Nottinghamshire Healthcare
NHS Foundation Trust

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Annual Report and Accounts 2017/18

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about integrated healthcare

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PERFORMANCE REPORT

OVERVIEW OF PERFORMANCE

This overview of performance provides a short summary of the organisation, its purpose, the key risks to achieving our objectives and performance throughout the year.

A statement from the Chair and Chief Executive

We are delighted to welcome you to this annual report for Nottinghamshire Healthcare NHS Foundation Trust. The report covers the period 1 April 2017 to 31 March 2018 and as we look back on what has been a very busy and challenging year there is much to share; both in terms of positive staff and service developments, as well as some more difficult service changes, brought about either by commissioning decisions or the need to safeguard Trust services. We hope you find that this report provides a balanced view of how the Trust has performed during the last year. Importantly we continue to deliver safe and compassionate services to our patients, service users, carers and volunteers thanks to the dedication and commitment of our staff.

In 2016 we developed a new 5 year strategic framework, setting out our vision and four strategic objectives. As we are approaching the mid-way point in delivering our 5-year objectives, the Trust's Board of Directors has recently reviewed progress to date and reviewed the overarching strategy in light of the NHS changing national and local landscape to assess whether the strategy remains relevant and is aligned to the system's vision. The general conclusion is that the strategy and vision remain aligned to the external environment however; the Board of Directors has indicated a re-focus in some strategic areas and a need to be clearer about the programme of work to support each objective. The detail of this will be worked through during Q1 of 2018/19 which will include a review of the metrics to measure progress.
The Trust continues to operate within two Sustainability and Transformation Partnerships (STP) footprints: i) Nottingham & Nottinghamshire and ii) South Yorkshire & Bassetlaw. Greater Nottingham has been identified as an accelerated Integrated Care System and the Trust is working to support the development of the emerging ICS approach across the whole Nottingham and Nottinghamshire STP footprint.

The Trust is also playing an active role in promoting and developing mental health services through collaborative working across the footprint and is taking the lead in developing the system's mental health strategy, led by our Medical Director.

The Care Quality Commission (CQC) featured large in the year, beginning as it did with an inspection at Rampton Hospital and then ending with the publication of a full Trust inspection into five of our core services and the well led domain. We were delighted that this second inspection resulted in the Trust being awarded a 'Good' rating, but recognise there are areas for learning and further improvement.

The Rampton Hospital inspection was disappointing with the Hospital being assessed to 'Require Improvement'. This resulted in a number of immediate actions to rectify the most pressing issues of staff working on their own and patient activities being cancelled due to staff shortages. This still remains an area where we need to make further improvements. Across the country there is a shortage of qualified and unqualified nursing colleagues. This has impacted on the Trust as elsewhere. As we end the financial year we have once again welcomed the CQC Inspectors into Rampton Hospital for a re inspection. The outcome of the visit is not yet known. Work has continued on our fabulous new £21m unit for Children, Young People and Families, Hopewood. We have had some memorable moments, when past and present patients and friends have visited the new site and written their hopes and aspirations for the unit on the steel girders which will support it. The response from neighbours has been warm and welcoming and we look forward to Hopewood accepting its first patients in early summer 2018. This will prove an outstanding legacy for the people of Nottinghamshire and beyond.

To further enhance the clinical and social environment, initially at Hopewood, and then across the Trust, we have recruited a professional fundraiser to increase our charitable income. Work started during February, in an innovative collaboration with Nottingham University Hospitals Charity. We look forward to seeing this work come to fruition, to the benefit of our patients and service users.

Across services there continued to be change and developments. Community Adult Mental Health teams were reorganised along geographical lines – to ensure parity of provision to all service users, whatever their location. This was a difficult time transitionally – however we anticipate that it will lead to improved services for those engaging with the new Local Mental Health Teams.

During the year some services proved vulnerable to changing commissioner intentions and extremely challenging contract negotiations. Lawrence Day Services for older people were decommissioned in the Mid Notts area. We also underwent an extensive period of trying to secure funding for The Woodlands drug and alcohol inpatient detoxification unit at Highbury Hospital. Ultimately this was unsuccessful and The Woodlands will close at the end of May 2018. Close working with Framework Housing Association has allowed us to work in partnership to support an ongoing service for this vulnerable group of patients.

The Lucy Wade Psychiatric Intensive Care Unit (PICU) at Millbrook closed to female patients as it was not clinically safe for this purpose. Future usage of this unit is still to be determined and we are currently negotiating future service provision for women patients requiring this service. In the meantime those patients are being cared for in a variety of other settings.

In more positive news at Millbrook, the wards were reconfigured to be fully single sex compliant, improving the wellbeing, privacy and dignity for our patients there.

Other new developments and celebrations during a busy year included:

- A successful Ward Community project at Rampton Hospital
- National Clean Air Day during June 2017

- The launch of a Consultant Mentorship Programme for medics
- Full consultation on the Sustainable Transformation Partnership plan for the local health and social care community
- Improvement to end of life care to allow patients to die at a place of their choosing
- Mobilisation of Peer Support Workers (PSWs) in Child and Adolescent Mental Health Services (CAMHS)
- The refurbishment of Parkside Day Unit for older people
- The tenth anniversary celebrations for the Women's Service at Rampton Hospital
- The opening of Bestwood Ward in Carlton for Adult Mental Health inpatients, in conjunction with The Priory and Partnerships in Care
- Brecon Ward Psychiatric Intensive Care Unit Accreditation at Rampton Hospital
- The launch of a new series of films about Rampton Hospital for Carers and friends of patients at the Hospital

During the year, our staff were successful in being shortlisted for and winning a number of awards:

Jane Young, Speech and Language Therapy Service Manager, was highly commended at the Shine a Light Awards in London for her dedication and commitment in championing children's speech, language and communication skills.

Lisa Evans, ECG Trainer has been named as a Healthcare Pioneer by the AF (Atrial Fibrillation) Association.

The Oral Health Promotion Team won the Best National Smile Month Event for their 'Tales with the Tooth Fairies' events by the Dental Awards, organised by Dental Republic.

The Sustainability Team was shortlisted for three awards at the NHS Sustainability Awards in the innovation, finance and procurement categories. In February 2018 the Trust was awarded a Certificate of Excellence for our 2016/17 Sustainability Annual Report, which was granted on behalf of the Sustainable Development Unit (SDU), NHS Improvement (NHSI) and the Healthcare Financial Management Association (HFMA). This score placed the Trust in 6th place overall out of the 472 providers and CCGs in the UK.

Highbury Live! was awarded £10,000 of National Lottery funding from the Big Lottery Fund. The grant will enable the Highbury Live Team to further develop our Come Grow with Me Project at Highbury Hospital which is a community allotment and garden. The project aims to support people with their recovery journey by providing them with a safe, welcoming green space.

Five teams were shortlisted for the Nursing Times Awards 2017. They were:

- The Nottinghamshire CAMHS Crisis Resolution and Home Treatment Team (two categories).

- Newmarket Ward Team, from the National High Secure Learning Disability Service at Rampton Hospital.
- Bridget Ingamells, Clinical Nurse Specialist, Rampton Hospital.
- Mandy Mudholkar, Nurse Consultant, Rampton Hospital.

Bassetlaw Community Services were visited by the Parliamentary Health Committee because of their advanced practice.
Ashfield Children's Centres have been awarded £1,000 from the Tesco Bags of Help initiative for their project 'The Big Day Out'. The project will help families to come together to learn new skills and meet new people in their community.

An initiative by the Trust's Tissue Viability Team, which has seen a high reduction in avoidable pressure ulcers in care homes through improving knowledge and skills with care home staff, was shortlisted in the Staff Engagement category of the Health Service Journal (HSJ) Awards.

Jacqueline Duffy and Nicola Headland from the Speech and Language Team were successful in achieving a Giving Voice Award for helping patients with communications difficulties.

The Come Grow with Me allotment at Highbury, and Spinney Meadow at The Wells Road Centre, were both judged outstanding by the RHS for their community participation, environmental responsibility and gardening achievement in the 'It's Your Neighbourhood' Awards.

The title of 'Queen's Nurse' is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice. During the year a number of our staff were awarded this accolade.

During the year we won two major contracts, to reprovide healthcare into HMP Ranby, at a value of £3m and a new contract to deliver Offender Personality Disorder services to HMP Whatton and North Sea Camp. The Trust continues to grow; welcoming new staff and developing new services. During the same period we tendered for a major contract in the City of Nottingham for Out of Hospital Community Services. In this we were unsuccessful, losing out to the incumbent provider. We also retendered for the HMP Doncaster cluster of prisons and again, due to a tight financial envelope, we were unsuccessful.

During the year a great deal of investment in our workforce has been taking place with our Developing our People and Culture Together programme. This involved a stocktake of where the culture of the Trust was; using information generated from focus groups around the organisation, the national staff survey and other regular feedback forums. The results were very wide ranging, as you would expect, but some points stood out. Staff generally felt that there was a lack of visibility from the senior team around the Trust and that they were only visible when things had gone wrong. There was also a feeling that organisational change was not handled well and that decisions were made unilaterally without involving staff. Some of the other areas were specific to individual workplaces; but there was recognition from all of us at Board level that more needed to be done to make the Trust a great place to work.

These findings were reinforced by the results of the national NHS Staff Survey. Our response rate was 47% - this is higher than the average for Mental Health, Learning Disability & Community Trust's in England [45%]. This puts the Trust's response in the 'better than average' ranking.
Staff engagement levels have deteriorated slightly from last year, and the Trust's score is a 'below average' ranking. Our score was 3.72 with a national average for Mental Health and Learning Disability Trusts of 3.79. During the year we have worked hard to improve communications and engagement and these results do show that our staff have the confidence to tell us what they are feeling.

We scored best in the areas of the percentage of staff working extra hours, which was lower than the national average; staff and colleagues reporting experience of violence; staff satisfaction with resourcing and support; staff reporting experience of harassment, bullying or abuse and the percentage of staff satisfied with the opportunities for flexible working.

Steps taken throughout the year to address some of these findings include the development of a now thriving BME Network. This has given colleagues from a BME background more of a voice within the Trust and allows them to influence an important agenda.

We have developed a core direct communication from the Chief Executive to the rest of the staff through a regular monthly message on Connect, the Trust's Intranet site. This has allowed a more interactive dialogue about difficult issues such as cost improvements and service changes in a transparent and open manner. We have also initiated a series of 'Open Conversations' across the Trust, giving staff the chance to speak to the senior team about the issues that are important to them in their working life.

Other developments have included:

- Staff wellbeing sessions
- Healthcheck drop in sessions
- Screening advice and sessions to improve physical health
- The Aspire Leadership Programme, a newly refreshed suite of training aimed at providing valuable skills that both leaders and aspirational leaders need to equip themselves with in order to maximise their impact in the workplace
- Vision 21 development for middle managers who are potential leaders in the organisation to equip them for the future of the NHS
- The launch of the Positive Stars staff recognition scheme – a monthly recognition of outstanding performance, nominated by peers

The Trust Board has been stable during the year with only one Non-Executive Director leaving the Trust. We wished Professor Patrick Callaghan well in his new role at London South Bank University and thanked him for his time with the Trust as well as welcoming a new partner Non-Executive, Di Bailey from Nottingham Trent University.

The Council of Governors has continued to provide an important level of assurance during the year and there were a number of changes to its makeup and constitution.

The Council of Governors has continued to provide an important level of assurance during the year and there were a number of changes to its makeup and constitution. In December 2017 the Trust undertook an election to fill 10 vacancies on the Council of Governors. The vacancies had arisen from a combination of governors reaching the close of their term of office or standing down due to personal reasons. Electoral Reform Services led the election process which concluded in February 2018. All seats except one were contested; only one nomination was received for South Yorkshire and the rest of the East Midlands Constituency. The composition incorporating the changes can be found in the Directors report.
At the end of the year we celebrated the achievements of all of our staff, volunteers, service users and carers, with the 15th OSCARs. This fantastic evening, with the most nominations ever, saw 10 Awards and one special Chair's Award presented to the most deserving group of people. Each year this is a huge celebration of all that is best in the Trust and all that we are most proud of. There could not be a more fitting end to the year and a tribute to what makes Nottinghamshire Healthcare a great place to work and a great place to receive services, despite all the challenges that the year has brought. We look forward to what the New Year will bring for all of us.

Dean Fathers
Chair

Ruth Hawkins
Chief Executive

Additional note from the Chair

As the end of the financial year approached, Ruth formally gave me notice of her intention to retire. She has been with the NHS since 1986 when she began as a Financial Services Manager for the Central Nottinghamshire District Health Authority. During her 32 years she has held a number of senior positions and since 2006 Director of Finance and then Chief Executive at Nottinghamshire Healthcare. She has significantly contributed to the good governance of this organisation and had a considerable positive impact on the lives of service users, carers and staff for which I have thanked her on behalf of the whole Trust.
Whilst I and, I am sure, many others will be very sorry to see Ruth leave; she has been very honest and open about her future plans. As she approaches her 60th birthday she, quite naturally, would like to spend more time on her own interests and step away from the considerable pressures that come with being Chief Executive. We will now begin the difficult task of finding a suitable successor to Ruth, whose shoes will not be easy to fill. For now, it is business as usual and I look forward to celebrating Ruth's many achievements before she leaves us at a date to be decided in September.

Dean Fathers
Chair

About us

Purpose and activities of Nottinghamshire Healthcare NHS Foundation Trust
Nottinghamshire Healthcare NHS Trust was created on 1st April 2001 and is a well-known and respected provider of high quality healthcare services. It was formed by bringing together the mental health and learning disability services previously provided by other NHS organisations (Bassetlaw Hospital and Community Services NHS Trust, Central Nottinghamshire Healthcare NHS Trust, Nottingham Healthcare NHS Trust, Rampton Hospital Authority and Rotherham Priority Services NHS Trust).

In 2011, we were successfully awarded the contract to deliver physical healthcare services to the residents of Nottinghamshire County, followed by the Bassetlaw population in November 2011 and became an integrated provider of physical and mental healthcare services. In 2015 the Trust was authorised as a Foundation Trust (FT).

As a Foundation Trust we are accountable to local people through our Council of Governors and are regulated by NHS Improvement, the health sector regulator. We provide a wide range of services across Nottingham and Nottinghamshire, as well as regionally and nationally. We provide services for children, young people, adults of working age and older adults, supporting their physical and mental health needs as well as providing services for those with an intellectual and developmental disability. The Trust also provides Offender Health services across various sites.

The Populations We Serve
We receive an annual income of circa £456m and staffing costs equate to around 74% of total expenditure. We are one of the largest employers in Nottinghamshire, employing over 8,800 talented and dedicated staff members across a wide range of professions and disciplines.

Although some of the services we offer cover a regional or national population, the core area and population the Trust serves is Nottingham City and Nottinghamshire County with a combined population of 1.1m and where services are commissioned by seven local Clinical Commissioning Groups (CCGs) and for some services by the Local Authority:

The local Clinical Commissioning Groups are:

- Nottingham City
- Nottingham North and East
- Nottingham West
- Rushcliffe
- Mansfield & Ashfield
- Newark & Sherwood
- Bassetlaw

There are large variations in the levels of deprivation across Nottingham and Nottinghamshire. For example, none of the population within Rushcliffe is identified as being in the lowest income quartile, whilst Nottingham City is identified as being in the top 25% of the poorest areas in England.

Projections for the Nottinghamshire population estimate:

- An increase of 2.7% over the next 5 years
- The number of people living beyond 85 years of age increasing by 16.3% over the next 5 years
- 36% of people aged 65-74 and 47% of people aged 75+ have a limiting longstanding illness
- 25% of the population will have a mental health condition

Our Services
We currently offer a wide range of services at different levels of specialism and intensity. Some are delivered by local teams and some by countywide or national

teams. We deliver services in a range of settings from people's own homes and community clinics, through to specialist hospitals.
Our services are delivered from over 109 different sites. Our main hospital sites are:

Locations	Services Offered
Highbury Hospital, Nottingham	Acute mental health inpatient beds and outpatient facilities
Millbrook Mental Health Unit, Mansfield	
Doncaster & Bassetlaw Hospital (Ward B2)	
Thorneywood, Nottingham (This will be expanding and relocating to a new purpose built facility from early summer 2018)	Children's mental health inpatient and outpatient services
Lings Bar Hospital, Nottingham	Physical rehabilitation for older people
John Eastwood Hospice, Mansfield Bassetlaw Hospice	End of life and palliative care
Wells Road Centre in Nottingham	Low, medium and high secure mental health services
Arnold Lodge in Leicestershire	
Wathwood Hospital in Rotherham	
Rampton Hospital in Retford	

Our clinical service model aims to deliver care and support in a way that enables people to be in a better position to take ownership of their own health and care needs. We want to move away from reactive, hospital based treatment models to a proactive approach of prevention and early intervention, delivered in community locations where this is appropriate.

Community and Integrated Care
We deliver a wide range of community and home based services for both adults and children with physical and/or mental health conditions. These include community based nursing and therapy teams to meet specific needs, as well as universal services for children and families, which are part of the Healthy Families Programme.

These services are delivered from facilities such as Children's Centres, local Health Centres and GP practices as well as people's own homes. Our community services range from providing short term support following a period of illness through to providing long term care to help people manage chronic mental health and/or physical health conditions, as well as providing support to people who require end of life care.

We are a significant provider of healthcare to offenders in a number of prisons across the East Midlands

Specialist and Inpatient Care
Our forensic services are nationally recognised amongst peer organisations for quality, safety and security. They provide care for those deemed to present a risk to themselves or others and who are admitted under the Mental Health Act.

We provide inpatient facilities at all levels of forensic security. Our facilities include Rampton Hospital which offers care in a High Secure environment, Arnold Lodge and Wathwood Hospital which provides care in a Medium Secure environment and the Wells Road Centre which offers care in a Low Secure setting along with a wider team of community forensic services.

Our acute mental health bed based services at Highbury, Millbrook and Bassetlaw offer services for adults, whilst our Thorneywood site, which is due to relocate to a new purpose built development in the spring of 2018, offers services for children and young people.

Our strategic vision and values

The Trust Board of Directors approved a 5-year strategy in March 2016.

Our vision
'Through partnerships, improve lives and the quality of care'

Our Values
The Trust is known and recognised for its ***POSITIVE*** value base. Our ongoing commitment is to listen and learn from our patients, service users, carers and staff and ensure that we live by our values in a real and meaningful way.

P*eople:*	*People are central to everything we do*
Openness:	We listen to and act on what people tell us; we are open to challenge; we value honesty and transparency
Safety:	We put safety first in everything we do
Involvement:	We work collaboratively with all our key stakeholders, including patients, carers, staff, volunteers and partners
Trust:	We are trustworthy and act with integrity
Innovation:	We use research, technology and global best practice to improve outcomes and lead the way
Value:	We value care, compassion, respect, dignity and diversity
Excellence:	Excellence is our standard

Our strategic objectives

Our objectives are the four key areas that describe how we will achieve our vision.

- Provide the best possible care and support
- Demonstrate best value
- Be the service provider of choice
- Make the Trust a great place to work

Delivering our objectives
Overall performance in the last 12 months has been good. We have secured some important contract renewals that were competitively tendered within our forensic portfolio and have continued the significant transformation in our adult mental health services.

During 2017, we made good and sustained progress in delivery of our strategy, including areas such as:

- Launching our Trust wide Quality Improvement approach with rollout being mainly in 2018.
- Design and rollout of our People and Culture Together strategy and open conversations
- Progressing New Models of care

A key consideration for delivery of the strategy continues to be the necessity to balance quality against the challenging financial environment we operate in. This will continue to remain a key area of focus for the Board of Directors.

