Board governance structure is underpinned by executive led operational committees attended by senior members of the divisional teams. The divisional structure and leadership model has been externally assessed as following many areas of good practice in relation to devolved divisional autonomy, with good medical engagement across the Trust and clear leadership from the divisional directors and heads of service, as well as a multi-disciplinary approach to working as a triumvirate. Similarly, the external review assessed the Trust's approach to divisional performance reviews as following many areas of good practice with high levels of director engagement, high quality reporting, professionally led meetings and divisional teams who take the process very seriously.

8. NHS pension scheme

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

9. Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

10. Carbon reduction

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

11. Information governance

Seven information governance (IG) incidents were reported to the Information Commissioner's Office (ICO) and investigated in 17/18:

Category	17/18	ICO Action Taken
Disclosed in error	2	No enforcement action taken
Unauthorised access/disclosure	5	No enforcement action taken
Total	**7**	

All IG incidents are assessed for severity according to HSCIC guidance. The Trust's Caldicott Guardian (or SIRO) confirms severity in each case and authorises reporting to the ICO via the IG Toolkit.

The Trust investigated all incidents and responded to the questions posed by the ICO. 'No further action required' was the outcome for all the reported breaches.

All new and revised information processing systems are assessed using the privacy impact assessment process to identify potential risks and concerns around data security. Where such risks are identified, robust control measures are put in place before information processing commences or continues.

The Trust's ICT network is routinely subject to penetration testing and vulnerability assessments. Recently significant investment has been made in a modern end point security suite to further protect our information assets and infrastructure.

IG incidents are examined to identify trends and potential weaknesses in processes. This information is used to identify specific roles, locations and activities for a more thorough assessment and to identify steps that may be available to help reduce the recurrence of incidents.

Most breaches of data security are related to user's actions. Annual IG training is mandated for all Trust employees to ensure they are aware of how to safely handle information and so minimise occurrence of information governance breaches.

12. Annual Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust's 17/18 Quality Account will be published on 30 June 18. The Trust has taken a number of steps to assure

itself of the accuracy of the account, including quality checks of the robustness of the data through the Trust's information governance processes; scrutiny of the report by the Trust Board, Joint Health Scrutiny Committee, Lead Commissioner (Nottingham Northe and East Clinical Commissioning Group), all of whom have been invited to comment on the account. At the time of submission of this statement, the Trust's external auditors, KPMG, are finalising their audit of the quality account.

12.1 Quality and accuracy of waiting time data

The Trust uses a weekly patient tracking list (PTL) and daily backlog manager to proactively manage waiting lists. The backlog manager presents information on total incomplete pathways as well as admitted and non-admitted patients. The PTL is refreshed approximately five times a day, and covers around 30,000 waiting patients.

The corporate operations elective performance team ensures all long waits are validated on a weekly basis. In addition, different specialties are selected for review, a process which includes checking waiting list data from Medway (the Trust's patient administration system) against electronically scanned letters from the patients' pathway. A suite of reports designed to capture any breaches in data quality are utilised across specialties and all waits in excess of 18 weeks are checked and validated. The corporate operations elective performance team also reviews patient pathways by exception.

There is a governance structure and process in place to escalate any waiting list issues as part of the management of elective care. The Trust uses 31 day and 62 day cancer pathway PTLs which are validated by cancer pathway coordinators to ensure the integrity of the data.

Diagnostic patients are tracked and reported on the weekly DM01 return. Diagnostics waiting list validation is undertaken weekly by all relevant departments to ensure the accuracy of the waiting list and any reported breaches. Performance and accuracy is challenged at the weekly PTL meetings.

13. Review of effectiveness, economy, efficiency the use of resources

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit committee and Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year end 31 March 2018. Governance relating to financial stewardship is exercised through the Trust Board where a monthly financial report is incorporated and discussed as part of the public agenda. In addition, the Trust Board has established a Finance and Investment Committee which meets monthly to discuss a wide range of financial issues which are also reported through to the Trust Board. The Audit Committee receives regular reports on aspects of internal control, including reports from internal audit, and reviews the Trust's accounting policies and statutory accounts.