As we enter 2018/19 we have identified a number of risks and mitigations to the delivery of our strategic objectives, which are documented in the Board Assurance Framework. The top five risks are:

- Failure to maintain quality and compliance standards leading to deteriorating safety and quality of services and loss of licence.
- System wide pressures and regulation regimes impact on the delivery of the financial strategy and lead to a lack of long term financial sustainability.
- If recruitment and retention issues are not resolved for High Secure services, then wards might not be appropriately staffed leading to lone working at night and/or the cancellation of patient day time activities with consequences for patient and staff safety, security and regulation.
- If the health, wellbeing and resilience of the workforce is not effectively supported and managed, then there will be adverse impacts on patient care and patient and staff experience.
- Inability to recruit and retain an engaged and appropriately skilled and motivated workforce, with the right behaviours and leadership capacity while addressing unacceptable variance across the Trust.

The Board Assurance Framework is reviewed regularly by the Board of Directors and appropriate Board committees. Further information is provided in the Annual Governance Statement in this report.

Going concern disclosure

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

PERFORMANCE ANALYSIS

Measuring performance
The Trust employs a number of overlapping reviewing mechanisms to monitor performance, to ensure that performance is considered as a whole whenever possible, and to enable consideration of different aspects of performance to ensure that we can fully understand how these interact and any resulting issues that may arise.

These measures include:

- Service user/carer experience surveys and responses
- Contracted service level targets for commissioners
- Targets for Commissioning for Quality and Innovation (CQUINs) payments
- Finance targets
- Workforce indicators (such as sickness and turnover)
- Performance against mandated national targets such as the NHS Improvement's Single Oversight Framework
- Trust performance against NHS Improvement service level targets such as Mental Health Specialist service dashboards
- Quality, Innovation, Productivity and Prevention (QIPP) programmes

Performance: Risk
Sound management of performance requires risks and uncertainty arising from performance to be addressed as part of the Trust's risk management strategy. Risk management involves understanding, analysing and addressing risk to make sure organisations achieve their objectives, which is underpinned by a proactive and informed review of Trust performance.

The Trust employs a Board Assurance Framework (BAF) which forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks. Each area of service within the Trust is required to regularly update their risk registers to ensure that performance issues are both identified and addressed, with corresponding actions and mitigations monitored in a timely manner. This approach enables risk and uncertainty around performance to be managed within the Trust's organisational hierarchy to ensure accountability and transparency.

Performance Management Framework
The Trust oversees performance through its Performance Management Framework, which requires regular oversight reviews at all levels, from service level meetings, directorate and divisional reviews to the Board of Directors' monthly Quality and Performance report. The Performance Management Framework ensures that different performance measurements are assessed together to give a more complete and comprehensive view of performance (such as finance information and workforce indicators) thus enabling issues behind performance concerns to be more fully understood. This triangulation process underlines a commitment to reviewing performance based on a holistic and interlinked approach, cognisant of how different measures may impact on, or overlap into, other areas of performance.

The reporting regime provides an overview of Trust performance at board level against locally agreed quality indicators, as well as the NHS Improvement's 'Single Oversight Framework' (SOF) operational performance metric targets as defined within the SOF Appendix 3.

A review of Trust performance for 2017/18 is given below, followed by a forward looking view of the Trust's development of performance management that will continue into 2018/19.

Summary of Performance 2017/18

Category	Indicator of Performance	Performance achieved
NHS Improvement (Feb 2018)	**Single Oversight Framework Segmentation** (1-4, with 1 being the best)	2
NHS Improvement (Feb 2018)	Single Oversight Framework **Operational Performance Standards**	Achieved 5 out of the 6 targets relevant to the Trust
Care Quality Commission Rating (February 2018)	Overall Rating	Good
Care Quality Commission Rating (February 2018)	**Safe**	Requires Improvement
	Effective	Good
	Caring	Good
	Responsive	Good
	Well-led	Good
National Staff Survey (2017)	**Staff recommendation of the organisation as a place to work or receive treatment** (the higher the better)	3.65 (against a national average of 3.68)
National Community Patient Survey (2017)	**Overall Score** (the higher the better)	7.2 (against a national average of 7.0)
NHS England (February 2018)	**The Friends and Family Test (FFT)**	95% approval rate

Issues arising from 2017/18 performance

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. Further information is included in the section of this report on NHS Improvements Single Oversight Framework.

Single Oversight Framework: Themes
The Board is advised of potential concerns within each of the five main Single Oversight Framework themes, in order to be transparent and aware of possible risks. This is reported in the Board's monthly Integrated Performance Report.
'Evident concerns' have been recognised by the Trust around quality of care and leadership and improvement capability. This is largely recognition of CQC reviews carried out in 2017 at Rampton High Secure Mental Health Hospital which concluded that improvement was needed in the 'well-led' domain. The CQC re-inspected Rampton Hospital in March 2018. The outcome is not yet known.

Whilst finance and use of resources are considered internally by the Trust to have 'emerging concerns', the Trust's finance and use of resources is externally rated as 1, the highest level that can be achieved (the emerging concerns raised internally relate to cost improvement programs managed within 2017/18 and further savings required by the Trust's commissioners resulting in additional cost pressures).
Operational Performance has been rated internally as having 'emerging concerns' due to the continued underperformance of the Trust against one of the six Single Oversight Framework Operational Performance Standards relevant to the Trust, namely 'Improving Access to Psychological Therapies (IAPT)/talking therapies: Waiting time to begin treatment within 6 weeks'. The Trust has not met the 75% target for two successive quarters.
The Trust's IAPT provision is based around three main geographical areas; two of which consistently achieve target with the remaining area being responsible for the continued underperformance at a Trust level. Two of the principal reasons for the underperformance have been retention of trained staff, and the quality of the data being produced. These issues have been reviewed and action plans put in place as part of a recovery plan.
Going forward a single IAPT service is being developed, working to a consistent Trust wide model, with one overall operational manager, to ensure such variance can be tackled more efficiently and quickly.

Strategic Change has been identified as an area of 'emerging concerns' as recognition of the Trust's increasingly complex and difficult external environment, rather than being a reflection of ongoing issues within the Trust. System efficiency challenges will put further pressure on maintaining all areas of service delivery and performance against the NHS England Five-year Forward View (5YFV).

Issues arising from 2017/18 performance: Workforce
Workforce pressures across the Trust have been an ongoing issue throughout 2017/18, with voluntary turnover running at over 12% towards the end of the financial year, and a vacancy rate nearing 8%. This has the inevitable effect of raising overtime, agency and bank workforce levels more than would be desired, but we are pleased to note that where extra staff is needed, we have seen throughout 2017/18 a growth in the deployment of our own Bank staff to cover shifts, rather than using external agency staff (whose usage has dropped to around 1%). Overtime usage remains stable over the last 6 months, although we would hope to see this decrease over time. Sickness and absence currently stands at 5.3%, above the Trust's target of 5%, but at a stable and manageable level.

The levels of monthly safer staffing (as outlined by NHS Improvement) reported by the Trust have started to improve over recent months, with the following current performance levels reported:

fill rate - registered Day	fill rate - care staff Day	fill rate - registered Night	fill rate - care staff Night
90.8%	94.6%	91.7%	96.8%

Mandatory training levels remain at around 90% and clinical supervision has remained stable, above 80% for 2017/18, although lower than the Trust's 85% target. The implementation of a new clinical supervision system late in 2017/18 is expected to improve both the quality of reporting in this area, and the levels of supervision being delivered. Performance Appraisal rates have declined over 2017/18, and are currently at around 82%. The Trust's Leadership team keep the Trust Board appraised of the ongoing situation around workforce issues, and the initiatives being put into place to lessen and mitigate the nationally recognised issues around staffing in the NHS which the Trust is facing.

Issues arising from 2017/18 performance: Mental Health waiting times
Whilst waiting times targets in Local Partnerships General Health services continue to be met across services, levels of waiting times for treatment and assessment remain an issue within Local Partnerships Mental Health services, mainly within the Adult Mental Health directorate. Whilst demand is high, the Trust is actively improving how it manages waiting times to reduce them wherever possible; a new system has been introduced which enables a more up to date and detailed picture of current waiting times across services to be accessed at team level to enable better self-management of waiting lists. Recent reviews of waiting times suggest that this approach is starting to bear fruit, with a tentative downward trend for long waiting patients being evidenced over recent months.

Issues arising from 2017/18 performance: Acute mental health out of area service provision
The growing requirement for acute adult mental health inpatient service provision has led to the Trust sub-contracting 16 beds locally in 2017/18. The Trust is aware that out of area services is an area which will be subject to greater national level scrutiny and reporting going into 2018/19; we recognise that we are still unable to offer all patients either subcontracted or Trust beds and that we still have recourse to private and other NHS trust service provision when there aren't sufficient beds available internally. The Trust is to improve its reporting at Board level to enable Directors and the public to be fully updated on the position on a month by month basis.

Performance Management Framework:

The Performance Management Framework has been revised in 2017/18 to bring a greater focus on enabling a culture of continuous improvement and devolved accountability centred on the following criteria:

- **Clarity -** clear objectives at all levels. A performance culture aligned to individual responsibility. Driving cultural change to improve service-line management.
- **Communication -** value based behaviours and mind sets. Solution and actions focused. Prioritising quality and safety.
- **Transparency -** clearly set out performance assessment, with services understanding what is required of them and what they are accountable for.
- **Information -** efficient data collection. User friendly information systems to exploit data to best advantage.
- **Structure -** clear and consistent sequence of review meetings with clear terms of reference.
- **Balance -** performance management interventions and actions are proportional to the scale of the risk; maintaining a balance between challenge and support.

Oversight and Review

Service Line Review and Divisional Oversight

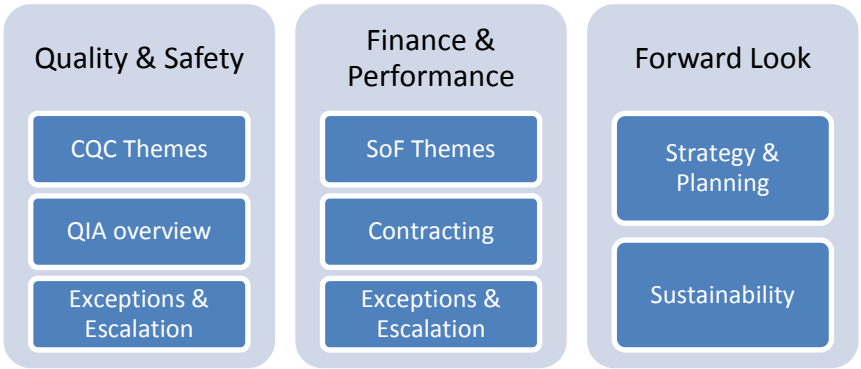
Ownership starts at service level; each service is expected to scrutinise its own level of performance and then identify and deliver the improvements that are needed if performance is not sufficient. Each division must ensure effective, adequate and timely reporting takes place with oversight leading to action.

Organisational Performance Oversight

Performance information is received monthly by the Board of Directors via the Integrated Performance Report and through the Board Agenda as a whole. The Board of Directors delegates detailed scrutiny and review of performance to the Finance and Performance Committee which interrogates performance on an exceptional basis, and, where there is likely to be significant risk, carry out a series of 'deep dives' into areas of concern.

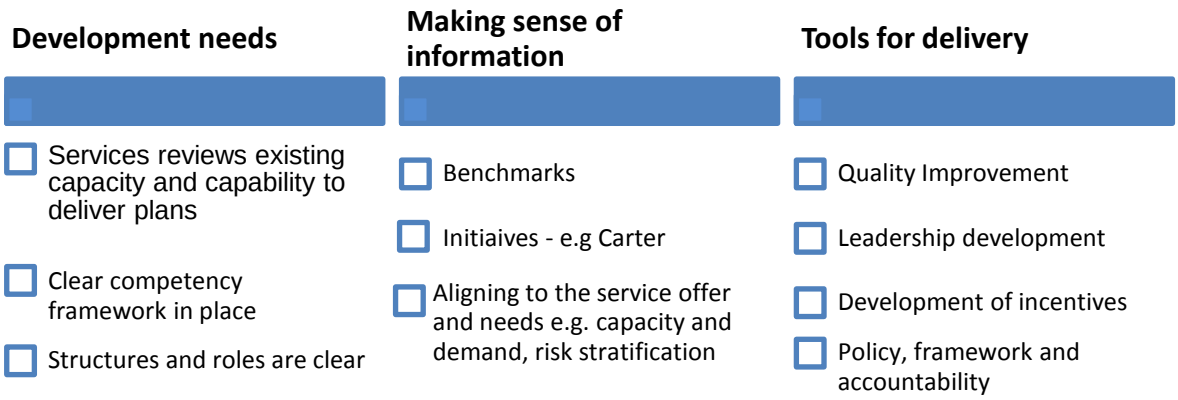
Formal Accountability Reviews

Regular accountability reviews are required for each division. These are chaired by the Chief Executive and supported by other members of the Executive team, with agreed levels of escalation and autonomy, to understand performance against the principles in the framework through the following structure:



Making our data work for us
Timely, accurate and 'current' information is critical to tell us how we're performing, and to allow early corrective action when required. The Trust has a scorecard ('ward to board') which enables staff to view a range of performance indicators from different information systems in one place. Our ambition for 2018/19 is to ensure this scorecard contains indicators that reflect current regulatory priorities and also to include a range of extra internally important indicators.

Implementation
Looking forward, there are a number of strands to bring together to ensure the Performance Framework is discharged effectively. The forward view to enable the Trust to deliver this is outlined below:



Conclusion

Whilst overall the performance for 2017/18 has been good, the areas outlined where we have not achieved what we would have wanted or is expected, underline the need to continuously improve.

However it is recognised that to deliver this, in the face of growing demand and a challenging financial situation requires a shift in cultural mind-sets across the Trust, so that ownership of performance becomes less hierarchical and more responsive, driven by better access to information about performance and more service level ownership of issues. These two requirements will underpin conversation about performance within the Trust going forward.

Financial performance

The Trust has delivered a strong financial performance and met all of its statutory financial obligations. The Trust is required to achieve at least breakeven position, ensuring that income is sufficient to meet expenditure. The Trust reported a surplus of £9,755k versus a plan and regulator control total of £9,622k, prior to the allocation of additional Sustainability and Transformation Funding (STF) from NHS Improvement. Following a further STF allocation received on 20th April 2018 of £2,593k this gave a total surplus of £12,348k for the financial year 2017/18. After the inclusion of £2,564k of impairments the Trust achieved a reported surplus for the year of £9,784k.

The Trust's main source of income is received from local Clinical Commissioning Groups and NHS England. Clinical income in the year equated to £402.2m. A further £53.8m was received from Local Authorities, Health Education England and other organisations relating to non-clinical income. From this income the Trust incurred £328.9m on staffing costs, equivalent to 74% of total expenditure (including PDC and other interest but excluding impairments). The remaining expenditure consisted of non-pay costs of £91.4m, with depreciation, PDC dividend and other finance costs of £23.3m.

Within the delivery of the above the Trust delivered £11.3m of efficiency savings. The resulting surplus of £12,348k resulted in an Income & Expenditure margin of 2.7%.

Working capital during the year remained strong with average net current assets of £26.8m and average liquidity to cover 23 days of operating expenses. Cash holdings at the end of March were £38.6m.

Capital expenditure of £19.4m included £12.2m on the CAMHS and Perinatal re-provision scheme, which will open in the first quarter of 2018/19. IT and communications infrastructure accounted for £3.0m, with the remainder relating to maintaining the Trust estate, other equipment and intangible assets. As part of the Trust's ongoing review on the use of its estate, asset disposals during 2017/18 realised proceeds of £1.7m and a profit on disposal of £0.3m.

The Trust was set a cap on total agency spend by NHS Improvement (NHSI) of £11.1m for 2017/18, which included within that a secondary cap on Medical agency of £4.3m. The Trust was successful in reducing overall agency expenditure during 2017/18 by 37% from the previous year. The total spend on agency staffing of £7.7m for the year is below the cap set by £3.4m, with the expenditure on medical agency of £3.1m, being £1.2m below that element of ceiling set by NHSI.

The Trust has not undertaken any work overseas during 2017/18.

Environmental performance

The Trust is committed to being a sustainable healthcare provider and as such, seeks to ensure that its services are delivered in a way which protects the environment and minimises the impact on it.

Our current Sustainable Development Management Plan was approved by the Board in 2015. Due to the progress made against existing objectives and changing guidance, this is now being updated and a revised plan will be presented for approval in June 2018.

The Trust aims to reduce its carbon footprint in tonnes of carbon dioxide equivalent (tCO_2e) per whole time equivalent (WTE) against a 2007/08 baseline by 34% by 2020, and 80% by 2050. Carbon emissions associated with Procurement remain the greatest contributor to our carbon footprint accounting for 66% of the total. Energy

accounts for 19% with Travel and Commissioning contributing 8% and 7% respectively.

During 2017 the Trust received recognition for the third year running at the Annual NHS Sustainability Day Awards in May 2017 and in addition, the Sustainable Food Project was also shortlisted for a HSJ Award.

Work continues to take place in relation to Travel and Transport as this is seen as a growing area of importance, particularly with the pending development of Clean Air Zones in the cities of Nottingham and Derby. A more detailed report is provided in the section on voluntary disclosures.

Social, community, anti-bribery and human rights issues

The Trust recognises and works to ensure that it operates as a socially responsible organisation, is supportive of and engages with the diverse range of communities and interests in the delivery of its principal purpose as set out within the Constitution (the provision of goods and services for the purposes of the health service in England) and complies with and upholds the principles of human rights for all those who come into contact with the Trust in relation to this principle purpose.
The Trust is known and recognised for its POSITIVE values base which underpin the Trust`s approach to social, community and human rights issues.
At a strategic level issues relating to social, community, anti-bribery and human rights issues are reflected within a range of strategic documents and enacted through Trust wide policies, operational policies and associated monitoring and reporting arrangements. Associated risks are assessed and reflected within the Board Assurance Framework or risk registers.

The Trust works closely and in partnership with a broad range of public, private and voluntary sector organisations in the delivery of services to identify, assess and meet the needs of communities, be these geographical or demographic. In so doing the importance of engagement with these communities is recognised as being of crucial importance as is ensuring that communities consider their voice has been heard and appropriately responded to.

Trust wide policies aim to ensure compliance with current legislation, regulation and national guidance. Policies are ordered under a number of categories, with policies in the following categories addressing varying aspects of human rights:

- Mental Health Legislation
- Human Resources – including Equality, Diversity and Human Rights
- Safeguarding
- Patient Care
- Confidentiality
- Risk Management

The Trust does not tolerate any form of fraud, bribery or corruption by, or of, its employees, associates, or any person or body acting on its behalf. The Trust

employs an independent dedicated agency to provide local counter fraud services to support staff in dealing with counter fraud issues.

The Trust's Audit Committee agrees the work plan for the counter fraud specialist and this is updated on a regular basis in relation to progress. The Trust also works closely with NHS Counter Fraud Authority for major investigations. The Trust's counter fraud policy is scrutinised by the Audit Committee and recommended to the Board of Directors for approval, and details the organisation's procedure for dealing with suspected fraud, bribery and corruption. Staff or service users who witness or have concerns that a fraud is being undertaken can contact the local counter fraud specialist in confidence, who will review and initiate an investigation where appropriate.

As a provider of secure forensic, offender health and mental health services, a specific focus is placed on ensuring that practice and processes for the provision of these services safeguards the interests of service users and patients in accordance with legislation, regulation and national guidance.