17/18 was the second financial year of the Trust's three-year plan aiming at returning the Trust to financial surplus. For the second successive year the Trust has achieved its financial control total, including delivery of financial efficiency savings of £40m in year (against a plan of 41m). The Trust has managed cash resources and stayed within its interim revenue support facility, linked to the income and expenditure control total. NHS Improvement (NHSI) measures use of resources through the Single Oversight Framework (SOF). The Trust achieved a score of three, which represents the best possible score that it could have achieved, given scoring a four on any component of the metric triggers an override to the calculation, as a result of the financial deficit achieved. The Trust delivered a score of one for hitting its financial plan and spending less on agency staffing than its cap. The latter was achieved through effective nursing and midwifery recruitment campaigns, provision of an internal bank service and tight agency controls in place across the Trust. The Trust also scores a rating of 'good' by the CQC and a reference cost of 103, demonstrating that its resources have been deployed effectively for the benefit of patient care.

The Trust uses the reference cost benchmarking tool alongside other operational information to highlight areas where there may be financial efficiency opportunities. The Trust makes active use of the model hospital dashboard and Carter metrics to target performance improvement in support of the financial efficiency programme and has an established performance management process to maintain divisional financial accountability, supported by high quality service line reporting. Accountability for economy, efficiency and effectiveness is maintained through to the Board and its committee structure, most notably through the Finance and Investment Committee. The role of the Finance and Investment

Committee in providing value for money assurance in 17/18 is highlighted below. The Board receives assurances of progress against strategic objectives, including the development and implementation of two-year productivity and efficiency plans. This is supported by the work of 360 Assurance (internal audit) to ensure that delivery of services takes place within a sound system of internal control, designed to meet the Trust's objectives and that controls are generally being applied consistently. The Head of Internal Audit issued a significant assurance opinion to that effect.

Although the Trust has not met all of its performance targets in 17/18, most notably ED performance, this in the context of unprecedented national health services pressures in this regard and is recognised as a being a health system wide pressure. To this end, the Trust plays a key role in the integrated care system. The commissioners and providers are committed to developing a fully integrated and effective care system across the Nottinghamshire area whilst bringing it into financial balance to achieve this aim.

In providing an audit opinion for the financial year, the Head of Internal Audit reflected upon the environment in which the Trust has been required to function and the need to meet quality challenges whilst reducing costs and responding to the sustainability and transformation agenda. The Head of Internal Audit noted that whilst this would undoubtedly impact on the operation of control, the system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure. From his review of the Trust's systems of control and arrangements for governance and the management of risk, primarily through the operation of the Board Assurance Framework in the year to date, and the outcome of individual assignments also completed in the year to date, a Significant Assurance opinion has been provided that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The Head of Internal Audit commented in his opinion that there are issues which weaken the strength of his opinion, most notably, the work required to continue to strengthen risk management and Board Assurance Framework processes and the need to ensure recommendations are implemented by originally agreed implementation dates. These will be a focus of activity in 18/19 under the leadership of the new Director of Corporate Governance.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide the Board with assurance. The assurance framework itself provides evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed regularly.

Other important sources of assurance are:

- The External Auditor's Annual Audit Letters
- The External Auditor's review of specific services
- The Care Quality Commission's system of registration, compliance, special and periodic reviews
- Internal Audit risk-based audit assignments
- The views of the Local Authority Overview and Scrutiny Committee (Joint Health Scrutiny Committee)
- The views of the Local Healthwatch and Health and Wellbeing Boards
- The views of the Local Safeguarding Boards

I am advised on the implications of the result of the reviews of the effectiveness of the system of internal control by the following Board and Senior Management Team committees:

- The Audit Committee
- The Finance and Investment Committee
- The Quality Assurance Committee
- The People Committtee (established January 2018)
- The Senior Management Team
- The Quality, Risk and Safety Committee (established August 2017)
- The Clinical Risk Committee
- The Organisational Risk Committee
- The Clinical Effectiveness Committee
- The Information Governance Committee
- The Trust Health and Safety Committee

Six of the internal audit assignments during the year were given a limited assurance opinion.

An assessment of the limited assurance reviews was undertaken which identified that, with one exception, all were provided in areas of known risk to the Trust; most notably the work regarding delayed transfers of care, waiting list initiative payments, midwifery staffing and contract management. To date, the only piece of 'core' audit work which has been provided with a limited assurance opinion was the operational risk management review. Actions have been agreed in response to this review, the implementation of which will be overseen by the Director of Corporate Governance.

14. Discharge of statutory functions

The Trust has reporting arrangements in place to check that it is discharging its statutory functions. From these reports, and the audit programme to support them, the Trust is not aware of any irregularities and considers that it is legally compliant.

15. Significant internal control issues

Achievement of the four hour emergency standard continued to be a challenge throughout 17/18 as did the achievement of the 62 day cancer target. The Board dedicated considerable time and resource to ensure clarity about the drivers for both these patient pathway challenges and the required actions both within NUH, its partner organisations and the wider health and social care community.

I chair the A&E Delivery Board which brings together commissioners, providers and local government senior officials. Through this governance arrangement a far reaching and collaborative plan to improve the four hour emergency standard was developed and there is evidence that this has had some positive effects, but with more work to do given the unprecedented challenges of the winter months.

In relation to the 62 day cancer target, a detailed recovery plan was agreed by the Trust Board at the beginning of 17/18 and by the end of quarter four the Trust had managed to achieve this target for the first time. The Trust plans to sustain this performance during 18/19, however this does depend on referral patterns.

NUH continued to face a short to medium term financial challenge in 17/18 and was rated in segment three* of NHSI's single oversight framework for finance and use of resources during the year as a consequence of delivering a financial deficit of £2.260m. However, the Trust did deliver a financial position better than the control total set by NHSI (£2.3m actual –v- £10.7m plan). A financial recovery plan is in place with the aim of returning the Trust to financial balance in 18/19.

** From October 2016, NHS Improvement (NHSI) has monitored NHS Trusts' financial performance using a composite indicator called the Single Oversight Framework (SOF) - a finance and use of resources metric, which measures a combination of the Trust's liquidity, its ability to service debt, its I&E margin, its distance from its financial plan and the Trust's compliance with the ceiling on agency spend. The Trust achieved a rating in segment three of the SOF - *Mandated support.*

The Trust has a number of estate infrastructure significant risks which will need major capital investment to resolve in the medium to long term.

16. Conclusion

Four significant control issues have been identified above, all of which have improvement plans to address them. Notwithstanding these, the Head of Internal Audit opinion provides significant assurance on the Trust's systems of internal control.

Tracy Taylor
Chief Executive

Date: 24 May 2018

Glossary

Accountability – the requirement for organisations to report and explain their performance. Acute – describes a disease of rapid onset, severe symptoms and brief duration. The majority of hospital services provided by QMC and Nottingham City Hospital are for acute illnesses.

Admission – the point at which a person enters hospital as a patient

Advanced Nurse Practitioners – a registered nurse who has acquired the knowledge, decision-making skills, and clinical competencies for expanded practice beyond that of a registered nurse.

Agency staff – staff working at NUH but employed by a private recruitment agency.

B

Bank staff – staff who are available for short-term or flexible work to help manage vacancies more effectively

Best practice – a way of working that is officially accepted as being the best to use.

Better for You – NUH's whole hospitals change programme. Launched in 2009, the programme enables NUH to deliver caring, safe and thoughtful care to patients. It is an opportunity, through acting on ideas from our staff and patients, to improve our systems and processes and make sure they help us deliver high quality, efficient patient care.

Biomedical Research Centre (BRC) – there are 20 centres of excellence for clinical research around the country, established by the National Institute of Health Research (NIHR). Nottingham was designated as a new BRC in April 2017 and focuses on six research areas – gastro-intestinal and liver disorders; Magnetic Resonance Imaging (MRI); respiratory disease; mental health and technology; musculosketal disease; and hearing.

C

Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian.

Care Quality Commission (CQC) – the independent regulator of health and social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations.

Caring around the clock – our unique version of 'hourly rounding' which ensures regular checks are made on all patients on our wards.

Carer's passport – a form of identification available to the main carer/carers of patients living with dementia or other particular needs. The carer's passport can be shown to the ward staff so that know that you may need to support the patient in different ways.

Carter Review – an independent review commissioned by the Secretary of State for Health into potential efficiencies in the NHS. The report, Operational productivity and performance in English NHS acute hospitals, was produced by Lord Carter of Coles and published in February 2016.

Capital expenditure – the money allocated for buildings, equipment or land, also known as fixed assets.

Clinical Commissioning Groups (CCGs) – the NHS organisations responsible for planning and funding the majority of healthcare.

Clinical outcomes – the end result of a medical intervention, such as survival or improved health.

Clinical Research Facility – dedicated and purpose built facilities, where specialist clinical research and support staff from universities and NHS Trusts work together on commercial and non-commercial experimental medicine studies.

Clinical Research Network East Midlands – provides the infrastructure that allows high-quality clinical research to take place in the NHS, so that patients can benefit from new and better treatments. It is hosted by University Hospitals of Leicester NHS Trust.

Clostridium difficile (C. diff) – a healthcare associated intestinal infection that mostly affects elderly patients with other underlying diseases.