The Board of Directors maintains oversight of arrangements through direct reporting or through the work of its committees e.g. the Mental Health Legislation Committee with regard to compliance with the Mental Health Act and associated legislation.

Night Time Confinement is approved on a number of wards at Rampton Hospital. The Board of Directors is asked to approve further continued use of Night Time Confinement at Rampton Hospital on a quarterly basis.

Working with suppliers
In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 2015, the Procurement Team continuously reviews its supply chains with a view to confirming that such actions are not taking place. The 2017 review of the Trust's Non Pay spend and associated supply chains identified the following general potential areas of risk as Provision of Food, Construction, Cleaning & Clothing (work wear).

All suppliers in these categories are contacted by letter, to confirm compliance with the Act and provide additional information on their organisation, their supply chains, the areas of risk and the due diligence undertaken.

In addition, the Procurement Team ensures that due diligence is undertaken for all new and ongoing suppliers of goods and services to the organisation and their associated Supply Chains by sourcing through the following compliant routes:

- Competitive OJEU (Official Journal of the European Union) procurements tendered in compliance with EU guidance which require suppliers to confirm they comply with the Modern Slavery Act. To support their response bidders are also required to state:

    - the organisation's structure, its business and its supply chains;
    - its policies in relation to slavery and human trafficking;

- its due diligence processes in relation to slavery and human trafficking in its business and supply chains;
- the parts of its business and supply chains where there is a risk of slavery and human trafficking taking place, and the steps it has taken to assess and manage that risk;
- its effectiveness in ensuring that slavery and human trafficking is not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate;
- the training and capacity building about slavery and human trafficking available to its staff.

- Procurement through EU compliant national government frameworks.

- All contracts and associated purchase orders are raised on the NHS Standard Terms and Conditions which suppliers are mandated to comply with.

- These conditions state:

  It shall: (i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and
  (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;

- It shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this clause and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy.

The Procurement Team upholds the Chartered Institute of Procurement and Supply (CIPS) Code of Professional Conduct.

Ruth Hawkins
Chief Executive
24 May 2018

ACCOUNTABILITY REPORT

The Trust's directors take responsibility for preparing the Annual Report and Accounts. We consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.
This accountability report is signed in my capacity as accounting officer.

Ruth Hawkins
Chief Executive
24 May 2018

DIRECTORS REPORT

The Board of Directors

The Board of Directors has overall responsibility for defining the Trust's strategy and strategic priorities, vision and values, for the overall management and performance of the Trust and for ensuring its obligations to regulators and stakeholders are met.

The decisions reserved for the Board of Directors and the delegated discharge of its responsibilities is set out under a formal Scheme of Delegation defining the allocated responsibilities for making and approving decisions relating to Trust business.

The Board of Directors meets 12 times per annum, routinely on the last Thursday of every month (with the exception of December). Meetings of the Board of Directors are held in public with members of the public welcome to attend to observe proceedings. Due to the confidential nature (commercial or personal issues) of some matters of business, the Board of Directors does reserve the right to undertake such business in private session. The meeting agendas are circulated to Governors in advance of the meeting with a standing invitation to each meeting of the Board of Directors (and of its committees) to observe the work of the Board of Directors. Papers and minutes of the public sessions of the meetings are available via the Trust's website.

The Board of Directors is a unitary board comprising Executive and Non-Executive Directors who make decisions as a single group and share the same responsibility to constructively challenge during Board discussions and support the development of proposals on priorities, risk tolerance, values, standards and strategy:
Executive Directors are employees of the NHS Foundation Trust, led by the Chief Executive, and are responsible for the day to day management of the Trust.
Non-Executive Directors are not employees and bring to the Board an independent perspective having a duty to challenge the executive and to hold Executive Directors to account.

All members of the Board of Directors have the same general legal responsibilities to the Trust and have a collective responsibility to act with a view to promoting the success of the organisation to maximise the benefits for the members of the Trust and for the public.

The Directors of the Trust bring a broad range of skills and experience to their roles on the Board to ensure an appropriate balance with the capability and capacity to meet the requirements of the Trust. The Board of Directors' Nominations & Remuneration Committee maintains an overview of the Board's composition.

To support the Board of Directors in the undertaking of its responsibilities, the following committees have been formally established, all being chaired either by the Chair of the Trust or by a Non-Executive Director:

- Audit Committee
- Quality Committee

- Finance & Performance Committee
- Workforce, Equality & Diversity Committee
- Mental Health Legislation Committee
- Nominations & Remuneration Committee
- Charitable Funds Committee

A programme of Board Development sessions have been held during 2017/18 focusing on a range of issues including strategy development, Board effectiveness and the Well Led framework, risk management, involvement and engagement, and system wide transformation.

Board members

Name	Position	Comment	End Date of Current Term of Office
Dean Fathers	Chair		31 December 2019
Sheila Wright	Non-Executive Director Vice Chair		28 February 2019
Peter Parsons	Non-Executive Director Senior Independent Director		31 January 2019
Steve Banks	Non-Executive Director		31 January 2019
Patrick Callaghan	Non-Executive Director	End Date: 30 June 2017	
Stephen Jackson	Non-Executive Director		17 July 2019
Christine Lovett	Non-Executive Director		28 February 2019
Di Bailey	Non-Executive Director	From: 1 November 2017	31 October 2020
Ruth Hawkins	Chief Executive		
Simon Crowther	Executive Director of Finance		
Julie Attfield	Executive Director of Nursing.		
Julie Hankin	Executive Medical Director		
Paul Smeeton	Executive Director: Local Partnerships		
Peter Wright	Executive Director: Forensic Services		
Angela Potter	Director of Business Development and Marketing	Non-voting Board member	
Clare Teeney	Director of Human Resources	Non-voting Board member	

All Non-Executive directors who served on the Board of Directors in 2017/18 are considered to be independent by virtue of the employment checks made on appointment, ongoing fit and proper person's reviews and the declaration of their actual and potential conflicts of interest. Further information can be found in the Annual Governance Statement.

Ruth Hawkins – Chief Executive

Ruth was appointed Chief Executive on 1 November 2014. This followed eight years as the Trust's Director of Finance, and for six years its Deputy Chief Executive. Prior to joining the Trust, Ruth was a Director of Finance in the NHS in a number of organisations, including spells with an NHS Trust, a Health Authority and a Primary Care Trust. Ruth has a BA in Public Administration and gained her chartered status with the Chartered Institute of Public Finance and Accountancy.

Dr Julie Hankin – Executive Director Medical Affairs

Julie is a Consultant Psychiatrist working in general adult services. She has worked in a number of management and leadership roles through that time including Clinical Director roles for Service Redesign, Service Improvement, and Adult Services. Prior to her appointment to the Executive Medical Director role in 2014 she was Clinical Director for Wiltshire, including service responsibility for adult and older people's community mental health services, acute adult inpatient units and crisis and home treatment services.

From 2012 to 2014 Julie was the National Professional Advisor for Mental Health for the Care Quality Commission (CQC) and was the clinical lead for the implementation of the new inspection regime.

She is a board member of the Mental Health Network of the NHS Confederation and chairs the Mental Health Medical Directors Forum which is hosted by the Confederation. She is also the Mental Health lead for the local Sustainability and Transformation Partnership (STP).
She holds an honorary Associate Professor role within the Health Sciences School of the University of Nottingham and is a panel member for the national Health Services and Delivery Research funding stream with the NIHR.

Dr Julie Attfield - Executive Director of Nursing

Dr Julie Attfield is the Executive Director for Nursing. She took up her role on 1 June 2015 and was previously Executive Director with responsibility for high secure provision at Rampton Hospital; medium secure units at Arnold Lodge in Leicester and Wathwood Hospital in Rotherham, the Low Secure and Community Forensic Directorate and Offender Health in the East Midlands and Yorkshire.

Julie began her career as a Registered Mental Nurse, and has since worked as a clinician, senior manager and director within mental health services in the East Midlands. Between these appointments Julie spent time as a full time lecturer in Nursing at the University of Nottingham, before returning to the NHS.

Simon Crowther - Director of Finance

Simon joined the Trust on 30 March 2015 as Executive Director of Finance. Prior to his appointment, Simon had worked at Board level in both provider and commissioning organisations within the NHS. He has gained extensive experience in not only finance but also in contracting, performance management and information strategy.

Since qualifying as a management accountant in 1996, Simon has complimented his accountancy background with further studies in leadership and change management, coaching, strategic financial management and corporate governance and assurance, the latter being completed at the Cass Business School in London.

Paul Smeeton - Executive Director, Local Partnerships

Paul Smeeton is Executive Director for Local Partnerships. Paul has been with the Trust since 2002 when he joined as Head of Health Informatics. He has then worked as Director of Business Development, then Operational Director for the community services the Trust took on in 2010. He first joined the NHS in 1986 as a general management trainee working in Preston and has held various jobs in the NHS ever since.

Paul has an MBA from the University of Durham, 1997; a Diploma in Managing Health Services, Open University, 1990 and a BA in Geography and Anthropology, University of Durham 1986.

Peter Wright – Executive Director, Forensic Services

Peter joined the Trust in 2016 having worked in prison services for 23 years, both in the public and private sectors. As well as his work in prisons, Peter has partnership experience including safeguarding children and adults, victim services and local criminal justice board collaboration. He previously worked in partnership with Nottinghamshire Healthcare for many years particularly in relation to the Trust's Offender Health services in prisons, for which he takes on responsibility as part of his role.

Angela Potter – Director of Business Development & Marketing *(Non-Voting Member)*

Angela has been with the Trust since December 2011 having started her career in the NHS in 1986 as a Registered General Nurse working in a number of Accident & Emergency departments across the East Midlands. She has undertaken a number of management roles in both operational services and business planning, including contract management and negotiation; business development and service planning.
Angela has a BA (Hons) in Health Studies and an MBA from De Montfort University.

Clare Teeney – Director of Human Resources (Non-Voting Member)

Clare joined the Trust in 2011 as the Head of HR for Local Services. In 2012 her portfolio extended to include HR for the Health Partnerships Division. She was appointed as the Director of HR with responsibility for HR, Learning and Development and Equality and Diversity in October 2015. Clare is a member of the Chartered Institute of Personnel and Development, has a BA (hons) Degree, a qualification in Employment Law and an MBA from Loughborough University. She has a particular interest in Equality and Diversity and health and wellbeing.

Dean Fathers (Chair)

Dean became Chair of Nottinghamshire Healthcare in January 2011 and subsequently took up the additional post of Chair of United Lincolnshire Hospitals NHS Trust in March 2016. Alongside his duties in the NHS, Dean is also a Non-Executive Director with the Parliamentary and Health Services Ombudsman. Prior to becoming Chair of Nottinghamshire Healthcare, Dean chaired NHS Bassetlaw, had a long period as a Non-Executive Director on the South Yorkshire Strategic Health Authority and has also chaired Doncaster Health Authority.

Dean has a strong interest in leadership/development as well as governance and has consequently held roles on the NHS's National Training Group, chaired the East Midlands SHA's Learning and Development Board, was a founder of the East Midlands Leadership Academy, of which he is also a Board Member, and also held roles on two Workforce Development Boards. He currently sits on the NHS's Workforce Race Equality Standards (WRES) Advisory Group, the NHS's Culture Advisory Group, has been involved with both the Accelerated Access Review and the National Strategy for Improvement and Leadership Development Advisory Group (Smith Review) and is a member of NHS Improvement's Chairs' Advisory Partnership Board.

Sheila Wright (Vice Chair)

Sheila Wright is the former Deputy Chief Executive of Nottinghamshire Probation Trust and Senior Executive of Derbyshire, Nottinghamshire, Leicestershire and Rutland Community Rehabilitation Company, and is currently a Trustee of a Nottingham City based charity Improving Lives. She has an Honours Degree in Applied Social Studies, a Certificate Qualification in Social Work (CQSW) and an MA in Social Policy from Sheffield Hallam University.

Sheila brings a wealth of experience to the Board in Transformation/Organisational Development, Equality Diversity and Inclusion, multi-agency working, contract negotiations, service user/ community engagement, Public Protection, Safeguarding and Forensic Services.

Christine Lovett (Chair of Audit Committee)

Christine Lovett is a qualified psychotherapist with an extensive business background in the private and public sector.
In addition to her marketing and customer management skills from her time as marketing director at Capital One, she brings a strong strategy background to the Board. Following her MBA from INSEAD, she worked as a strategy consultant for the Boston Consulting Group where she worked on a diverse set of projects ranging from post-merger integration to IT governance. More recently she was the Strategic Director for Strategy and Organisation Development at the National College for School Leadership. Christine uses her skills gained in a range of businesses and in the public sector in the area of mental health and learning disabilities.

Peter Parsons (Senior Independent Director)

Peter Parsons joined the Trust as a Non-Executive Director in February 2009. His lead responsibilities include delivering the Estates Strategy and developing the Trust's commercial capabilities to achieve growth.

A retired director of Innes England, Peter brings with him 40 years' experience in the Commercial Property market with particular expertise in development and regeneration. He has worked as a regular consultant for the University of Leicester, East Midlands Development Agency (EMDA) and the NHS and was a Development Consultant to the National Space Science Centre in 2000.

Peter has always been interested in the NHS and in particular, mental health in children and adolescents. He wants to give the benefit of his experience to the public sector through his work at the Trust, helping drive the improvement of the building environment for both patients and staff to result in a higher quality of clinical care.

Steve Banks

Steve Banks has extensive experience operating at board level within the private sector and in a Non-Executive capacity within the community. He is currently Chairman of The Tinnitus Clinic and his previous posts include Director of Professional Standards and Superintendent Pharmacist, IT Director and Director of HR at Boots, where he has a long history of providing healthcare services.

He first started working with the Trust whilst at Boots, most recently as a member of the Council of Governors. Steve's first degree was in Pharmacy from Leicester and he has since completed an MBA at Nottingham University as well as numerous Leadership Development Programmes. Alongside his strong strategy and transformation background he has always been passionate about getting it right for patients.

Stephen Jackson

Stephen Jackson is a qualified accountant who has had a varied career in both the private and public sectors. After qualifying as an accountant Stephen joined Bass plc. and had several senior financial roles in the company's pubs and hotel subsidiaries. He has had a wide variety of posts since, including five years in Hong Kong as Chief Financial Officer and Head of Development and IT for Holiday Inn – Asia Pacific.

In 2003, Stephen joined Nottingham Trent University where he held the post of Chief Financial and Operations Officer with overall responsibility for Finance, Estates, Commercial Development, Legal, Registry, IT, and Governance Services. He was also appointed as a member of the Board of Governors and the Academic Board. In May 2016 Stephen retired from NTU.

Stephen also acts as Non- Executive Director with each of the following local organisations: -

- Marketing NG (and Chair of F and GP);
- Derbyshire Health United
- Chair of the Active Partners Trust (set up to increase participation in sport and active recreation in Nottinghamshire and Derbyshire)
- The Nottingham BID.

Di Bailey

Di is responsible for the overall management and leadership of the Division of Social Work and Health within the School of Social Sciences at Nottingham Trent University. She is also Director of Research for the School of Social Sciences and Chairs the School's Research Committee.

Di's teaching subject areas include

- mental health
- working with individuals with complex needs
- service user involvement in education and service development
- organisational change and development
- adult learning and research skills.

Prior to joining Nottingham Trent University in 2010, Di held the position of Reader in Social Work at Durham University from 2005.

Between 1995 and 2005, Di was employed by the University of Birmingham where she held the role of Principal Lecturer in Mental Health. In 2002 during her time at Birmingham Di was a National Teaching Fellow for excellent teaching in interdisciplinary mental health education.

Di is a Principal Fellow of the HEA and a Chartered Member of the CIPD. She is a registered social worker with the HCPC.

Board of Directors: attendance at Board Meetings 2017/18:
The Board met on 12 occasions in 2017/18

Name	Role	Meetings Attended 2017/18	% Attendance
NON-EXECUTIVE DIRECTORS			
Dean Fathers	Chair	11 of 12	92%
Sheila Wright	Non-Executive Director / Vice Chair	8 of 12	67%
Peter Parsons	Non-Executive Director / Senior Independent Director	12 of 12	100%
Steve Banks	Non-Executive Director	11 of 12	92%
Patrick Callaghan	Non-Executive Director (until 30/06/17)	1 of 3	33%
Stephen Jackson	Non-Executive Director	12 of 12	100%
Christine Lovett	Non-Executive Director	10 of 12	83%
Di Bailey	Non-Executive Director	5 of 5	100%
EXECUTIVE-DIRECTORS			
Ruth Hawkins	Chief Executive	11 of 12	92%
Simon Crowther	Executive Director of Finance	12 of 12	100%
Julie Attfield	Executive Director: Nursing	11 of 12	92%
Julie Hankin	Executive Medical Director	12 of 12	100%
Paul Smeeton	Executive Director: Local Partnerships Division	12 of 12	100%
Peter Wright	Executive Director: Forensic Services Division	10 of 12	83%
Clare Teeney*	Director of Human Resources	12 of 12	100%
Angela Potter*	Director of Business Development & Marketing	10 of 12	83%

* Non-voting members of the Board of Directors
Overall attendance 2017/18 (voting members): 90%

Performance Evaluation

The Board of Directors recognise the importance of ensuring ongoing assessment of its performance, that of its committees and of its directors, including the Chair, to

ensure all aspects remain fit for purpose and support the sustainability of the Trust and the delivery of its strategic vision.

All of our Non-Executive Directors fulfil the same primary role and it is important for us to acknowledge the additional activities which are undertaken in order to support their understanding of the Trust, its challenges and best practice.
Activities include:

- Organisation Site Visits – visit teams/services trustwide in accordance with a refined programme to ensure all teams/services are visited by Board members. Non-Executive Directors will routinely invite Governors to observe their site visit to enable accountability. In addition to this, visiting clinical areas allows Non-Executives to triangulate their understanding and provides an opportunity to challenge and scrutinise the governance and practice of the services and teams within the Trust
- External training and networking – Non-Executive Directors willingly participate in national training and networking events, some of which are occasionally specific to elements of their enhanced duties (e.g. Audit Committee Chair, Senior Independent Director and Vice Chair).
- Stakeholder engagement – where needed Non-Executive Directors have actively engaged with key stakeholder organisations to support wider system development and engagement within the membership and general public

The Chair uses performance assessments and evaluations as a basis for determining individual and collective professional development programmes for Non-Executive directors relevant to their duties as Board members.
The Trust commissioned Pricewaterhouse Cooper, the Trust's external auditors, to undertake an independent review of the leadership and governance of the organisation in line with the Well-Led Framework. The review consisted of:

- Review of documents and Trust governance structures to support compliance with each domain of the Well-Led Framework
- Consideration of the Boards self-assessment undertaken in August 2017.
- Interviews with Board members and other key members of Trust staff. This incorporated questions required for the discovery phase of 'Developing our People and Culture Together' programme
- Observation of Trust Board meetings, Board committees and other key governance meetings
- Appraisal of Board governance, including committee structures and Board to ward assurance

In summary, the independent review found that the Trust measured well against the Well-Led Framework, had invested significantly in the devolved leadership structure, noting a focus on improving risk management and the positive work ongoing relating to the cultural development programme. However, the report recommended that the Trust should continue to evolve its approach to governance and how it engages leadership and hold individuals to account to ensure its governance remains fit for purpose in the future.

The Chair is appraised twice a year jointly by the Senior Independent Director and the Lead Governor. The appraisal is informed by a 360 degree appraisal questionnaire which is completed by a selection of Governors, Directors and other staff. The appraisal is reported to the Governor's Nominations and Remuneration committee before being reported to the full Council of Governors.