Commissioning – the process of identifying the needs of local people and funding services to meet those needs; commissioning is done at a number of different levels in the NHS, but the majority of services patients receive are commissioned by the Clinical Commissioning Group for their local area.

Community care – long-term care for people who are mentally ill, elderly, or disabled which is provided in the patient's own home, in a residential or care home rather than in hospitals.

Commissioning for Quality and Innovation (CQUIN) – a system of reward payments made by commissioners to hospitals to encourage better experience, involvement and outcomes for patients.

Cognitive Behavioural Therapy (CBT) – a talking therapy that can help manage your problems by changing the way you think and behave.

Cystic fibrosis (CF) – a genetic disease that causes blockages in the lungs and other organs, such as the liver and the pancreas.

D

Dementia – describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. Dementia is caused when the brain is damaged by diseases, such as Alzheimer's Disease or a series of strokes.

Discharge to assess – enabling patients to be assessed for their longer term health and social care needs at home or in the community, rather than waiting for this to happen in hospital.

E

Early Warning Score (EWS) – a categorisation that uses data taken from routine patient observation to calculate a score indicating potential severity of illness and to act as a prompt to nursing staff to request a medical review at specific trigger points. (PEWS is a specific type of early warning score designed to assess children.)

East Midlands Radiology Consortium (EMRAD) – part of the national Vanguard programme, this is a consortium set up to transform radiology services across seven NHS trusts across the East Midlands. The programme is developing a new radiology IT system, capable of handling millions of patient x-rays and scans and ensuring these can be seen and interpreted by specialist teams wherever they are based. The system will eventually manage 1.6 billion images.

Elective care – care that is planned. This is usually where the patient is referred by their GP or other healthcare professional. Appointments, treatments and admissions to hospital will be confirmed in advance.

Elective surgery – an operation that is planned ahead and for which the patient will be given a date to be admitted to hospital.

Emergency care improvement programme (ECIP) – a national team set up to provide support to health and social care communities in reviewing their local system for urgent and emergency care.

Emergency Department (ED) (also known as Accident and Emergency) – the department specialising in the care of patients with life-threatening or life-changing needs, which require immediate, specialist care.

Emergency tariff – the payment rate for treating an emergency patient. A provider receives payment at 30% of the tariff price for all emergency activity above the baseline in 2008/09. Equality and diversity – equality is about creating a fairer society where everyone can fully take part. It means giving people an equal opportunity to have their individual needs considered and met, in recognition that society comprises different people with different needs at different times. Diversity is the positive recognition of difference.

End of life care – ensuring that the care people receive at the end of life is compassionate, appropriate, and gives people choices regarding where they die and how they are cared for. Care is co-ordinated across health and social care services.

End PJ Paralysis – an initiative developed by NUH and now adopted nationally, to support patients to return to routine day-to-day activities as soon as possible after surgery as part of their recovery. It is characterised by encouraging patients to get out of bed and dress in their usual clothes, rather than their "pyjamas".

E-observations – a digital system for recording vital signs of a patient (such as blood pressure, temperature and heart rate). NUH clinical staff use a mobile device to collect and store patient observations, creating a set of information that can assist in making clinical judgments. This can help indicate signs of deterioration, for example sepsis and acute kidney injury.

Evidence Based Practice (EBP) – the integration of clinical expertise and the best research evidence into the decision making process for patient care.

F

4Cs – patient experience as measured by complaints, concerns, comments and compliments submitted by patients and their friends/family.

Financial control total – the maximum amount of deficit or surplus that an NHS organisation is required to achieve. This amount is set by NHS Improvement and agreed with each organisation, or as part of the wider health and care community.

First attendance – the first or only time a patient attends hospital after being referred by their GP or health professional.

Five Year Forward View – published by NHS England on 23 October 2014 and updated in March 2017, the Forward View sets out a new shared vision for the future of the NHS based around the new models of care.

Follow-up attendances – the second and subsequent times patients attend hospital for assessment, diagnosis or treatment as an outpatient.

Forever Stars – a charity founded in Nottingham to support the needs of parents who experience a child bereavement.

Foundation Trust – see 'NHS Foundation Trust'.

Francis Inquiry – an independent inquiry conducted by Sir Robert Francis in February 2013, examining the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009.

Friends and Family Test (FFT) – the national patient satisfaction programme which gives every patient the opportunity to feedback on the quality of their care. There is also a version of this survey for NUH staff.

Full time equivalent (FTE) – the measurement and calculation of total staff numbers, using a standard working day. Also known as whole time equivalent (WTE).

H

Health and Wellbeing Board – Health and wellbeing boards were established to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

Healthcare Assistant (HCA) – staff who work under the guidance of a qualified healthcare professional, usually a nurse. Sometimes staff working in HCA roles are known CQUIN) - a system of reward payments made by commissioners to hospitals to encourage better experience, involvement and outcomes for patients.

Cognitive Behavioural Therapy (CBT) – a talking therapy that can help manage your problems by changing the way you think and behave.

Cystic fibrosis (CF) – a genetic disease that causes blockages in the lungs and other organs, such as the liver and the pancreas.

D

Dementia – describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. Dementia is caused when the brain is damaged by diseases, such as Alzheimer's Disease or a series of strokes.

Discharge to assess – enabling patients to be assessed for their longer term health and social care needs at home or in the community, rather than waiting for this to happen in hospital.

E

Early Warning Score (EWS) – a categorisation that uses data taken from routine patient observation to calculate a score indicating potential severity of illness and to act as a prompt to nursing staff to request a medical review at specific trigger points. (PEWS is a specific type of early warning score designed to assess children.)

East Midlands Radiology Consortium (EMRAD) – part of the national Vanguard programme, this is a consortium set up to transform radiology services across seven NHS trusts across the East Midlands. The programme is developing a new radiology IT system, capable of handling millions of patient x-rays and scans and ensuring these can be seen and interpreted by specialist teams wherever they are based. The system will eventually manage 1.6 billion images.

Elective care – care that is planned. This is usually where the patient is referred by their GP or other healthcare professional. Appointments, treatments and admissions to hospital will be confirmed in advance.

Elective surgery – an operation that is planned ahead and for which the patient will be given a date to be admitted to hospital.

Emergency care improvement programme (ECIP) – a national team set up to provide support to health and social care communities in reviewing their local system for urgent and emergency care.

Emergency Department (ED) (also known as Accident and Emergency) – the department specialising in the care of patients with life-threatening or life-changing needs, which require immediate, specialist care.

Emergency tariff – the payment rate for treating an emergency patient. A provider receives payment at 30% of the tariff price for all emergency activity above the baseline in 2008/09. Equality and diversity – equality is about creating a fairer society where everyone can fully take part. It means giving people an equal opportunity to have their individual needs considered and met, in recognition that society comprises different people with different needs at different times. Diversity is the positive recognition of difference.

End of life care – ensuring that the care people receive at the end of life is compassionate, appropriate, and gives people choices regarding where they die and how they are cared for. Care is co-ordinated across health and social care services.

End PJ Paralysis – an initiative developed by NUH and now adopted nationally, to support patients to return to routine day-to-day activities as soon as possible after surgery as part of their recovery. It is characterised by encouraging patients to get out of bed and dress in their usual clothes, rather than their "pyjamas".

E-observations – a digital system for recording vital signs of a patient (such as blood pressure, temperature and heart rate). NUH clinical staff use a mobile device to collect and store patient observations, creating a set of information that can assist in making clinical judgments. This can help indicate signs of deterioration, for example sepsis and acute kidney injury.

Evidence Based Practice (EBP) – the integration of clinical expertise and the best research evidence into the decision making process for patient care.

F

4Cs – patient experience as measured by complaints, concerns, comments and compliments submitted by patients and their friends/family.

Financial control total – the maximum amount of deficit or surplus that an NHS organisation is required to achieve. This amount is set by NHS Improvement and agreed with each organisation, or as part of the wider health and care community.

First attendance – the first or only time a patient attends hospital after being referred by their GP or health professional.

Five Year Forward View – published by NHS England on 23 October 2014 and updated in March 2017, the Forward View sets out a new shared vision for the future of the NHS based around the new models of care.

Follow-up attendances – the second and subsequent times patients attend hospital for assessment, diagnosis or treatment as an outpatient.

Forever Stars – a charity founded in Nottingham to support the needs of parents who experience a child bereavement.

Foundation Trust – see 'NHS Foundation Trust'.

Francis Inquiry – an independent inquiry conducted by Sir Robert Francis in February 2013, examining the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009.

Friends and Family Test (FFT) – the national patient satisfaction programme which gives every patient the opportunity to feedback on the quality of their care. There is also a version of this survey for NUH staff.

Full time equivalent (FTE) – the measurement and calculation of total staff numbers, using a standard working day. Also known as whole time equivalent (WTE).