The Chair appraises the Chief Executive's performance twice yearly. Due to the nature of the closeness of their working relationship, a 360 degree appraisal tool is used to enable Non-Executive Directors and Executive Directors to provide feedback to the Chair on the Chief Executive's performance. The results are used by the Chair in order to bring a wider perspective to the review.

It is within the powers of the Council of Governors to remove or suspend any Non-Executive directors. The process is set out within the Trust Constitution. These powers have not been required in 2017/18.

Declaration of interests
Governors and Directors are required to, and have signed to say that they will comply with their respective codes of conduct and declare any potential conflict of interest. Registers of interest are maintained of the Governors' and Directors' interests. These registers can be accessed on the Trust's website, www.nottshc.nhs.uk, and copies can also be obtained by members of the public by writing to the Trust Secretary at Trust headquarters.

Audit
Audit committee
The Audit Committee met on 5 occasions in 2017/18:

Name	Position	Meetings attended in report period	% Attendance
Christine Lovett	Non-Executive Director - Chair	5 of 5	100%
Steve Banks	Non-Executive Director	3 of 5	60%
Stephen Jackson	Non-Executive Director	5 of 5	100%
Patrick Callaghan	Non-Executive Director	2 of 2	100%
Peter Parsons	Non-Executive Director	5 of 5	100%
Di Bailey	Non-Executive Director (from 1 Nov 17)	1 of 1	100%

Overall attendance 2017/18: 91%

The Audit Committee is required to review the establishment and maintenance of an effective system of internal governance, risk management and internal control.
Key activities of the last year include the following:

- Consideration of the results of the External Audit for the year ended 31 March 2017 prior to approval of the financial statements. Matters discussed included uncorrected misstatements, sales and expenditure cut off errors and the valuation of PPE.

- Reviewed the Annual Governance Statement, together with the Head of Internal Audit and External Audit opinion.
- An internal audit of Quality Governance provided significant assurance. Oversight of this and scrutiny of the Quality Account took place in the Quality Committee, with the Audit Committee receiving an update via the Committee Summary reports.
- Provided ongoing oversight of the risk management strategy and processes. This included a discussion on risk appetite in July 2017 which was followed by a Board Development session in September 2017, helping to ensure a common understanding on this topic.
- The Committee reviewed Compliance with the FT licence at the May 2017 meeting and again in February 2018. A detailed review of the Code of Governance took place in February 2018, which provided assurance over compliance with a few small actions to consider in the year end processes.
- External assurances were received from PWC and the CQC regarding the well led framework, with recommended actions being monitored at Board level. Some of these were around ensuring clear and effective processes for managing risks, issues and performance.
- The Committee undertook a detailed review of the Trust's Standing Orders and Financial Instructions in October 2017 which were subsequently approved by the Board at its November meeting. This included a review against the Code of Governance and Trust practices, to ensure alignment.
- Issues around the number of policies, how they are written, communicated, monitored, and complied with has been an area of focus for the Committee over the last year, as non-compliance was a common theme emerging from Internal Audits in 2016/17. Much effort has been made to rationalise and ensure policies are in date.
- Compliance with regulations has been an area of focus, with a number of internal audits as well as new regulations requiring action.
- A report on the revised statutory guidance on Conflicts of Interest was reviewed in October 2017. Actions were required, with a new policy being implemented for December 2017.
- A report on the General Data Protection Regulation (GDPR) implementation plans was reviewed in February 2018. More work is required in advance of the May deadline, with further updates going to the Finance and Performance Committee.

The Committee has considered on a number of occasions, changes to accounting policies and emerging accounting issues, their implications for the Trust and how these are being addressed. In April 2017 the Committee reviewed and were assured by the work plan to address Intermediaries Legislation (IR35) which came into effect 6 April 2017. In July 2017 the committee reviewed and received assurance on costing processes that support reference costs submission. In October a full overview of the Trust's financial procedures and the process for their periodic review was provided. It was agreed the Committee would receive an update following the Financial Leadership Team review each year.

The Committee has continued to receive the Board Summary reports from other Committees. In October 2017 we reviewed a paper from the Trust Secretary

outlining options to consider going forward. The framework described was used in the production of annual reports from each Committee. This was a useful process we will continue to build on as we move forward.

Internal audit
The Trust's internal audit service is provided under contract by 360 Assurance who provide one of the main independent sources of assurance to the Board of Directors. 360 Assurance undertake audit reviews in accordance with the Trust's internal audit plan as approved by the Audit Committee. The plan provides for core assurance provision and assurance against identified risks having potential to impact on the achievement of the Trust's strategic objectives (alignment with the Board Assurance Framework). It supports the Trust in the evaluation and continual improvement of the effectiveness of its risk management and internal control processes. The plan is flexible to ensure it meets the Trust's assurance needs in respect of the changing risk environment in which it operates and provides the basis for the provision of a robust annual Head of Internal Audit Opinion to support the Trust's Annual Governance Statement.

The Trust's Audit Committee monitors the delivery of the Internal Audit Plan at each of its meetings. 360 Assurance attend all meetings of the Committee presenting a progress update on new and follow-up reviews, the key findings of each audit review undertaken, agreed recommendations and the associated Audit Opinion.
The Committee continues to maintain oversight of implementation of agreed internal audit actions at each meeting, with detailed scrutiny of slippages occurring at the relevant Board Committees. The annual reporting process identified differences across Committees in how this is done. Going forward, at each Committee there will be standing formal agenda items to review any outstanding medium or high risk internal audit action items. Summary reports are provided to the Board of Directors following each meeting with any identified issues of concern escalated as appropriate.

External audit
External audit services are provided by Pricewaterhouse Cooper. The contract started in June 2016 for a period of three years (+two years) with a value of £66k pa for the standard agreed service in 2018 (including the quality report).

At each meeting, the Committee receives a report from Pricewaterhouse Cooper, outlining progress and highlighting matters such as emergent national guidance and findings of national benchmarking reviews.

The Audit Committee received and supported the 2017/18 External Audit Plan in February 2018 based on a risk assessment undertaken by External Audit.

Counter fraud and security management
At each meeting, the Committee continues to receive and discuss a detailed report against plan, an overview of local fraud investigations, fraud warnings and intelligence bulletins.

One area of focus has been on prevention. In order to help ensure all new starters are familiar with Counter Fraud, work has been done to develop a new e-learning

package. The Committee also receives a tracker showing progress against recommendations, to help ensure lessons are learned.

Details of any political donations
Nottinghamshire Healthcare NHS Foundation Trust has made no Political donations during 2017/18.

Better Payment Practice code
The better payment practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is the later.

The Trust's performance against the code in 2017/18 has been calculated as follows:-

Measure of compliance	Number	£000s
Non NHS Payables		
Total non NHS trade invoices paid in the year	66,723	207,193
Total non NHS trade invoices paid within target	57,098	194,291
Percentage of non NHS trade invoices paid within target	86	94
NHS Payables		
Total NHS trade invoices paid in the year	2,220	13,739
Total NHS trade invoices paid within target	2,012	13,222
Percentage of NHS trade invoices paid within target	91	96

Where invoices are sent directly to the Accounts Payable department, the payment period is calculated from the date of the invoice, plus a buffer of 4 days to allow for the invoice to arrive at the Trust.
Where invoices have been sent directly to off-site locations, the payment period is calculated from the date the invoice is received within the Accounts Payable Department.
The Trust is signed up to the Prompt Payment Code and no interest was paid under the Late Payment of Commercial Debts (Interest) Act during the 2017/18 financial year.

Income disclosures
The Trust's main source of income is received from local Clinical Commissioning Groups, NHS England and Local Authorities. The requirement that the Trust's income from the provision of goods and services for the purpose of the health service in England must be greater than income from the provision of goods and services for any other purposes has been met. The majority of the Trust income is

received for the provision of healthcare. In relation to non-healthcare services the intention is to at least recover all costs ensuring there is no detrimental impact on the provision of goods and services for the purpose of the health services in England.

Compliance with cost allocation and charging guidance
The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

NHS Improvement's well led framework
Foundation Trusts are required to undertake a Well-Led Governance Review every three years. The Trust commissioned a well-led review which was undertaken between September and October 2017. This commenced with a self-assessment against the ten questions set out under the four domains of the well-led review. The reviewers undertook extensive visits, document review and observations and interviews with a range of directors, commissioners, service users and staff. This review determined that the Trust had conducted an accurate self-assessment and set out nine developmental recommendations to assist the Trust in further developing its leadership. The Board of Directors has remained sighted on progress in implementing the recommendations. The high level findings from the review were:

- The Trust operates with a relatively mature and effective model of devolved leadership and management. Service teams are empowered and supported to lead and make decisions in the best interests of delivering high quality, sustainable services.
- The Board has a good mix of skills and experience. Board meetings function effectively, and sub-committees are leveraged to provide scrutiny and obtain assurance over performance, risk and delivery of plans.
- The Trust has a clear vision, set of values and credible strategy. The strategy and values are well understood and resonate with the staff at Divisional and Directorate levels.
- The culture of the Trust is open and supportive. Staff PwC met consider the Trust leadership approachable and to have the best intentions for patients, service users and staff
- Trust and Divisional leadership have a clear understanding of service performance and challenges. More consistent focus on taking action to address risks should be considered.
- Governance, risk and quality is prioritised and actively engaged in. More systematic reporting from Directorates, recording and monitoring actions would further strengthen its impact.
- The Board is well sighted on risks and risk management is a core focus of Divisional and Service governance. Risk reports should be developed further to provide more detail on mitigation and how this is assured
- The Trust is patient centred and prides itself on high levels of engagement with those who use the services. This supports a culture of learning and improvement, with the Trust clearly focused on quality improvement.
- The supportive culture at the Trust and investment in leadership development needs to be balanced with the need for rigorous and consistent performance management.

Entity Information
Nottinghamshire Healthcare NHS Foundation Trust is a Public Benefit Corporation established in accordance with the National Health Service Act 2006 as amended by the Health & Social Care Act 2012.
The entity is based in and wholly operates in England with its registered office being located at The Resource, Duncan Macmillan House, Porchester Road, Nottingham, NG3 6AA.

Disclosure to auditors
Each director of the Board of Directors has confirmed that:

- So far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware and
- They have taken all the steps they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information

COUNCIL OF GOVERNORS
Composition of the Council of Governors

Constituency	Sub-Constituency	Elected / Appointed	Number of Governors	Number of Members*
Public, Patient, Service User & Carer	Nottingham City	Elected	6	2,218
	Nottinghamshire County		11	4,742
	South Yorkshire and the Rest of the East Midlands		2	1,790
	Rest of England & Wales		2	622
Sub Total			**21**	**9,372**
Staff	Nursing	Elected	2	2,631
	Allied Health Professionals		2	1,300
	Clinical Support		2	2,315
	Medical		1	240
	Non-Clinical Support		1	2,245
Sub Total			**8**	**8,731**
Partners		Appointed	8	
Sub Total			**8**	
TOTAL			**37**	**18,103**

*Membership figures are subject to ongoing changes and are therefore indicative

Duties and Responsibilities of the Council of Governors
The Council of Governors forms an important and integral element of the Trust`s governance structure, having two statutory general duties, these being:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

- To represent the interests of the members of the Trust as a whole and the interests of the public

Matters reserved for the Council`s decision and set out within the Trust`s Constitution are:

- The appointment and removal of the Trust`s Chair and Non-Executive Directors
- Determination of the terms of service, remuneration and other allowances of the Trust`s Chair and Non-Executive Directors
- To approve the appointment of the Chief Executive (other than the initial Chief Executive of the NHS Foundation Trust)
- To approve amendments to the Trust`s NHS Foundation Trust Constitution
- The appointment and removal of the Trust`s external auditor
- To provide views to the Board of Directors on the strategic direction of the Trust and targets for the Trust`s performance and in monitoring the Trust`s performance in achieving those strategic aims and targets
- To hold the Board of Directors to account in relation to the Trust`s performance
- To give the views of the Council of Governors to the Directors for the purpose of the preparation of the Forward Plan
- To consider and give/withhold approval for applications for a merger, acquisition, separation or dissolution
- To consider and give/withhold approval for the Trust to enter into a Significant Transaction (as defined within the Constitution)
- To be presented with the Trust`s annual accounts, any report of the auditor on them and the annual report
- To consider resolutions to remove a Governor
- To respond as appropriate when consulted by the Directors
- To exercise other functions at the request of the Directors

Activity of the Council of Governors
During 2017/18 key activities of the Council of Governors and Governors have included:

- awareness and knowledge enhancement of Governors
- gaining assurance and enhanced understanding with regard to the Trust`s performance (activity, quality and financial), strategy and processes
- raising assurance questions and concerns
- review of Chair and Non-Executive remuneration and terms of service
- Non-Executive Director appointments and re-appointments
- Sustainability and Transformation Partnerships overview and consultations
- constitutional amendments
- consideration of the Annual Audit Letter
- consideration of the Annual Plan
- attendance as observers at meetings of the Board of Directors and Board Committees
- presentation by the Lead Governor at the 2016/17 Annual General meeting / Annual Members Meeting

- identification of an internal indicator to be audited
- participation in ward and service area visits with Non-Executive Directors
- attendance at national networks and conferences
- membership engagement

Arrangements for the resolution of disagreements between the Council of Governors and Board of Directors

The Board of Directors and Council of Governors seek to ensure a successful and constructive relationship focused on realising the Trust`s ambition of providing high quality sustainable services. Both the Board and the Council are committed to developing and maintaining a constructive and positive relationship.

It is recognised that disagreements and differences of opinion may arise between the Board of Directors and the Council of Governors. The aim at all times is to resolve any potential or actual differences of opinion in a timely manner through discussion and negotiation without resorting to formal dispute resolution processes.

The Trust`s Constitution (annex 8, section 8) sets out the dispute resolution process by which disagreements between the Council of Governors and Board of Directors will be addressed. During 2017/18 none of these processes were required.

Council of Governors and supporting structure

The Council of Governors performs its role and responsibilities through general meetings of the Council, monthly accountability and development meetings, participation in service area visits and observations at the Board of Directors and related sub committees.

In 2017/18 the Council held 4 meetings, these held in April, July and October 2017 and January 2018. In addition the Trust`s Annual General Meeting / Annual Members Meeting was held in July 2017.

The Council of Governors is supported by a Steering Group formed of the Lead and Deputy Lead Governors, the Chair, Vice Chair, Trust Secretary and the Governor Support and Development Officer. The Steering Group takes responsibility for setting and agreeing the agenda of the formal Council of Governors meetings.

The Council of Governors Nomination & Remuneration Committee is responsible for reviewing and making recommendations to the Council of Governors with regard to Chair and Non-Executive Director terms of service, remuneration and appointments. The Committee is chaired by the Lead Governor and has a membership consisting of the Deputy Lead Governor and 4 additional Governors with relative skills and experience.

During 2017/18 the Council of Governors has not exercised its power under paragraph 10C of schedule 7 of the NHS Act 2006 to require one or more of the Directors of the Trust to attend a meeting of the Governors for the purpose of obtaining information about the Foundation Trust`s performance of its functions or the Director`s performance of their duties.

In November 2017 an Annual Review was carried out to test the effectiveness of the Council of Governors and to identify any development needs of individual Governors. The review specifically sought to assure that all governors were equipped to carry

out their statutory duties. The final report identified areas of development for the Council of Governors.

Governor and Member engagement
The Council of Governors have a statutory duty to represent the views of the membership and the wider public on key issues relating to the Trust's forward plans, its objectives, priorities and strategy. During 2017/18 Governors have continued to hold the Trust to account on its priorities through the monthly accountability sessions and its formal Council meetings. Governors have had the opportunity to join in focus sessions with the Care Quality Commission as part of the Well-Led Review, and support the "Developing Our People And Culture Together" (DOPACT) programme. Governors have taken the opportunity to engage with their constituents by:

- Attending consultation events
- Attending local Trust Annual Members' Meeting/Annual General Meeting
- Members attending the Council of Governors meeting
- Membership of the local Citizenship Board
- Contact from members via the Trust website

The Trust will continue to seek to further enhance the processes by which the Council of Governors is engaged and supports the development of the Trust's future plans, ensuring that all stakeholders have an opportunity to contribute.

Lead / Deputy Lead Governor
The Lead Governor is supported in this role by the Deputy Lead Governor. The Council of Governors agreed the process by which the Lead Governor and Deputy Lead Governor were elected, these positions held in 2017/18 as follows:

Position	Post holder	Dates	
		From	To
Lead Governor	Jenny Britten[1]	01/03/2017	To date
Deputy Lead Governor	Suzanne Foulk[2]	15/07/2016	23/05/2017
Deputy Lead Governor	John Collins	02/06/2017	To date

[1] Re-elected as Lead Governor
[2] Stood down due to retirement

Governor Members 2017/18
In December 2017 the Trust undertook an election to fill 10 vacancies on the Council of Governors. The vacancies had arisen from a combination of Governors reaching the close of their term of office and standing down due to personal reasons. Electoral Reform Services led the election process which concluded in February 2018. All seats except one were contested; only one nomination was received for South Yorkshire and the rest of the East Midlands Constituency.