H

Health and Wellbeing Board – Health and wellbeing boards were established to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

Healthcare Assistant (HCA) – staff who work under the guidance of a qualified healthcare professional, usually a nurse. Sometimes staff working in HCA roles are known as nursing assistants, nursing auxiliaries or auxiliary nurses.

Healthcare for older people (HCOP) – a general term for the range of services designed around the needs of older people.

Healthcare Resource Groups (HRGs) – standard groupings of clinically similar treatments which use common levels of healthcare resource. Health Service Ombudsman – investigates complaints that individuals have been treated unfairly or have received poor service from the NHS in England. HfMA – professional body for the healthcare finance staff.

Healthwatch Nottingham/Nottinghamshire – the local service affiliated to Healthwatch England, the national consumer champion in health and care. They have statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

Histopathology – the study of diseased tissue, for example, breast lumps or specimens of bowel removed because of suspected cancer, including examination under the microscope.

Hospital Standardised Mortality Rates (HSMR) – an indicator of healthcare quality that measures if the death rate at a hospital is higher or lower than you would expect. The HSMR compares the expected rate of death in a hospital with the actual rate of death. Factors such as age and severity of illness are taken into account.

I

Information Governance – the set of multi-disciplinary structures, policies, procedures, processes and controls implemented to manage information to ensure an organisation's regulatory, legal, risk, environmental and operational requirements.

Inpatient – a patient who is admitted to hospital for a period of treatment or to undergo an operation. Inpatients are those that stay in hospital for 24 hours or more.

Integrated Care System – new developments in NHS care which bring together commissioners and healthcare providers to plan and deliver care without organisational and financial boundaries.

Integrated discharge – planning and managing a patient's discharge from hospital across all services and all part of the hospital.

Intervention – any measure to improve health or alter the course of disease.

In-session utilisation – the proportion of time used effectively within timetabled operating sessions in operating theatres. (also see Session utilisation).

J

Joint Health Scrutiny Committee/Overview and Scrutiny Committee – a function of local councils in England. The committee has the responsibility to review policies, decisions and services in their own council and in other organisations, including the NHS, which may impact on local residents.

'Just Do It' Awards – part of our Better for You programme which empowers staff at all levels to take forward and implement ideas and suggestions and receive recognition for these.

Lesbian, Gay, Bisexual and Transgender (LGTB) staff association – a group to promote equality in sexual orientation that is open to all staff who are lesbian, gay, bisexual, heterosexual or transgender. It provides a safe environment to share and discuss work related experiences in order to gain support and advice.

Linear accelerator (LINAC) – is the device most commonly used for radiation treatments for patients with cancer. The linear accelerator is used to treat all parts/organs of the body. It delivers high-energy x-rays (or electrons) directly to the patient's tumour.

Local Health Resilience Partnership – a multi-agency strategic forum that plans the local response to emergencies in the health sector.

Local Safeguarding Boards – the statutory committee operating in each local authority area to coordinate work to safeguard and promote the welfare of children and to ensure the effectiveness of the work organisations do individually and together.

Locum staff – nurses and doctors employed by the NHS on a temporary, fixed-term basis.

M

Magnet® – the only international recognition programme for excellence in nursing care. It sets the standard for the quality of care patients receive and is an indication of the world-class standards of care that the whole hospital team provides.

Major Trauma Centre – QMC is home to the major trauma centre for the East Midlands. It treats people with very serious, multiple injuries like those you would associate with car accidents, serious gun and knife wounds or falling off a horse.

Magnetic resonance imaging (MRI) – is a test that uses a magnetic field and pulses of radio wave energy to make pictures of organs and structures inside the body. The technology was developed in Nottingham and gives different information about structures in the body than can be seen with an X-ray, ultrasound, or computed tomography (CT) scan.

Methicillin Resistant Staphylococcus Aureus (MRSA) – is a type of bacteria that is resistant to a number of commonly used antibiotics. It lives on the skin and is mostly harmless unless it gets deeper into the body, for example, if it gets into a wound or where the skin is broken.

Mindfulness – a mental state achieved by focusing awareness on the present moment used as a therapeutic technique.

N

National emergency access standard – a national standard for all Emergency Departments/Accident and Emergency Departments. The standard measures the number of patients seen, admitted or discharged within four hours; hospitals are expected to achieve 95%. It is often known as the 'four hour' standard.

National Patient Survey – ensures patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services. All NHS trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. There are inpatient and outpatient surveys.

Never events – serious, but largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

National Institute for Health Research (NIHR) – is the research arm of the NHS which manages and funds research programmes across healthcare and academic organisations.

NHS England – the body that leads the National Health Service (NHS) in England. It sets the priorities and direction of the NHS and is also the organisation that commissions specialist health services, as well as the contracts for GPs, pharmacists, and dentists as well as supporting Clinical Commissioning Groups (CCGs).

NHS Improvement – is responsible for overseeing NHS trusts, as well as independent providers that provide NHS-funded care.

NHS Treatment Centre – see 'treatment centre'.

NHS trust – a statutory, self-governing NHS organisation providing healthcare services. NHS trusts – and NHS Foundation trusts - provide the majority of hospital, mental health and ambulance services. Their income is derived from service agreements and contracts with clinical commissioning groups or, for some highly specialist services, NHS England. They have freedom to decide staff numbers and rates of pay and some powers to invest and borrow money.

Non-elective care – is provided when the patient is assessed as needing treatment or hospital admission urgently or in an emergency.

Non-Executive Director – a member of the trust's board of directors who is not part of the executive team. A non-executive director typically does not engage in the day-to-day management, but is involved in policy making and planning exercises. In the NHS Non-Executive Director appointments are managed by NHS Improvement.

NUHonours Awards – an annual awards ceremony that recognises and pays tribute to those staff and volunteers from NUH who have gone the extra mile for patients, visitors and colleagues.

Nurse Associate – a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients.

O

Ombudsman/ Parliamentary Health Service Ombudsman (PHSO) – the Ombudsman makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations.

On-the-day cancellation – refers to a planned operation that is cancelled on the day the patient was due to arrive (at hospital), after the patient has arrived in hospital or on the day of the operation if the patient is already in hospital.

Overview and Scrutiny Committee – see Joint Health Scrutiny Committee.

P

Palliative care – services for people living with a terminal illness where a cure is no longer possible. Palliative care aims to treat or manage pain and other physical symptoms. It will also help with any psychological, social or spiritual needs.

Pathway of care – the planned and most efficient way to provide care from referral to diagnosis, treatment and follow-up care. Pathways are in place for most common diseases and conditions, using evidence based practice to determine the best way for patients to be seen and treated.

Patient Administration System (PAS) – computerised system to record non-medical patient details such as name and address as well as appointments/visits to the hospital.

Patient Advice and Liaison Service (PALS) – provides information, advice and support to help patients, families and their carers. Patient experience – the experience a patient has in our hospitals, whether as an inpatient or an outpatient. This includes not only the care received

Patient experience – how it feels to be an inpatient or an outpatient. This includes not only the care received, but also aspects such as the hospital facilities and the patient's comfort throughout their visit.

Patient flow – the different elements that make up a patient's progress through the hospital system from referral through to diagnosis, treatment and discharge. This includes all of the staff, departments and organisations who are involved in providing the end-to-end care.

Patient level costing (PLICS) – computerised information systems in hospitals to track and enable analysis of the costs of care incurred by individual patients.

Patient safety conversations – this is a programme of visits to clinical areas by Board members and senior leaders, which gives frontline staff the opportunity to share their experience of patient and staff safety in NUH.

Public Sector Equality Duty – the public sector's legal duty to eliminate discrimination, advance equal opportunities, and foster good relations, and publish data on progress.

Q

Quality Account – every NHS Trust is required to publish a Quality Account, setting out how we continue to improve the quality of services we provide covering three key areas: patient safety, clinical effectiveness and patient experience.

Quality assurance – the maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production.

Quality Innovation, Productivity and Prevention (QIPP) – a large-scale programme to drive forward quality improvements in NHS care, at the same time as making healthcare more efficient.

Quality governance framework – a set of standards for trusts to continuously monitor themselves against.

R

Radiology – is the science that uses images to diagnose and in some cases treat diseases. It is a general term which covers X-ray, CT and MRI scans.

Readmissions – the number of patients re-admitted as an emergency within either 7 or 28 days of being discharged following previous treatment.

Recurrent income – ongoing income, expenditure or savings.

Red2Green – an internal initiative to support high quality care whilst reducing unnecessary delays.

Reference Cost Index – unit costs to the NHS of providing defined services in a given financial year to NHS patients in England, published by the government. Resilience – the ability of an organisation to adapt and respond to disruptions, whether internal or external, to deliver organisationally agreed critical activities.