The following Governors served on the Council of Governors in 2017/18:

Governor Members 2017/18
The following Governors served on the Council of Governors in 2017/18:

Constituency	Sub-Constituency	Governor	Elected / Appointed	Term of Office		Formal Meetings attended (2017/18) whilst in office
				From	To	
Public, Patient, Service User & Carer	Nottingham City	Jenny Britten (Lead Governor)	Elected	1 March 2017	29 February 2020	4 out of 4
		Bettina Wallace		1 March 2017	29 February 2020	4 out of 4
		David Cracknell		1 March 2017	28 February 2018	3 out of 4
		Jane Stevenson		1 March 2017	28 February 2018	0 out of 4
		Rebecca Cassidy		1 March 2018	28 February 2021	0 out of 0
		Lorna Marshall		1 March 2018	28 February 2021	0 out of 0
		Rebecca Chellaswamy		1 March 2017	3 September 2017	0 out of 2
		Julie Jackson		1 March 2015	28 February 2018	3 out of 4
	Nottinghamshire County	Steve How*	Elected	1 March 2018	28 February 2021	3 out of 4
		Derek Brown**		1 January 2016	28 February 2019	3 out of 4
		Maxine Robinson**		1 January 2016	28 February 2018	2 out of 4
		Mike Holmes**		1 January 2016	28 February 2018	3 out of 4

Constituency	Sub-Constituency	Governor	Elected / Appointed	Term of Office		Formal Meetings attended (2017/18) whilst in office
		Linda Bennett		1 March 2017	29 February 2020	2 out of 4
		John Collins (Deputy Lead Governor)		1 March 2017	29 February 2020	4 out of 4
		John Ferris		1 March 2017	28 February 2019	2 out of 4
		Paul Radin		1 March 2017	28 February 2019	3 out of 4
		Tad Jones		1 March 2018	28 February 2021	0 out of 0
		Susan Kernahan		1 March 2018	28 February 2021	0 out of 0
		Teresita Martin-Browning		1 March 2018	28 February 2021	0 out of 0
		Sharon Cook		1 March 2015	28 February 2018	0 out of 4
		Carol Burkitt		1 March 2015	28 February 2018	1 out of 4
		Anita Astle		1 March 2015	28 February 2018	3 out of 4
	South Yorkshire and the Rest of the East Midlands	Pam Beech	Elected	1 March 2018	28 February 2021	0 out of 0
		Keith Sykes		1 March 2015	28 November 2017	1 out of 3
		Judith Walker		1 March 2015	28 February 2018	2 out of 4

Constituency	Sub-Constituency	Governor	Elected / Appointed	Term of Office		Formal Meetings attended (2017/18) whilst in office
	The Rest of England and Wales	George Allerton-Ross	Elected	12 June 2017	11 June 2019	2 out of 3
		Gbenga Shadare		1 March 2018	28 February 2021	0 out of 0
		Sheena Foster		1 March 2015	28 February 2018	2 out of 4
Staff	Nursing	Craig Goffin	Elected	1 March 2017	29 February 2020	2 out of 4
		Steven Kerry		1 March 2017	29 February 2020	1 out of 4
		Nichola Mistry		1 March 2017	22 June 2017	0 out of 1
	Allied Health Professionals	Susan Baker	Elected	1 June 2017	31 May 2019	1 out of 3
		Mike Marriott		1 March 2017	29 February 2020	1 out of 4
		Suzanne Foulk		1 March 2015	24 May 2017	1 out of 1
	Clinical Support	Corrine Hendy	Elected	1 March 2017	29 February 2020	3 out of 4
		David McCallin		1 March 2017	28 February 2019	2 out of 4
	Medical	Stuart Leask	Elected	1 March 2017	28 February 2019	4 out of 4
	Non-Clinical Support	Tony Bradstock*	Elected	1 March 2018	29 February 2020	3 out of 4

Constituency	Sub-Constituency	Governor	Elected / Appointed	Term of Office		Formal Meetings attended (2017/18) whilst in office
Partners	3rd Sector – Carers Federation	Rob Gardiner***	Appointed	1 March 2015	28 February 2018	1 out of 4
	3rd Sector - Framework	VACANT***		N/A	N/A	N/A
	Nottingham Trent University	VACANT***		N/A	N/A	N/A
	Police & Crime Commissioner	Paddy Tipping***		1 March 2015	28 February 2018	2 out of 4
	Chamber of Commerce	Lucy Robinson		1 January 2016	31 December 2018	0 out of 4
	Nottinghamshire County Council	Cllr Stuart Wallace		14 June 2017	13 June 2020	2 out of 3
	Nottingham City Council 3rd Sector Organisation	Imogeen Denton		1 January 2016	31 December 2018	1 out of 4
		VACANT***		N/A	N/A	N/A
	3rd Sector – Carers Federation	Rob Gardiner***		1 March 2015	28 February 2018	1 out of 4
	Nottingham Trent University	Di Bailey		1 March 2017	31 October 2017	2 out of 3
	Nottinghamshire County Council	Cllr Muriel Wiesz		1 March 2015	13 June 2017	0 out of 1

*Re-elected in the most recent election

**Terms of office have been extended to align the election process and reduce unnecessary costs to the trust. This was formally supported by the Council of Governors at its January 2018 meeting

***The Trust is currently reviewing its complement of partner governors and has invited those whose term of office has expired to remain for a further 6 months until the process has been finalised and formally approved.

Membership Eligibility Criteria and Constituencies

Public, Patient, Service User & Carer membership

Trust membership is open to any individual aged 12 or over who lives in England or Wales. There are four public membership geographical constituencies: Nottingham City, Nottinghamshire County, South Yorkshire and the Rest of the East Midlands, and the Rest of England and Wales.

Criteria which prevent an individual becoming a member or retaining membership of the Trust are set out within the Trust's Constitution. Any public member wishing to stand for election as a Governor must be aged 16 or over.

Trust staff membership

Staff who meet the criteria below* are automatically enrolled as members of the relevant staff constituency on appointment. All staff members have the right to opt-out of membership at any time and information about this can be found in the staff handbook on Connect, the Trust intranet site.

*A person who is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months or has been continuously employed by the Trust under a contract of employment for at least 12 months. A staff member will be a member of the relevant staff constituency dependent on the role undertaken (Medical, Nursing, Allied Health Professional, Clinical Support and Non-clinical Support). A member of staff cannot be a member of more than one sub-constituency or be a member of a Public, Patient, Service User & Carer and Staff Constituency.

Membership Strategy and Engagement

The Trust's Membership Strategy sets out four key objectives around recruitment, communication, engagement and support to the Council of Governors. An update on progress on implementation of the strategy is reported annually to the Annual Members' Meeting/Annual General Meeting, providing an overview of the overall membership, activity undertaken and opportunities provided for the active engagement of members. Following a consultation with our members, the Trust Membership Strategy was refreshed and updated for 2017-2020.

The importance of membership engagement is an integral element of the Trust's overall approach to involvement and engagement. It is recognised that there are various levels at which members wish to engage e.g. receiving information about the Trust, its services and developments; being offered the opportunity to be engaged on an ad hoc basis on issues of interest or being actively engaged on an ongoing basis. The Trust's strategic approach seeks to ensure these levels of engagement are accommodated.

We seek to ensure a representative (reflecting geographies, services and demographic diversity) and appropriately engaged membership which adds value in terms of informing the development and provision of high quality services. A database is maintained and is used to analyse representativeness of the Trust's membership to focus recruitment (although there are no set targets for membership

recruitment we aim to have a greater public membership base than staff and to focus on an engaged membership).

The Trust plans to improve links with third sector organisations and local communities to improve engagement and membership representation based on demographics of our communities and the Trust membership. A working group 'working with and engaging our communities' includes the Head of Equality and Diversity, Director of HR, and the Head of Involvement. The main aim is to have a more strategic and co-ordinated approach to engaging communities. This group meets bi-monthly and reports back to the Quality Committee.

A monthly e-bulletin is sent to all members by email (and is available via the Trust's website). The bulletin details a wide range of both internal and external engagement opportunities together with information about the Trust and its developments. In addition, targeted opportunities are notified by email to specific elements of the membership according to their specified interests and preferences. The Trust website provides details of how members and the public can become involved and engaged with the Trust, access to the Trust's Positive magazine and how people can take up membership of the Trust. As well as following the Trust on social media, members can read the Trust blog and Involvement blog.

We have two active Involvement Centres that engage service user, carer and volunteer members in a wide range of activities. The Involvement Centres play a key role in supporting people to work with the organisation. We have developed our approach and strategy over a number of years and are proud of our approach which has won national awards and international interest. The involvement centres support people to get involved in services and provide staff across the Trust with space to work with service users, carers and volunteers on co-production and decision making**.** The centres provide a focal point for volunteers to be part of wider community of volunteers across the Trust. This has included participation in service development groups, Trust induction and training, staff recruitment, Patient-Led Assessments of the Care Environment (PLACE) audits, collecting feedback, projects such as the Ideal Ward Round and Ideal Waiting Room projects.

Members are also involved though the Nottingham Recovery College, accessing a range of courses.

Contact Information
Trust Members can contact Governors either via the Governor Support Office (Becky.cassidy@nottshc.nhs.uk) or the Membership Office membership@nottshc.nhs.uk

There is also a dedicated email address for Governors (governors@nottshc.nhs.uk) and a membership free phone number: 0800 012 1623.

Staff members can make contact with their relevant Staff Governor via Connect, the Trust intranet site.

Information about Trust Governors and the constituencies they represent can be found on the Trust website. Members can also follow the Trust and Governors on

Social Media including Twitter @InvolveT1 @NottsHCGovernors and Facebook @nottinghamshirehealthcare.

Significant partnerships

Sustainability and Transformation Partnerships

The Trust continues to operate within two STP footprints, these being:

- Nottingham & Nottinghamshire
- South Yorkshire & Bassetlaw.

The most significant of these for the Trust portfolio is Nottingham & Nottinghamshire. Greater Nottingham has been identified as an accelerated Integrated Care System and the Trust is working to support the development of the emerging ICS approach across the STP footprint. The Trust is leading in promoting and developing mental health services across the footprint through the development of a system wide mental health strategy.

As the largest provider of community and mental health services in Nottingham and Nottinghamshire, the Trust continues to play a key role in working towards the STP's vision and in developing and responding to the system's 'out of hospital' model of care. In order to help manage demand the Trust is working collaboratively with acute and primary care partners, including supporting the work being conducted by Centene to inform and highlight system wide efficiency opportunities and ongoing improvement.

New Models of Care and Vanguard Programmes

In March 2015, the Trust entered into an Alliance Agreement with health and social care partners across Mansfield, Ashfield, Newark and Sherwood to enable more integrated care to be delivered to meet the population needs and target resources more effectively. In addition to this, during 2017 the Trust has been working in partnership with Rushcliffe Principia Multi-Speciality Community Provider (MCP) to develop an agreement to establish closer working relationships and delivery of locality specific services across Greater Nottinghamshire.

The Trust has continued to develop our partnership working with the Mid-Notts Alliance throughout the last year. This has consisted of our organisations working together to establish new ways of working and develop new models of care to improve patient care and experience whilst maximising system efficiency. 2017/18 has seen the Alliance focus upon a number of areas but specifically in regards to system wide and significant redesign of musculoskeletal (MSK) services. The Trust has continued to be engaged as one of the provider organisations within the Alliance, to develop a new MSK pathway in order to deliver a more effective and efficient model. This work is ongoing and will remain a key part of Alliance activity during 2018/19.

This activity is in addition to a continuing focus across the Trust in aligning internal resources to better regulate capacity and demand.

Rushcliffe Principia Multi-speciality Community Provider (MCP)
The MCP in Rushcliffe is one of the national vanguard sites for new models of care (as set out in the Five Year Forward View). The Trust is an active partner in the MCP development and during 2017/18 has played a key role in the successful delivery of the new clinical models programme and the development of the MCP governance and delivery structures. To support ongoing review of the wide range of services introduced as part of the MCP an evaluation was undertaken in 2017 to identify further improvements and provide system wide learning from the success of these approaches.

In addition we have established strong provider to provider relationships with primary care and in particular the GP provider organisation Partners Health and will continue to build on these.

Transforming Care in Bassetlaw
As part of our transformation, the Trust's Bassetlaw Together Programme has continued its work to design and implement a new model of integrated mental and physical health care. A key deliverable of this programme will be to integrate mental and physical health care provisions. It is anticipated that each of these developments will be delivered in a phased approach from April 2018.

Service Delivery
In addition to system wide partnership work that the Trust has been engaged in over the last year, we also continue to deliver services in partnership with other specialist providers, with the Trust either working as a sub-contractor or having sub-contracts in place with other organisations. The nature of the lead organisation is always defined by the service type in order to offer integrated pathways in the most efficient manner.

Intellectual Development Disabilities
During 2017 the Trust has worked with the Transforming Care Partnerships (TCP) to develop community services in order to reduce avoidable admissions, improve in-patient flow whilst responding to commissioner intensions to reduce the number of beds across all providers. The trust has implemented a number of developments including:

- Orion Unit building works commenced to reduce bed numbers by 1, to provide additional segregation/seclusion accommodation
- Implementation of Intensive Community Assessment and Treatment Team (ICAT) pilot offering a more proactive and preventative approach.

Work will continue into 2018/19 to further improve service provision.

Children, Young People & family services
Working in partnership with Family Action and North Notts College, the Trust won the contract to deliver the new 'Healthy Families Programme'. This programme began mobilisation in 2017 and involved significant service redesign and workforce development. There will be an ongoing focus on embedding the healthy families programme and bringing together CAMHS and healthy family practitioners to embed mental health interventions into all areas of family development.

Information technology
The Trust has worked in partnership with other national and local health and social care providers to improve information sharing and the quality of information to improve patient care, experience and clinical outcomes. The Trust has been working collaboratively as part of 'Connected Notts' in developing a local digital road map. This includes working closely with primary care partners to refine and increase the availability of information to facilitate earlier intervention and reduce avoidable admissions. Further digitalisation of patient records has been undertaken to increase accessibility of patient level information including improving the information recording process to increase data quality.

Patient and carer Engagement
During 2017, the Trust created a short film in partnership with carers, about Rampton Hospital. This has been developed to help families and friends of patients being cared for at Rampton Hospital to understand more about the Hospital and the high secure environment. It also shows the treatment and therapies available and how to keep in touch with and visit patients. The film has received positive feedback and is going some way to demystifying the work of the Hospital and break down the stigma that is often associated with high secure care. This has contributed to the Trust achieving stage two of the Triangle of Care, which is an initiative to promote collaborative working with carers.

Collaborative Service Change
To maximise our partnership working and engagement, the Trust has been developing a Collective Service Change model. This is designed to encourage partnership working with system providers, GPs and patient/carer groups around how we implement and deliver service change. The work has been designed as part of a collaborative programme with The Kings Fund and our patients. The programme is still in development and will be rolled out in 2018/19.

Complaints handling
The Trust remains committed to improving overall patient experience and aims to resolve all complaints swiftly. Complaints are issues that need investigating and require a formal response from the Trust. The complainant is kept informed of progress throughout the process and will receive a comprehensive written response including being informed of any actions taken. Informal concerns can be resolved locally and require a less formal response; this can be with input from the Patient Experience team and/or the service involved. However written feedback detailing the steps that have been taken to resolve the complaint, the outcome and any learning points are recorded.

A total of 822 complaints were received across the Trust in 2017/18. This is a reduction of 6% on 2016/17 despite a change in reporting that resulted in an increase in complaints for the general health services within the Local Partnerships division.

The table below provides the data for the clinical divisions.

Division	Number of Complaints Received in 2017/18	Number of Complaints Received in 2016/17	Number of Complaints Closed in 2017/18 Upheld	Number of Complaints Closed in 2017/18 Upheld in Part	Number of Complaints Referred to the Ombudsman
Local Partnerships – Mental Health	220	299	19	126	4
Local Partnerships – General Health	87	54	5	18	1
Forensic Services	517	523	79	51	13
Trust wide Total	**824**	**876**	**103**	**195**	**18**

The Trust implements improvements to patient care when issues have been identified through the investigation of complaints and concerns, examples of measures taken over the past year include enhanced information to patients and carers about services and improved appointment arrangements. In addition the Trust encourages further feedback by subscribing to 'Care Opinion' which is a feedback platform for health and social care services. This is a publically accessible website that allows patients, service users and carers to share their experiences of our services. Posts are responded to by senior staff within two working days.

Service Improvements from Feedback

The aim is to listen to our patients, service users and carers in meaningful, comprehensive and varied ways. To use the information we receive intelligently and with understanding so we respond honestly and make changes that improve people's health and wellbeing.

The Trust is committed to both listening and responding to feedback. There is a range of ways that we capture feedback including a Trust wide survey, active promotion of the online feedback site, Care Opinion, as well as a range of patient and carer forums. All the feedback we receive from surveys and Care Opinion is visible online at feedback.nottinghamshirehealthcare.nhs.uk/ . All the survey comments are analysed so that the key issues people are raising can be seen for each service. The Trust has a number of mechanisms in place to ensure that feedback is responded to.

Each month we produce a Patient Voice report for the Board of Directors. This focuses on a particular Directorate and outlines all the key issues raised from feedback for that service. Each Directorate reports on the 3-5 main issues raised about their services and details what action they are planning to take. Updates on progress made are provided to the Board after three months and one year.

Changes made in the last year as a result of feedback, include improvements to the physical environment, amended visiting times, improved access to dental services and increased activities for patients. Also, the stories posted on Care Opinion have led to 21 changes and a further 11 planned/intended changes are currently in progress.

Information for Patients
We set out to use the most effective methods and technologies including our website and social media to reach out to and engage with our service users, carers, members and communities.

During the year we have improved the information we share on the Trust website relating to opportunities for service users, carers and families to contribute their views and experiences in ways which help us to improve our services. This includes volunteering opportunities, as well as opportunities to support service redesign projects and to help us to collect feedback from service users and carers. We have also improved and updated the information we provide for carers on the Trust website as well as continuing to distribute our Guide to Carers and Confidentiality.

In addition the Involvement and Experience Team have been keeping people up to date with information and opportunities for involvement via their Twitter account, twitter.com/InvolveT1, and a blog, involvementvolunteeringexperience.wordpress.com/.

We also produce a monthly e-bulletin which goes out to our membership. This includes information about the Trust and opportunities for involvement in the Trust and the wider health community.

Information Governance Communication Materials – volunteers have been involved in providing feedback in how Information Governance is communicated to patients and carers which will be used when developing new materials.

Patient and Public Involvement
We have continued to work with patients, service users, carers, members and our communities in ways that enable us to truly listen and respond to them and to develop and shape services in partnership using both traditional and innovative approaches. A number of projects have been undertaken to bring about improvements to services and to involve people in reviews of our care through PLACE audits and CARe reviews.

Key activities include:

- Collaborative Service Change Project which began in May 2017. The aim was to develop how we work in partnership to improve services. With the support of the King's Fund, around 30 people got together to design a Collaborative Service Change model over 5 workshops. The group consisted of service users and carer volunteers, staff from Framework, Turning Point, County Council, and a number of staff from the Trust. The project ran until October 2017 and worked with Adult Mental Health Community Services and Respiratory Services in mid-Nottinghamshire. The model developed with participants has now been completed in the form of an infographic with principles and an easy to follow process. The project helped us to learn a lot about collaborative working including the value of dialogue addressing power dynamics and the importance of working in partnership from the start of any project.

- Families and young people have been involved in the design of the new Child and Adolescent and Perinatal unit which is due to open early summer 2018.
- The Trust was awarded its second gold star for its successful completion of phase 2 of the Triangle of Care. This is an initiative to promote collaboration between service users, professionals and carers. As a result many teams have improved how they work with carers.
- A series of films have been developed at Rampton Hospital to help families and friends of patients understand a bit more about the Hospital, the treatment and therapies available and how to keep in touch with and visit patients.
- Service user and carer volunteers have been involved in seven PLACE (Patient-Led Assessments of the Care Environment) assessments. These have been carried out at a number of sites including Highbury Hospital, Millbrook Mental Health Unit Centre, Queen's Medical Centre and Bracken House.
- The Ideal Ward Round recommendations have now been incorporated into an Adult Mental Health policy. This project looked at ward rounds or reviews in inpatient adult mental health settings. The policy and an online learning tool for staff are two of the outcomes, as well as a valuable learning around co-production and collaboration. The group continues to meet.
- Mental Health Services for Older People (MHSOP) have continued with the Worry Catcher service where patients and their families can discuss any worries or concerns they have about their care on Silver Birch and Cherry Wards. The Worry Catcher service has been of great benefit to the wards. The post is now going to be extended across all MHSOP wards.
- The 0-19 Healthy Family Teams have been working with young people attending North Notts College to develop an Important Health Information package to support the transition to adulthood. Further sessions are planned to incorporate the views of young people. We are in the process of developing the package to be able to give this out to young people leaving school in May 2018.
- Volunteers have been involved in 14 Compliance Assurance Reviews (CARe). These are cross-divisional assessments that check the various sites against the fundamental standards of quality and safety that are also monitored by CQC.

As we increasingly work as part of the Health and Social Care system the value of collaborative working with patients, service users, carers, members and our communities takes on a more significant role.

New or Significantly Revised Services

Mental Health Services
In 2017 the Trust initiated an adult mental health transformation programme in order to develop a more sustainable and viable model of inpatient care, including an assessment of current bed management processes and step-down capacity across the Trust. As a result of the review, the Trust implemented a number of initiatives, including commissioning an additional 20 beds from the Priory, a private sector provider to support short term demand management and reduce out of area

placements. Work has also commenced to review and improve 'flow' in in-patient care, including improving discharge processes and will continue throughout 2018/19.

In addition to work undertaken to improve in-patient services, the Trust has embedded new approaches to community mental health teams. During 2017 the Trust established Local Mental Health Teams across Mid-Nottinghamshire, Bassetlaw and Greater Nottinghamshire to further increase and improve mental health provision across the community. This was further developed to include community medical teams across Mid Nottinghamshire to facilitate joint working to deliver further integrated services through refined referral patterns.
This work has continued in the latter part of 2017/18 with the commencement of further transformation of our community service offer in response to commissioner intentions. This will see continued integration of our community mental and physical healthcare teams with wider system working with primary care and 3rd sector organisations. Mobilisation of new service provisions is due to commence in 2018//19.

The Trust is also continuing to work with commissioners to respond to the national plan, including ongoing identification of areas where extra funding is required to deliver against the Mental Health Five Year Forward View.

Children, Young People & Family services
Initiated in 2016 and continuing into 2017 the Trust has commissioned the building of a new campus style development, named as 'Hopewood'. The development is due to open in early summer of 2018 and will increase our Children and Adolescent Mental Health Services (CAMHS) inpatient services from 13 to 24 beds; as well as developing a new 8-bed Psychiatric Intensive Care Unit; a new Education Centre for CAMHS inpatients; and a new CAMHS community unit. It will also re-provide perinatal mental health inpatient beds, increasing the number of beds from 7 to 8.

End of Life
The Trust, working with system wide partners, has commenced a redesign of the End of Life pathway across Mid-Nottinghamshire, Rushcliffe and Greater Nottinghamshire. Work is underway to develop a seamless End of Life pathway which utilises current skills and expertise to support patient care and staff experience delivering compassion led services through existing Hospice at Home, Day Therapy and Bereavement services in each locality. The new pathways for End of Life which are being developed will be completed in 2018/19.

HMP Ranby
In 2017/18 the Trust successfully won the Integrated Healthcare Services for HMP Ranby. The contract will run for 3 years with a possible 2 x 1 year extension with a contract value of £3m per annum. The Trust will provide regular healthcare provision for all adult prisoners and will commence from April 2018.

Personality Disorder Service
The Trust was also successful in securing a new two year contract to deliver Offender Personality Disorder services at HMP Whatton and North Sea Camp. The service will offer specific services both within HMP sites and community outreach. The contract is due to commence from April 1st 2018.

Woodlands
In January 2018, the decision was made to not renew or extend the current service contracts for The Woodlands inpatient detoxification unit once the current contracts expire in 2018. The decision was based on consultation with staff and commissioners with consideration being given to the Trust's ability to provide a high quality, safe service within the contract values made available by commissioners. The Trust is working with commissioners to support transition to a new provider.

Ruth Hawkins
Chief Executive
24 May 2018

REMUNERATION REPORT

ANNUAL STATEMENT ON REMUNERATION FROM THE CHAIR OF THE NOMINATIONS AND REMUNERATION COMMITTEE

Senior Managers' remuneration relates to voting and non-voting Directors of the Board.

The Trust has two Nomination and Remuneration Committees. One is established by the Board of Directors and comprises Non-Executive Directors that oversee the nomination and remuneration of executive appointments and the composition of the Board of Directors. The second, established by the Council of Governors and formed of Governors, oversees the nomination and remuneration of Non-Executive Director appointments.

In line with other employees of the Trust, the Nominations and Remuneration Committee approved a 1% cost of living pay increase, for the financial year 2017/18, for the voting and non-voting Directors of the Board.

SENIOR MANAGERS' REMUNERATION POLICY

This policy applies to Employed and Non–Executive Directors of the Board. The current components of the remuneration packages for Employed Directors, includes:

- their salary - determined by market conditions and capability requirements;
- expenses (which are paid in accordance with Agenda for Change terms and conditions);
- an entitlement to be part of the NHS pension scheme.

For Non-Executives Directors the remuneration package includes:

- their salary- determined by market conditions and capability requirements;
- expenses- claimed in accordance with Agenda for Change terms and conditions or, where applicable, in accordance with the conditions set out by NHS Improvement (previously Trust Development Authority).

The table, below, summaries the component parts of the remuneration package:

	Employed Director	Non-Executive Director
Salary	Y	Y
Expenses	Y	Y
Pension	Y	N

The Medical Director received remuneration for a Clinical Excellence Award payment, this payment is detailed below.

EMPLOYED DIRECTORS OF THE BOARD

There are three component parts to the pay of employed Directors. These are; a salary payment, pension contribution and expenses and are detailed in the table below.

The salary for each of the employed directors is determined by the Nominations and Remuneration Committee, and the decisions regarding pay rates are informed by

benchmarking data, personal performance and the performance of the Trust as a whole. Personal performance is considered by the Committee following annual appraisals. National Agenda for Change pay awards are also considered.

The wider skills requirements of the Board are also considered as part of assessing remuneration, as it is important that there is sufficient capacity and capability in the short and long term to support the strategic objectives of the Trust. This is assessed alongside benchmarking data.

The maximum payable is determined by the market forces and the need of the business at that time. The current payments being made are consistent with those being paid to others in similar roles.

The pension element is paid in accordance with the NHS pension scheme contributions whereby the employee contributes either 13.5% or 14.5% (depending on salary) and the employer makes a 14% contribution.

Expense claims are paid in accordance with Agenda for Change terms and conditions. The maximum amounts that can be claimed are determined nationally and are set out in national terms and conditions.

The Medical Director, in accordance with National Terms and Conditions for Doctors and Dentists, can be awarded a payment via the Clinical Excellence Awards Scheme. The Medical Director is in receipt of an annual award of £14,933. Employed Directors of the Board are required to participate in the Trust's on-call arrangements; no additional remuneration is paid for this.

Where an Employed Director of the Trust is paid more than £150,000, the Trust has assured itself that this payment is reasonable and appropriate. Relevant benchmarking has been undertaken and labour market conditions have been reviewed and tested.

Increases in pay can be withheld where it is considered, through the annual appraisal process, that individual or Trust performance warrant this. These increases can also be withheld subject to affordability and the labour market conditions. There are no provisions for the recovery of sums paid to Directors.

Performance is considered as part of an annual appraisal cycle. Should a situation arise where performance is considered poor, then the principles of the Trust's Conduct and/or Capability Policy would be applied. In the case of the Medical Director, the Trust policy on Maintaining High Professional Standards would apply. In all cases of ill-health, the Trust's sickness absence policy would be applied. In all cases, alternative employment within the Trust and/or wider NHS would be considered, in accordance with the Trust's overall approach towards redeployment. There are no other or new components to the remuneration package. For Employed Directors pay is determined by the Nominations and Remunerations Committee in accordance with the Trust Policy and Procedure for Determining the Remuneration of Employed Directors. Other Trust employees are paid in accordance with NHS national terms and conditions, except where they have transferred into the Trust according to TUPE arrangements; retaining their former terms and conditions.

Wider Trust employees were not specifically consulted with in the development of the Policy and Procedure for Determining the Remuneration of Employed Directors. However, the policy was developed with full consideration of the terms and conditions of other staff groups in addition to national guidance.

The policy is aligned, in many ways, to the terms and conditions of other staff groups. In determining remuneration levels, benchmarking data from comparative organisations, was used to inform decisions taken by the Remunerations Committee. The policy is reviewed on a regular basis.

Components of remuneration packages

COMPONENTS OF THE REMUNERATION PACKAGE FOR SENIOR MANAGERS

	Salary	Pension	Expenses	Clinical Excellence Award
Description	Determined by Nominations and Remuneration Committee. Benchmarking data is used to inform the decision along with the skills requirements for the board.	Employer contribution 14% in accordance with the NHS pension scheme.	Paid in accordance with Agenda for Change terms and conditions.	Payment is only applicable to the Medical Director and is in accordance with the local and national scheme.
How the Component Supports the Short and Long Term Strategic Objectives of the Trust-	Ensuring recruitment and retention and board stability in the short and long term. Ability to attract and retain staff.	Ensuring recruitment and retention and Board stability in the short and long term. Ability to attract and retain staff.	Ensuring recruitment and retention and Board stability in the short and long term. Ability to attract and retain staff.	Ensuring recruitment and retention and Board stability in the short and long term. Ability to attract and retain staff.
Review Mechanism and Timeframe	Annually via annual appraisal and Nominations and Remuneration Committee.	Reviews are undertaken nationally as this is a nationally applicable scheme.	In line with any national change to terms and conditions.	In line with any national change to the clinical excellence award scheme.
Maximum and Minimum that can be paid	Reviewed annually according to performance of Trust, performance of individual, benchmarking data and skill requirements of the Board. The maximum and minimum amounts payable are reviewed annually. In circumstances where poor performance is identified, this is managed in accordance with the Trust's policies for conduct and capability. In the case of the Medical Director it is the policy for Maintaining High Professional Standards.	N/A	N/A	Determined by local and national policy.

Non-Executive Directors

The pay for Non-Executive Directors is determined by representatives of the Council of Governors who make up the Nominations and Remunerations Committee. The remuneration is made up of their pay for their duties, with an additional responsibility payment being made to the Senior Independent Director, Vice Chair and the Chair of Audit Committee. These individuals are identified in the table below. As Non-Executive Directors are not employees they do not pay contributions or receive pension payments. They are entitled to claim expenses payments in accordance with Agenda for Change Terms and Conditions or where applicable in accordance with the conditions set out previously by the Trust Development Authority. No other fees are paid to Non- Executive Directors for their duties with the Foundation Trust.

Consideration as to the skills requirements of the Board are also made as part of assessing the remuneration and terms of office, as it is important that there is sufficient capacity and capability in the short and long term to support the strategic objectives of the Trust. This is assessed along with the benchmarking data. The maximum that would be payable would be determined by the market factors and the needs of the business at that time. The current payments being made are consistent with those being paid to others in similar roles.

Normally Non-Executive Directors would fulfil their current term of office, if however this is not possible one month's notice is required.

Non-Executive Directors' Appointments and Terms of Office

The initial term of office of Non-Executive Directors is 3 years with an option for a further 3 year term providing for a maximum term of office of 6 years. At the conclusion of the 6 year period, a Non-Executive Director may be reappointed for an additional 1 year term subject to exceptional circumstances being deemed by the Council of Governors to apply.

The Council of Governors has approved the process by which terms of office will be reviewed and appropriately extended going forwards. Factors to be taken into account are:

- the Non-Executive Director wishing to continue in their role
- a good/outstanding appraisal outcome
- guidance in force at the time of the consideration
- the reappointment being considered to be in the Trust`s best interests

All Chair and Non-Executive Director appointments including re-appointments require Council of Governor approval. Non-Executive Director terms of office may be terminated by the Council of Governors in accordance with the provisions of the Trust's Constitution.

Non-Executive appointments:

During 2017/18 the Council of Governors appointed one Non-Executive Director to the Board of Directors in accordance with an agreed recruitment and appointments process established by the Council of Governors. This position was the subject of open-advertising and a competitive recruitment process.

Service contract obligations
There is no obligation to pay any entitlements for loss of office under these contracts with the exception of statutory entitlements, (should they apply), for redundancy and notice periods.
Employed Directors of the Board are required to give and receive six months' notice of termination of employment. Redundancy payments are calculated in accordance with Agenda for Change Terms and Conditions, and those for Medical and Dental staff in the case of the Medical Director.
The notice period has been determined to allow for changes in senior managers to be managed and for vacant positions to be recruited to, ensuring the stability and continuity of the Board of Directors and the Trust.

Annual report on remuneration

This section of the remuneration report includes some elements that are subject to audit.

Information not subject to audit
Employed Directors are on permanent service contracts; the notice period, for termination, is 6 months.

Director	Job Title	Start date
Ruth Hawkins	Chief Executive	November 2014
Julie Attfield	Executive Director of Nursing	June 2016
Simon Crowther	Executive Director of Finance	March 2015
Julie Hankin	Executive Medical Director	November 2014
Peter Wright	Executive Director Forensic Services	October 2016
Paul Smeeton	Executive Director Local Partnerships	October 2016
Angela Potter	Director of Business Development and Marketing – Non-voting	December 2011
Clare Teeney	Director of Human Resources - Non-voting	November 2015

Service terms and conditions for Non-Executive Directors are shown above.
Notice period for Non-Executive Directors is 1 month.

Name	Position	Comment	End Date of Current Term of Office
Dean Fathers	Chair		31 December 2019
Sheila Wright	Non-Executive Director Vice Chair		28 February 2019
Peter Parsons	Non-Executive Director Senior Independent Director		31 January 2019
Steve Banks	Non-Executive Director		31 January 2019
Patrick Callaghan	Non-Executive Director	End Date: 30 June 2017	

Name	Position	Comment	End Date of Current Term of Office
Stephen Jackson	Non-Executive Director		17 July 2019
Christine Lovett	Non-Executive Director Chair of Audit Committee		28 February 2019
Di Bailey	Non-Executive Director	From: 1 November 2017	31 October 2020

Nominations and Remuneration Committee

The Nominations and Remuneration Committee met on 4 occasions in 2017/18. Its membership and attendance is listed below:

Name	Position	Meetings attended in report period	% Attendance
Dean Fathers	Chair	4 of 4	100%
Sheila Wright	Non-Executive Director – Vice Chair	3 of 4	75%
Peter Parsons	Non-Executive Director	3 of 4	75%
Patrick Callaghan	Non-Executive Director (until 30/06/17)	1 of 1	100%
Steve Banks	Non-Executive Director	3 of 4	75%
Christine Lovett	Non-Executive Director	4 of 4	100%
Di Bailey	Non-Executive Director (From 01/11/17)	0 of 1	0%
Stephen Jackson	Non-Executive Director	4 of 4	100%

Overall attendance in 2017/18: 85%

Governors' Expenses 2017/18 & 2016/17

Total number of Governors in office during 2017/18 was 45 of which 6 received expenses.

Total number of Governors in office during 2016/17 was 49 of which 8 received expenses.

Name	Constituency	Total 2017/18 (£00)	Total 2016/17 (£00)
Jenny Britten	Public, Patient, Service User and Carer	1	1
Sheena Foster	Public, Patient, Service User and Carer	7	14
John Collins	Public, Patient, Service User and Carer	4	1
Derek Brown	Public, Patient, Service User and Carer	1	1
George Ross	Public, Patient, Service User and Carer	10	-
Tony Bradstock	Staff	1	-
Maxine Robinson	Public, Patient, Service User and Carer	-	1
Judith Walker	Public, Patient, Service User and Carer	-	2

Sue Clayton	Public, Patient, Service User and Carer	-	1
Sue Clifford	Public, Patient, Service User and Carer	-	1
Grand Total		24	22

A register is maintained of the declared interest of Governors and can be found on the Trust website by visiting www.nottinghamshirehealthcare.nhs.uk/meet-your-governors

Directors Expenses 2017/18 & 2016/17

Total number of Directors in office during 2017/18 was 16 of which 13 received expenses.

Total number of Directors in office during 2016/17 was 20 of which 17 received expenses.

Name	Total 2017/18 (£00)	Total 2016/17 (£00)
Julie Attfield	25	19
Simon Crowther	4	4
Dean Fathers	35	36
Julie Hankin	12	12
Ruth Hawkins	14	13
Stephen Jackson	7	5
Christine Lovett	6	6
Peter Parsons	27	31
Angela Potter	15	14
Paul Smeeton	10	20
Clare Teeney	3	4
Peter Wright	24	10
Sheila Wright	10	15
Jane Warder	-	3
Simon Smith	-	6
Dean Howells	-	1
Christopher Clark	-	6
Grand Total	192	205

Information subject to audit

Salary and pension entitlements of senior managers

A) Remuneration

2017/18 **Name and title**	Salary (Bands of £5000)	Expense payments (taxable) Total to nearest £100	Performance pay and bonuses (bands of £5000)	Long term performance pay and bonus (Bands of £5000)	All Pension related benefits (bands of £2500)	Total (Bands of £5000)
RE HAWKINS - Chief Executive	180 - 185	0	0	0	25 - 27.5	205 - 210
S CROWTHER - Executive Director of Finance	125 - 130	600	0	0	85 - 87.5	210 - 215
P SMEETON - Executive Director Local Partnerships	125 - 130	0	0	0	122.5 - 125	245 - 250
DH FATHERS - Chair	45 - 50	0	0	0	0	45 - 50
J ATTFIELD (formerly HALL) - Executive Director of Nursing	110 - 115	0	0	0	0	110 - 115
J HANKIN - Executive Medical Director	150 - 155	0	0	0	32.5 - 35	185 - 190
A POTTER - Non Voting Director of Business Development & Marketing	100 - 105	0	0	0	92.5 - 95	195 - 200
C TEENEY - Non Voting Director of Human Resources	95 - 100	3,200	0	0	22.5 - 25	120 - 125
P CALLAGHAN – Non-Executive Director (left 30 June 17)	0 - 5	0	0	0	0	0 - 5
S BANKS – Non-Executive Director	10 - 15	0	0	0	0	10 - 15
S WRIGHT – Non-Executive Director	15 - 20	0	0	0	0	15 - 20
CP LOVETT – Non-Executive Director	15 - 20	0	0	0	0	15 - 20
P PARSONS – Non-Executive Director	15 - 20	0	0	0	0	15 - 20
JS JACKSON – Non-Executive Director	10 - 15	0	0	0	0	10 - 15
P WRIGHT - Executive Director Forensic Services	110 - 115	0	0	0	25 - 27.5	135 - 140
D BAILEY – Non-Executive Director (joined 1 November 17)	5 - 10	0	0	0	0	5 - 10
TOTAL	1140 - 1145	3,800	0	0	412.5 – 415	1560-1565

Expense payments

All payments are taken from P11’d information and are in respect of lease cars.

The Medical Director in accordance with National terms and conditions for Doctors and Dentists can be awarded a payment via the Clinical Excellence Awards Scheme. The Medical Director is in receipt of an annual award of £14,933 which is included in the figures above.

2016/17 **Name and title**	Salary (Bands of £5000)	Expense payments (taxable) Total to nearest £100	Performance pay and bonuses (bands of £5000)	Long term performance pay and bonus (Bands of £5000)	All Pension related benefits (bands of £2500)	Total (Bands of £5000)
RE HAWKINS - Chief Executive	180 - 185	0	0	0	42.5 - 45	225 - 230
SP SMITH – Executive Director of Local Services (left 02 Oct 16)	50 - 55	0	0	0	2.5 - 5	55 - 60
S CROWTHER - Executive Director of Finance	120 - 125	0	0	0	27.5 - 30	150 - 155
D HOWELLS – Executive Director of Nursing, Quality and Patient Experience (left 31 May 16)	15 - 20	1,000	0	0	0	15 - 20
P SMEETON – Chief Operating Executive Health Partnerships (ceased 01 Oct 16) - Executive Director Local Partnerships (from 02 Oct 16)	115 - 120	0	0	0	125 – 127.5	240 - 245
DH FATHERS - Chair	45- 50	0	0	0	0	45 - 50
J ATTFIELD (formerly HALL) – Executive Director of Forensic Services/Executive Director of Nursing (01 Jun 16)	110 - 115	0	0	0	0	110 - 115
J HANKIN - Executive Medical Director	145 - 150	0	0	0	42.5 - 45	190 - 195
A POTTER - Non Voting Director of Business Development & Marketing	100 - 105	0	0	0	30 – 32.5	130 - 135
C TEENEY - Non Voting Director of Human Resources	95 - 100	2,700	0	0	122.5 - 125	215 - 220
P CALLAGHAN – Non-Executive Director	10 - 15	0	0	0	0	10 - 15
S BANKS – Non-Executive Director	10 - 15	0	0	0	0	10 - 15
S WRIGHT – Non-Executive Director	15 - 20	0	0	0	0	15 - 20
CP LOVETT – Non-Executive Director	10 - 15	0	0	0	0	10 - 15
P PARSONS – Non-Executive Director	10 - 15	0	0	0	0	10 - 15
JE WARDER – Non-Executive Director	10 - 15	0	0	0	0	10 - 15
AC MORRIS – Non-Executive Director (left 20 Apr 16)	0 - 5	0	0	0	0	0 - 5
CR CLARK – Interim Executive Director Forensic Services (from 01 Jun to 02 Oct 16)	55 – 60	0	0	0	110 – 112.5	165 - 170
JS JACKSON – Non-Executive Director (start 18 Jul 16)	5 - 10	0	0	0	0	5 - 10
P WRIGHT - Executive Director Forensic Services (start 03 Oct 16)	50 - 55	0	0	0	2.5 - 5	55 - 60
TOTAL	1205 – 1210	3,700	0	0	512.5 – 515	1725-1730

Expense payments
All payments are taken from P11’d information and are in respect of lease cars.