Respiratory – the specialty which deals with illnesses and conditions affecting breathing.

Ropewalk House – the city centre campus of NUH that provides breast screening and audiology services.

Resilience Team – the team is responsible for writing, updating and exercising all the emergency plans for NUH. In the event of a major incident the Emergency Planning Team helps to co-ordinate the Trust's response.

Referral to Treatment (RTT) – national maximum waiting times set out in the NHS Constitution from the point a patient is referred to hospital by their GP.

S

Safety Thermometer – monthly audits on our adult wards of the prevalence of pressure ulcers, falls, urinary infections, treatment for Venous thromboembolism (VTE), and catheter-associated urinary tract infections.

Safety culture – the attitude, beliefs, perceptions and values that employees share in relation to safety in the workplace. Safety culture is part of organisational culture; a positive safety culture is a key part of improving the quality of care.

Sepsis – a life-threatening condition that arises when the body's response to an infection causes injury to its own tissues and organs. Common signs and symptoms include fever, increased heart rate, increased breathing rate, and confusion.

Serenity Suite – funded by the Forever Stars charity, these facilities provide a safe space at QMC and City Hospital for parents and loved ones dealing with the death of a child.

Shared governance – a management structure for nurses which empowers frontline staff to work together and make decisions that affect nursing practice and patient care. It involves teamwork, Evidence Based Practice (EBP), and accountability with the aim of improving productivity and patient outcomes.

Staff engagement – encouraging staff to be committed to their organisation's goals and values, motivated to contribute to organisational success, and enhance their own sense of job satisfaction.

Sustainability and Transformation Partnership (STPs) – joint health and social care partnerships for improving the health of local people through joined-up working and the development of new models for providing services. There are 44 partnerships across England including the one for Nottingham and Nottinghamshire, which includes NUH.

Sustainability and Transformation Fund – a national budget to support the development of NHS services, set up in 2015. It is allocated to hospitals based on their achievement of a number of specific targets

Sustrans – UK charity enabling people to travel by foot, bike or public transport for more of the journeys we make every day.

SWAN – an initiative to improve the care for people at the end of their lives, including recognising the needs of families and loved ones.

T

Teaching trust – a hospital that provides clinical education and training to future and current health professionals in partnership with university medical schools. NUH is the third largest teaching hospitals in the country.

Tertiary care – there are three levels of healthcare in the NHS: primary care (the first point of contact for patients including GPs, dentists, pharmacists and opticians); secondary care (specialist services, often provided by a hospital, that patients are referred to from primary care); and tertiary care which is further specialised treatment and care provided by professionals with specific expertise in a given field, for example neurosurgery, cardiac surgery and cancer management.

Tertiary referrals – referrals for specialist care from consultant to consultant. These can be within the same hospital/service or between different hospitals and services.

Think Drink – an internal project within NUH to increase the fluid intake of patients and ensure that they are always hydrated.
Treatment centre – the Nottingham Treatment Centre is based at the QMC campus. Circle Health, an independent healthcare provider, runs it. The local clinical commissioning groups commission NHS services from the Treatment Centre; it is also used by private patients.

Tumour sites – the place in the body affected by cancer. Most cancers start in one part of the body – the primary tumour site. For example, if you have cancer that starts in the breast, you have primary breast cancer.

Two-ticks – a recognition scheme given by Jobcentre Plus to employers based in Great Britain who have agreed to take action to meet five commitments regarding the employment, retention, training and career development of disabled employees.

U

Urgent care centre – based in the centre of Nottingham, the Urgent Care Centre is open every day of the year between 7am and 9pm. It is designed to provide care for people who have an urgent, but not life-threatening injury or illness.

Urgent treatment centre – a service staffed by GPs available 7 days a week to manage patients with urgent, but not life-threatening conditions.

V

Values and behaviours – we believe our patients should always feel cared for, safe and confident in the treatment they receive when under our care. We have developed a set of behavioural standards for our staff following consultation with our patients, visitors and staff.

Vanguards – a national programme of improvement projects, supported by NHS England and delivered in local communities. The idea of the Vanguard programme is that is leads the development of new ways of providing joined-up care or health and social care services through local teams who pilot new ideas. Once the pilots have been completed, the results will go on to be used across the NHS projects, so that everyone benefits from the improvements.

W

Waiting times – the period that a patient may wait before being seen at a routine appointment or for admission to hospital. The standards and maximum waiting periods are set nationally under the NHS Constitution.

We Listen
We Care

Design Job 0719. Designed by NUH Communications Team