The Medical Director in accordance with National Terms and Conditions for Doctors and Dentists can be awarded a payment via the Clinical Excellence Awards Scheme. The Medical Director is in receipt of an annual award of £14,933 which is included in the figures above.

B) Pension benefits of senior managers

2017/18 Name and Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 1 Apr 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employers contribution to stakeholder pension
	(Bands of £2500) £000	(Bands of £2500) £000	(Bands of £5000) £000	(Bands of £5000) £000	£000	£000	£000	To nearest £100
RE HAWKINS - Chief Executive	0 - 2.5	5 - 7.5	80 - 85	250 - 255	1,741	136	1,894	0
P SMEETON - Executive Director Local Partnerships (X)	5 - 7.5	7.5 - 10	55 - 60	100 - 105	684	131	821	0
S CROWTHER - Executive Director of Finance (X)	2.5 - 5	5 - 7.5	40 - 45	105 - 110	522	98	625	0
J ATTFIELD (formerly HALL) - Executive Director of Nursing	0 - 2.5	0 - 2.5	55 - 60	170 - 175	973	64	1,047	0
J HANKIN - Executive Medical Director (X)	2.5 - 5	(0 – 2.5)	40 - 45	105 - 110	600	68	674	0
A POTTER - Non Voting Director of Business Development & Marketing (X)	5 - 7.5	7.5 - 10	40 - 45	110 - 115	654	117	777	0
C TEENEY - Non Voting Director of Human Resources (X)	0 - 2.5	0 - 2.5	40 - 45	0 - 5	414	48	466	0
P WRIGHT - Executive Director Forensic Services (X)	0 - 2.5	0 - 2.5	0 - 5	0 - 5	17	38	55	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total

membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2017/18 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. The inflation rate used is 1%.

Members of the 2015 section of the NHS Pension Scheme (X) have no lump sum entitlement.

2016/17 Name and Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 1 Apr 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employers contribution to stakeholder pension
	(Bands of £2500) £000	(Bands of £2500) £000	(Bands of £5000) £000	(Bands of £5000) £000	£000	£000	£000	To nearest £100
RE HAWKINS - Chief Executive	2.5 - 5	7.5 - 10	80 - 85	240 - 245	1,626	115	1,741	0
SP SMITH – Executive Director of Local Services – (left 02 Oct 16)	0 – 2.5	0 – 2.5	45 - 50	135 - 140	1,020	0	0	0
D HOWELLS – Executive Director of Nursing, Quality and Patient Experience (left 31 May 16) (X)	0 – 2.5	0 – 2.5	25 - 30	80 - 85	407	3	423	0
P SMEETON – Chief Operating Executive Health Partnerships (ceased 01 Oct 16) - Executive Director Local Partnerships (from 02 Oct 16) (X)	5 - 7.5	7.5 - 10	50 - 55	90 - 95	582	102	684	0
S CROWTHER - Executive Director of Finance (X)	0 – 2.5	0 - 2.5	35 - 40	100 – 105	487	35	522	0
J ATTFIELD (formerly HALL) – Executive Director of Forensic Services/Executive Director of Nursing (01 Jun 16)	0 - 2.5	0 - 2.5	55 - 60	170 - 175	935	38	973	0
J HANKIN - Executive Medical Director (X)	2.5 - 5	0 – 2.5	40 - 45	105 - 110	553	47	600	0
A POTTER - Non Voting Director of Business Development & Marketing (X)	0 - 2.5	0 – 2.5	35 - 40	100 - 105	610	44	654	0
C TEENEY - Non Voting Director of Human Resources (X)	5 - 7.5	0 - 2.5	35 - 40	0 - 5	333	80	414	0
CR CLARK – Interim Executive Director Forensic Services (from 01 Jun 16 to 02 Oct 16)	5 – 7.5	15 – 17.5	55 - 60	175 - 180	790	102	1,090	0
P WRIGHT - Executive Director Forensic Services (start 03 Oct 16) (X)	0 - 2.5	0 - 2.5	0 - 5	0 - 5	0	8	17	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2016/17 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. The inflation rate used is 0%.

Members of the 2015 section of the NHS Pension Scheme (X) have no lump sum entitlement.

Fair Pay multiple
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid Director in Nottinghamshire Healthcare NHS Foundation Trust in the financial year 2017/18 was £180,000 to £185,000 (2016/17: £180,000 to £185,000). This was 7.38 times (2016/17: 7.32) the median remuneration of the workforce, which was £24,876 (2016/17:£24,826).
In 2017/18 one (2016/17: one) employee received remuneration in excess of the highest paid Director. Remuneration ranged from £190,000 to £195,000 (2016/17: £185,000 to £190,000).

Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.
Changes to the ratio are a result of adjustment to the number or composition of the general workforce resulting from the loss of the Doncaster Offender Healthcare Cluster contract in year.

There have been no payments to any senior manager for loss of office during this financial year or the previous financial year. No payments have been made to individuals that are not currently senior managers but who were previously.

Ruth Hawkins
Chief Executive
24 May 2018

STAFF REPORT

Our Workforce Developments and Changes
During 2017/18 an average number of 8,502 whole time equivalent (WTE) staff worked for the Trust**.** These staff are geographically dispersed across 173 properties (spread across 109 sites).

Over the next financial year, we anticipate a net decrease of approximately 16 permanent WTEs. We have planned decreases across non-medical clinical staff and non-clinical staff. There are also planned reductions for agency, bank and overtime usage.

This net decrease arises from known cost improvement programmes and developments, service changes, known recruitment, reduction in temporary staffing usage and amendments to service contracts. Known developments include provision changes in Child and Adolescent Services that will have an impact during 2018/19. Our final workforce position also reflects an updated forecast outturn position and is based on revised turnover and recruitment figures.

Average number of employees (WTEs) – subject to audit				
	2017/18			**For the Year ending 31 March 2017**
	Permanent	**Other**	**Total**	**Total**
	Number	**Number**	**Number**	**Number**
Medical and dental	211	79	290	258
Ambulance staff	4	0	4	2
Administration and estates	2,080	157	2,237	2,158
Healthcare assistants and other support staff	2,000	244	2,244	1,902
Nursing, midwifery and health visiting staff	2,478	93	2,571	2,568
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	1,072	48	1,120	1,096
Healthcare science staff	0	0	0	1
Social care staff	29	7	36	36
Agency and contract staff	0	0	0	173
Bank staff	0	0	0	473
Other	0	0	0	0
Total average numbers	**7,874**	**628**	**8,502**	**8,667**
Of which:				
Number of employees (WTE) engaged on capital projects	6	0	6	6

Average number of employees (WTE)

The Foundation Trust Annual Reporting Manual states the average number of employees is calculated as the whole time equivalent (WTE) number of employees

under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The “contracted hours” method of calculating whole time equivalent number should be used. That is, dividing the contracted hours of each employee by the standard working hours. However, there are no means of reporting available to us on weekly hours contracted, in our current financial or human resource, solutions to facilitate this requirement. The method used is the monthly WTE, in total for each group of staff, divided by the number of months. This provides a sufficiently accurate approximation of this measure.

Analysis of staff costs – subject to audit

			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	241,704	20,984	262,688	262,436
Social security costs	24,742	-	24,742	24,640
Apprenticeship levy	1,263	-	1,263	-
Employer’s contributions to NHS pension	31,947	-	31,947	32,231
Pension cost - other	25	-	25	23
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	853	-	853	381
Temporary staff	-	7,702	7,702	12,354
Total gross staff costs	300,534	28,686	329,220	332,065
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	300,534	28,686	329,220	332,065
Of which				
Costs capitalised as part of assets	354	-	354	353

Exit Packages

During the period 1 April 2017 - 31 March 2018 the Trust had a total of 11 compulsory redundancies which resulted only after the Trust had explored all options of suitable alternative employment. The remaining 435 ‘other departures agreed’ represent members of staff who either chose to leave the employment of the Trust or whose employment was terminated and to whom a payment was due in accordance with their contract of employment e.g. an outstanding annual leave entitlement, a remaining period of contractual notice. Details are shown in the tables below.

Reporting of Compensation Schemes - subject to audit
Exit Packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	3	432	**435**
£10,001 - £25,000	2	2	**4**
£25,001 - 50,000	3	1	**4**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	2	-	**2**
>£200,000	-	-	**-**
Total number of exit packages by type	**11**	**435**	**446**
Total resource cost (£)	**£619,000**	**£234,000**	**£853,000**

Negative values totalling £36,000 for 132 individuals (2016/17, £68,000 for 137 individuals) have been netted off total exit packages reported in the above table; on a gross basis exit packages arranged total £889,000 for 314 individuals (2016/17, £449,000 for 334 individuals).

Reporting of Compensation Schemes
Exit packages 2016/17

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	4	461	**465**
£10,001 - £25,000	1	2	**3**
£25,001 - 50,000	1	1	**2**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	7	464	**471**
Total resource cost (£)	**£92,000**	**£289,000**	**£381,000**

Exit Packages Other (non-compulsory) Departure Payments				
	2017/18		2016/17	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	3	1
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	7	5	6	5
Contractual payments in lieu of notice	427	217	455	283
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	1	12	-	-
Total	**435**	**234**	**464**	**289**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Workforce Composition

Breakdown by Gender

Gender	Staff Grouping	Heads	Percent
Female	Directors	5	0.1%
	Other Senior Managers	23	0.4%
	Employees	6,542	99.6%
Female Total		6,570	74.9%
Male	Directors	3	0.1%
	Other Senior Managers	21	1.0%
	Employees	2,182	98.9%
Male Total		2,206	25.1%
Grand Total		8,776	

Staff by Gender (Source ESR - March 2018)

Breakdown by Ethnicity (these figures do not include staff who have not stated their ethnicity*)

Ethnic Group	Staff Grouping	Heads	Percent
White British	Director	8	0.1%
	Senior Manager	37	0.5%
	Employees	7,598	99.4%
White British Total		7,643	87.1%
White EU	Senior Manager	2	1.3%
	Employees	154	98.7%
White EU Total		156	1.8%
BME	Senior Manager	3	0.4%
	Employees	820	99.6%
BME Total		823	9.4%
Grand Total		**8,622**	

Staff by Ethnicity (Source ESR - March 2018) (*154 did not declare their ethnicity)

Sickness Absence

The Trust's cumulative sickness absence rate during 2017/18 was 5.3% against a Trust target of 5%. During the winter months there was a peak of sickness with a rate of 6.4%.

For 2017/18 the total staff years available was 7,765.63. The total WTE days lost due to sickness absence was 154,689.98 with the average absence being 19.65 days per WTE.

Workforce Policies

Recruiting and retaining a diverse workforce that is inclusive of, and reflects, the diverse communities it serves is one of the Trust's four key strategic priorities. Accordingly, the Trust is committed to meeting and exceeding the requirements of being a Disability Confident Employer and the Mindful Employer Charter. We guarantee to interview all disabled applicants who meet the minimum criteria for any post advertised, providing the applicant has indicated on the application that they have a disability in accordance with the Equality Act 2010. As with all staff we are passionate about ensuring that disabled staff are valued and supported within the organisation and receive appropriate training, which meets their ongoing professional needs. This is outlined in our Employing People with Disabilities Policy, which is embedded within the overarching Employment Policy and sets out the responsibilities of both managers and disabled people themselves within the workplace.

This Policy is supported by internally developed documents such as the Reasonable Adjustments Guide, our Dyslexia and Asperger's guidance for staff. Supporting the policy framework is the Disability Equality Steering Group who, in addition to providing support for Disabled Staff, inform, champion and influence policy development within the organisation and beyond, in meeting the diverse needs of disabled staff. These policies apply to disabled people wanting to work for the Trust and staff who become disabled during the course of their employment. There are a number of initiatives in place to support managers to effectively manage diverse

teams and support the needs of all staff including those with disabilities of both a physical and mental nature. Mentoring, coaching, work shadowing and additional support; such as: extended development opportunities, work rotation and enhanced supervision are available.

In order to ensure our managers are effective in identifying and supporting individual staff needs, we have integrated these competencies within our current management and leadership development programmes; middle management programme for bands 4-6 and Vision 21 for senior managers, bands 7-8b. At a senior leadership level, similar competencies have been embedded within the Trust Leadership Council programme and conferences. The trust appraisal system enables these skills to be measured as part of management competencies and to highlight areas for further development.

In addition, the Trust actively promotes and supports the employment of people who use our services, and particularly encourages applications from people with disabilities in all job adverts. As a matter of good practice, we have service user and carer representation in our recruitment processes; which greatly benefits the organisation as framed within its values.

Staff are consulted on any formal employment changes in accordance with the organisational change policy; this involves engaging with our workforce at the earliest possible stage increasing staff engagement throughout the process. We utilise our staff-side constitution as well as strong working relations with our staff-side colleagues to ensure we work in a partnership approach. Employees are actively engaged in the review of services and the performance of the Trust. The performance of the Trust is reviewed by employees at all levels through the accountability structure and partnership forums as well as through individual appraisals. The Leadership Council is regularly engaged to review performance to determine how services can be improved.

For 2017/18, NHS Foundation Trusts continued to be required to comply with NHS Counter Fraud Authority guidance. These provisions include the requirement for a nominated Lead Counter Fraud Specialist (CFS) to be in place to undertake work across four generic areas of action. The Trust has a counter fraud, bribery and corruption policy in place which reinforces the commitment of the organisation to maintain an embedded counter fraud culture and to take robust action where allegations of fraud, bribery and corruption are proven.

The Trust has a range of communication channels in place to ensure that staff are aware of and share in the aims, values and objectives of the organisation and understand their contribution to making these real and achievable. Through these, staff are kept informed and engaged to help improve their experience and the delivery of services. This includes monthly email bulletins, face to face briefings and meetings, Positive newsletter, Intranet, Internet, corporate products and events, the use of social media, such as Facebook, Twitter and LinkedIn, ward visits from the Executive Team, equality & diversity networks, a system of ‘Champions’ across the Trust and the Leadership Council. We also work closely with staff side colleagues and staff directly to ensure that any issues or concerns are addressed. During 2017/18 the Trust reviewed its approaches and methodologies to enabling ‘staff

voice' to ensure that we are maximising the opportunities and mechanisms staff have available to be listened to and to contribute to decision making.

During 2017/18 we completed the Discovery Phase of our 'Developing our People and Culture Together' programme which has helped us to understand our current culture and leadership approach. We have started the Design and Delivery stage of the programme which will continue throughout 2018/19 and have commenced with new initiatives which include Open Conversations, a new Staff Voice Board report and we are looking to develop a Behaviours Charter. This phase incorporates a Design Engagement Group to ensure that input on initiatives and ideas are sought from a wide range of employees. The programme is supported by a strong communications plan and branding that ensures that staff across the Trust are aware of the programme and have the opportunity to contribute to and shape changes, processes and practices.

The Trust is committed to ensuring the prevention of injury and ill health and to improve its safety performance and provides a comprehensive Occupational Health service to all staff. A full range of services can be accessed including pre-employment health assessments, immunisation programmes, health and safety advice, health surveillance and infection control. During 2017/18 we reviewed the occupational health contract and have renewed it with the existing provider. This commitment further extends to not only meeting but exceeding applicable legal and other requirements imposed upon it. The Trust has a robust, outcomes driven suite of Health and Safety Policies, which support the Trust Health and Safety Management System (HSMS).

Staff Survey

Summary of Performance

Within the annual National NHS Staff Opinion Survey 2017, the Trust achieved a response rate of 47% and was ranked in the 'average' of Mental Health, Learning Disability and Community Trusts.

Good staff engagement is a Board of Directors' priority. Through further enabling the staff voice and encouraging staff to speak up and the delivery of our Developing Our People and Cultural Together programme it is anticipated that the culture will become one of openness. The approach taken will include mechanisms by which the Trust can triangulate patients and service user views with those of staff, in order that these views can inform the decisions taken by the Trust.

Response Rates

	2016	2017		Trust deterioration in % points
	Trust	Trust	Combined Mental Health, Learning Disabilities & Community Comparator Average	
Response Rate	48%	47%	45%	-1

Areas of Improvement and Deterioration

Staff Survey Top 5 Ranking Areas (*lower score the better)

	2016	2017		Trust Movement in % points
	Trust	Trust	Combined Mental Health, Learning Disabilities & Community average	
KF16 Percentage of staff working extra hours	68%	68%	71%*	0+/-
KF24 Percentage of staff / colleagues reporting most recent experience of violence	89%	89%	88%*	0+/-
KF14 Staff satisfaction with resource & support	3.38	3.34	3.33	+0.04
KF27 Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	58%	57%	57%*	+1.0
KF15 Percentage of staff satisfied with the opportunity for flexible working patterns	60%	58%	58%	+2.0

Staff Survey Bottom 5 Ranking Areas (*lower score the better)

	2016	2017		Trust Movement in % points
	Trust	Trust	Combined Mental Health, Learning Disabilities & Community average	
KF4 Staff motivation at work	3.88	3.81	3.93	-0.07
KF6 Percentage of staff reporting good communications between senior management and staff	33%	29%	34%	-4.0
KF8 Staff satisfaction with the level of responsibility and involvement	3.87	3.81	3.90	-0.06
KF18 Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure	55%	57%	53%*	-2.0
KF31 Staff confidence and security in reporting unsafe clinical practice	3.71	3.61	3.72	-0.10

The areas of concern highlighted by the survey are recognised within the table showing the areas of deterioration. Evidence from the national staff opinion survey will be used within the design and delivery phase of our Developing Our People and Cultural Together programme. This will allow us to identify areas of particular focus, including groups that are traditionally seldom heard; for example: equality and diversity strands and specific professions; such as: Medics and Allied Health Professionals. From this analysis we can test out themes within key focus groups and interviews, following the Developing Our People and Cultural Together programme methodology.

There are a number of elements in place to address the areas of concern, which support the working of the Developing out People and Culture Together Programme in the form of staff forums, working collaboratively with the Equality and Diversity strands steering groups. These in addition, to providing development opportunities for staff, are a valuable resource to the organisation in terms of policy development and practices particularly through the medium of giving staff a voice. These enable us to implement appropriate actions to address identified areas for improvement, with the support and buy-in of our workforce.

Progress against all of our action plans is monitored through the Workforce Equality and Diversity Committee of the Board of Directors. Workforce data is also monitored monthly by the Board of Directors as part of the overall performance report.

Future priorities

During 2018/19 we will continue to embed our People and Culture Strategy throughout the Trust. We will continue to highlight the importance of staff health and wellbeing and invest in and support a number of initiatives promoting health and wellbeing for our staff such as our musculoskeletal staff self-referral service, Mindfulness Cognitive Based Therapy sessions and ongoing health and wellbeing events for staff to attend. We have an active network of Health and Wellbeing Champions deployed across the Trust, who promote various health and wellbeing activities, events, and raise awareness of the Trust's health and wellbeing agenda, supporting work colleagues. As part of our commitment to health and wellbeing we will also continue our commitments to pledges placed under the Department of Health Responsibility Deal and comply with the Five Year Forward View on Staff Health and Wellbeing and NICE guidance.

Our key commitments for 2018/19 will be smoking cessation, supporting mental health and wellbeing (including domestic violence and abuse) as well as addressing alcohol consumption and physical activity. We will use the findings from the national staff opinion survey to support the design phase of our Developing Our People and Cultural Together programme. In 2017 we conducted a staff survey on the whole organisation and achieved a 47% response rate which gave us 4085 responses. We have committed to undertake full surveys for the next two years.

We will continue to measure staff engagement through regular surveys and focus groups and utilise this data to prioritise our workforce initiatives and improve retention levels across the Trust. We aim to improve the employee voice across the Trust by investing in our staff to empower them to make changes in their own work areas through different initiatives; our local Freedom to Speak Up Guardian has

developed a network of Freedom to Speak Up Champions throughout the Trust to support the speak up agenda and our 'Speak In Confidence' system which is an anonymous two way dialogue programme, continues to be utilised.

Expenditure on consultancy
Expenditure on consultancy in 2017/18 was £642,000 (£495,000 in the period 1 April 2016 to 31 March 2017).

Off payroll engagements
Nottinghamshire Healthcare's approach to the use of off payroll engagements is set out in the Trust's Employment Policy. The policy includes a process to assist in determining a workers employment status. During the last financial year there have been no off payroll arrangements relating to senior manager positions.
Further information on off payroll engagements is shown in the following tables.

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2018	11
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	5
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	5

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which:	
Number assessed as within the scope of IR35	1
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	1
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	0

In any cases where individuals are included within the first row of this table the trust should set out:

Details of the exceptional circumstances that led to each of these engagements.	n/a
Details of the length of time each of these exceptional engagements lasted	n/a

DISCLOSURES SET OUT IN THE NHS FOUNDATION TRUST CODE OF GOVERNANCE

Statement of Compliance with the Code of Governance Provisions

Nottinghamshire Healthcare NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust has reported compliance with the Code of Governance, the evidence base for which has been reviewed and supported by the Trust's Audit Committee at its meeting in February 2018, gaining assurance of there being no issues of significant non-compliance with the Code`s provisions. It is recognised that work is ongoing on a developmental basis in respect of a number of areas to further enhance the level of compliance.

The Audit Committee has been charged by the Board of Directors to maintain ongoing oversight of the NHS Foundation Trust`s compliance with the Code of Governance and to identify to the Board of Directors any emergent areas of significant non-compliance.

A specific set of disclosures is required to meet the Code of Governance. The following table lists the disclosures and references to where the relevant information can be found in the annual report.

Code of Governance Disclosures

Ref	Criteria	Compliance	Evidence
LEADERSHIP			
A 1	**The role of the Board of Directors**		
A 1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors.	Compliant	○ Monthly board meetings ○ Constitution details roles and responsibilities of the Council of Governors and process for addressing disagreements between Board and Council ○ Scheme of delegation reviewed and approved November 2017 ○ Information included in the Directors report in this annual report.
A 1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report.	Compliant	○ Annual report details all Board and relevant committee memberships and attendance in the Directors report and the remuneration report.
A 5	**Governors**		
A 5.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Compliant	○ Information include in the section on the Council of Governors. ○ Record of attendance maintained
Additional	The annual report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors.	Compliant	○ This data is routinely recorded and reviewed and information is included in the council of governors section of this annual report.

Ref	Criteria	Compliance	Evidence
EFFECTIVENESS			
B 1	**The composition of the board**		
B 1.1	The Board of Directors should identify in the annual report each Non-Executive Director it considers to be independent with reasons where necessary.	Compliant	○ This information is outlined in the Directors' report. ○ Requirements set out within the Constitution ○ Appointment processes ○ Fit and Proper Persons
B 1.4	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	Compliant	○ Annual report contains Director profiles in the Directors report. ○ Annual review of Board composition by NED NomRem. Confirmed as remaining fit for purpose
Additional	The annual report should include a brief description of the length of appointments of the non-executive directors and how they may be terminated.	Compliant	○ Annual report contains this information in the Remuneration report.
B 2	**Appointments to the board**		
B 2.2	Directors on the Board of Directors and Governors on the Council of Governors should meet the "Fit and proper" persons test described in the provider licence.	Compliant	○ "fit and proper" persons declarations made by each Director annually. ○ Declaration by Governors when seeking election and ongoing reporting requirement ○ DBS, Bankruptcy etc. checks re Board members
B 2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Compliant	○ Compliance with NHS Foundation Trust Annual Reporting Manual ○ Terms of reference available upon request. ○ Information included in the Remuneration report.
Additional	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Compliant	○ During 2017/18 open advertising was the method of NED recruitment.

Ref	Criteria	Compliance	Evidence
B 3	**Commitment**		
B 3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report.	Compliant	○ Details of how to access declarations of Interest can be found in the Directors report ○ Declarations of Interest identified as part of recruitment process ○ Annual checks on Fit and Proper persons established.
B 5	**Information and support**		
B 5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Compliant	○ Forward plans shared with and consulted on with CoG ○ Consultation processes ○ Governors engaged with consultation processes ○ Engagement strategy
Additional	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. *Power to require one or more of the Directors' to attend a Governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance). **As inserted by section 151 (6) of the Health and Social Care Act 2012)	Compliant	○ This power has not been formally exercised during 2017/18 as there has been open disclosure of the performance of the Trust reported at each Council of Governors meeting. ○ There have been no concerns regarding the performance of directors. ○ Executive Directors proactively attend the Council of Governors meetings to provide updates/reports on matters relating to their individual portfolios.
B 6	**Evaluation**		

Ref	Criteria	Compliance	Evidence
B 6.1	The Board of Directors should state in the annual report how performance evaluation of the Board, its committees, and its directors, including the Chairperson, has been conducted.	Compliant	○ Ongoing review of committee structure and effectiveness thereof ○ Committee self-assessments ○ Internal and external auditor perspectives ○ Ongoing Board Development Programme ○ Chair and Director appraisal processes ○ Information included in the Directors report of this annual report.
B 6.2	Where there has been external evaluation of the Board and/or governance of the Trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Compliant	○ Positive outcome of external well-led review by PwC. Reported to Board November 17.
ACCOUNTABILITY			
C 1	**Financial, quality and operational reporting**		
C 1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Compliant	○ Accountability report of this annual report (page 27) ○ Report of external auditors ○ Annual Governance Statement (page 103) ○ Letter of representation
C 2	**Risk management and internal control**		
C 2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	Compliant	○ Annual Governance Statement. ○ Head of Internal Audit Opinion ○ Internal Audit reviews ○ Committee structures and reporting ○ Board development sessions on risk management

Ref	Criteria	Compliance	Evidence
C 2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Compliant	○ Directors report ○ 360 Assurance
C 3	**Audit Committee and auditors**		
C 3.5	If the Council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Compliant	○ Not applicable
C 3.9	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: a. the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; b. an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and c. if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Compliant	○ Annual Report content – see section on the Audit Committee (page 38)

Ref	Criteria	Compliance	Evidence
REMUNERATION			
D.1	**The level and components of remuneration**		
D 1.3	Where an NHS Foundation Trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the Director will retain such earnings.	Compliant	○ Not applicable
RELATIONS WITH STAKEHOLDERS			
E 1	**Dialogue with members, patients and the local community**		
E 1.4	Contact procedures for members who wish to communicate with Governors and/or Directors should be made clearly available to members on the NHS Foundation Trust's website and in the annual report.	Compliant	○ Membership office ○ Log of all membership communications maintained ○ Regular membership e-bulletin issued to members ○ Membership Strategy ○ Involvement, Experience and Volunteering Strategy ○ Enhanced website ○ Further details contained in the Council of Governors section of this annual report
E 1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Compliant	○ Annual report content in section on Council of Governors ○ Member feedback ○ Involvement, Experience and Volunteering Strategy ○ Ward visits programme ○ NED attendance at CoG ○ AGM /AMM

Ref	Criteria	Compliance	Evidence
E 1.6	The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Compliant	○ Membership data-base ○ Membership Strategy ○ Involvement, Experience and Volunteering Strategy ○ Annual report ○ Annual Involvement Report
Additional	The annual report should include: A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; Information on the number of members and the number of members in each constituency; and A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	Compliant	○ See membership strategy in this annual report
Additional	The annual report should disclose details of company directorships or other material interests in companies held by Governors and/or Directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. As each NHS Foundation Trust must have registers of Governors' and Directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	Compliant	○ See Directors report and remuneration report included in this annual report

NHS IMPROVEMENTS SINGLE OVERSIGHT FRAMEWORK

Single oversight framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence. Further information is provided in the Performance Analysis section of this report.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

The Trust is currently in segment 2. This segmentation information is the trust's position as at 18 April 2018. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18 scores				2016/17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	2	2	2	2	2	2
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E margin	1	1	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1	1	1
	Agency spend	1	1	1	1	2	2
Overall scoring		1	1	1	1	1	1

STATEMENT OF CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Nottinghamshire Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Nottinghamshire Healthcare NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Ruth Hawkins
Chief Executive
24 May 2018

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation 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 Foundation 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 Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Nottinghamshire Healthcare NHS Foundation 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 Nottinghamshire Healthcare NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Risk management is recognised by the Trust as an integral part of good management practice. Risk management involves understanding, analysing and addressing risk to make sure organisations achieve their objectives.

The Trust approved the updated Risk Management Strategy (RMS) 2016 – 2021 in June 2016 following the publication of its new 5 year strategy and new strategic objectives at the Board of Director's meeting in March 2016.

The RMS:

- sets out the Trust's **objectives** for the management of risk at a strategic and operational level;
- describes the risk management **framework** that is in place by defining a systematic approach to how risk will be managed across the Trust; and
- ensures that associated thinking and practice is **embedded** in everyday processes, policies and activity.

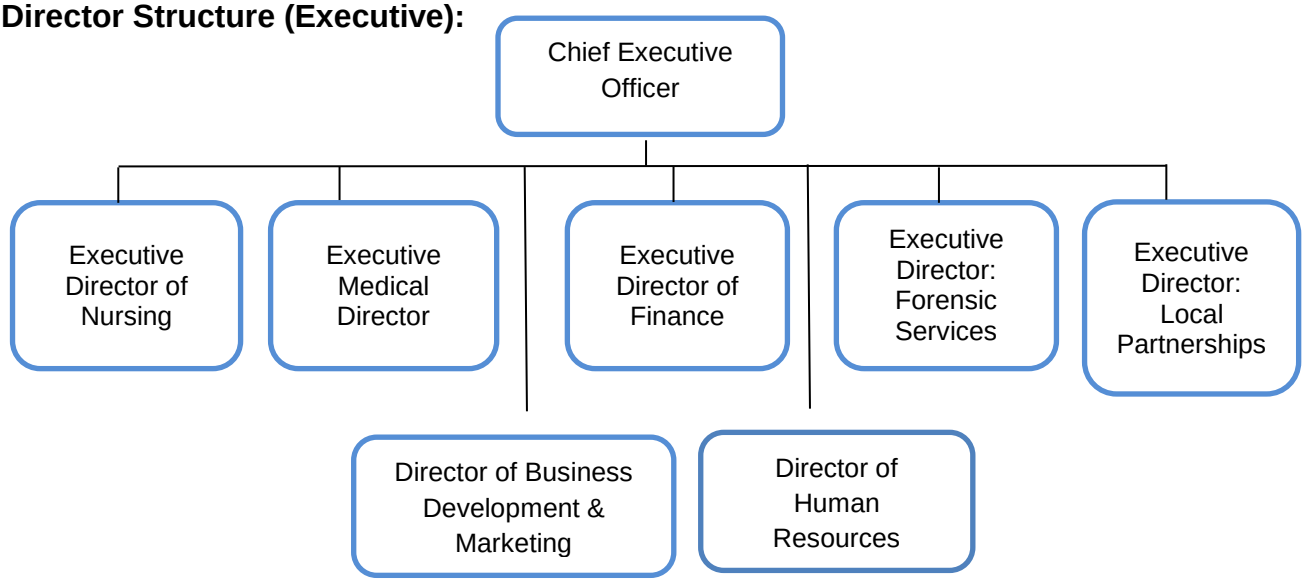
An Annual Implementation Plan is in place to deliver the six objectives set out in the RMS. The Plan is monitored at Divisional risk meetings and an update is provided to the Audit Committee.

During 2017/18 the Trust has continued to develop and enhance its approach to governance and risk management, recognising the changing and challenging environment in which it operates. The identification and appropriate management of

risk forms an integral part of the Trust's overall approach to integrated governance and one which is explicit in every activity the Trust and its employees are engaged. Whilst recognising the essential requirement to identify, assess and appropriately manage risk, the Trust recognises the importance of proportionate risk mitigation and control acknowledging that not all risks can be wholly eliminated and to do so may indeed be detrimental to the provision of quality recovery based services.

The Trust's approach to risk is discharged through clearly focusing executive responsibility for clinical governance and risk management with the respective Executive Directors. These Directors have responsibility for all Trust care services and supporting corporate functions working closely with the Chief Executive Officer in this context. The principal management lead for risk management during 2017/18 was the Executive Director of Nursing.

Director Structure (Executive):



The aim of risk management is to support the Trust's vision and values by promoting a consistent and integrated approach across all parts of the organisation to ensure we are aware of our risks and are responsive, but not risk averse. The Trust aims to do this through a robust governance structure, sound processes and systems of working, and an open and fair culture that is focused on patient and staff safety. Capacity is developed across the Trust through training events commensurate with staff duties and responsibilities and includes risk management training for all new staff. Training opportunities are outlined in the Learning and Development Prospectus.

The Trust has an extensive range of organisation-wide policies and service/division specific procedures which support and align with the Trust's approach to risk management.

The Risk and Control Framework

The RMS sets out the Trust's approach to risk and risk appetite/tolerance and sets out the leadership, responsibility, monitoring and accountability arrangements for risk management.

The Trust follows the 4 step risk management process below:

1. **Identify and recording risks:** answering the question: what could stop you achieving your objectives/cause harm?
2. **Assess and score risks:** assessing the risk and risk assessment (information about the risk/its effect)
3. **Control and manage risks:** the process of selecting and implementing measures/controls to manage the risk to the agreed level.
4. **Monitor and review risks**: reviewing the risks, monitoring activity and measures put in place and evaluating the effectiveness of the controls.

The Trust Audit Committee has the primary responsibility to provide *assurance to the Board* with regard to the continued effectiveness of the Trust's system of integrated governance, risk management and internal control. Each of the Trust's four Committees (Finance and Performance, Quality, Mental Health Legislation and Workforce, Equality and Diversity) has responsibility for the oversight of specific risks associated to their respective remit.

Board Assurance Framework
The BAF is the framework for identification and management of strategic risks that might compromise the achievement of the strategic objectives. The purpose of the BAF is to:

- Provide timely and reliable information on the effectiveness of the management of major strategic risks and significant control issues
- Facilitate escalation of risk and control issues requiring visibility and attention by senior management, by providing a cohesive and comprehensive view of assurance across the risk environment
- Provide an opportunity to identify gaps in assurance needs that are vital to the organisation, and to address them
- Provide critical supporting evidence for the production of the Annual Governance Statement.

The BAF is reviewed by the Board, the Executive Leadership Team and Committees on a regular basis. The BAF is an extract from the Organisational Risk Register, driven by the Trust's agreed risk appetite.

Executive responsibility for the BAF process is held by the Executive Director of Nursing. Principle Risk Owners are identified for each identified risk together with a responsible Board Committee. The respective committees review those risks for which they have defined responsibility at each meeting.

The BAF has continued to be developed and enhanced during 2017/18 with the four Committees adopting a robust approach to reviewing and monitoring risks associated with their respective remit. Each Committee considers any gaps in risks, the effectiveness of controls and the extent to which they are assured by the evidence presented for each risk.

The Audit Committee membership includes the Chairs of the four Committees and through this positioning, can effectively review updates from Committee Chairs in relation to their respective oversight of the BAF and the extent of their assurance.

In line with the Audit Committee's Forward Plan, the Committee has agreed to focus on one Committees oversight of respective risk at each of its standard meetings. The Committee also carries out a 'deep dive' into specified risk theme areas, these have included: an assessment of the Trust's approach to risk appetite and its process for identifying emergent risks, an assessment of how well the Trust is identifying and quantifying risks and what lessons can be learned, and the consideration of an assurance radar to identify where actions need to be agreed to strengthen the controls to provide further assurance to the Board.

A Board Development session was arranged on 18 January 2018 to carry out a 'deep dive' of the highest scored BAF risks that the Board was not assured about. Members were allocated to one of four groups to carry out a review of the 4 highest scored BAF risks. Each group was asked to answer the 3 following questions:

1. How assured are we that the controls are effective?
2. What can be done to gain assurance?
3. Are the current Actions adequate?

Following the session, actions were agreed which the Executive Leadership Team has monitored through to completion.

Risk Registers

Beneath the BAF sits a risk register structure detailing identified operational and corporate risks at trust-wide, divisional and directorate levels. The Trust has a risk escalation process in place which tracks operational risks and enables the organisation to escalate risks appropriately. This process has been scrutinised by the Audit Committee as part of their programme that focussed on risk management and also the subject of an internal audit.

Risks are monitored and reviewed according to their score and type. It is the responsibility of individual risk owners to ensure each risk is captured on the relevant Risk Register which is reviewed in an appropriate group or committee.
Changes in risk scores are reported to the Board, Committees and divisional groups in line with monitoring levels set out in the RMS.

Risk Appetite

Risk appetite is determined through Board discussion, primarily through the Board of Director's Development Programme.
The RMS sets out the Trust's General Statement with regard to risk appetite and also states the risk appetite/tolerance levels for each strategic objective/sub objective – which is reflected in the framework for risk treatment and monitoring purposes.

A Board Development Session was held on 9 November 2017 to review the Trust's risk appetite/risk tolerance levels. The Chair, Chief Executive and Executive Director of Nursing (executive responsibility for the BAF process) and 11 other members were present. Board members agreed the 'risk appetite/tolerance' levels for the sub-

objectives using an interactive voting system. The results were captured and the BAF updated.

Quality of Performance Information and Care Quality Commission (CQC) Assurance

The Board of Directors receives a monthly Integrated Performance Report which details Trust performance against all relevant Single Oversight Framework targets and other relevant Trust indicators, as well as providing an overview of current Trust performance against the themes outlined in the Single Oversight Framework. The Overview of these themes, particularly 'Quality of Care' and 'Leadership and Improvement Capability' enables CQC review of Trust activity to be reported and discussed.

Performance against Trust key performance indicators is provided at Trust and Division level. Exception reports are received providing an explanation of areas of underperformance identified as significantly at variance against target.

The Trust has a Performance Indicator Assessment Process to verify and ensure the quality of reported data. Each indicator is assessed against five data quality domains to provide an overall data quality assurance rating which is included in the Quality and Performance Report. Data quality has remained an on-going area of focus during 2017/18 and will continue to be during 2018/19.

It is our ambition that every person who uses our services receives the best health care possible every time they have contact with us. Listening to patients, their carer's and families will assist us to understand their experience and will help us to achieve this ambition. Our staff are already recognised for delivering outstanding care and compassion for patients. We continue to build upon this achievement and strive to deliver integrated care that is safe and effective every time. Our Quality Priorities continue to help us to achieve this ambition.

The Board Committee with overall responsibility for monitoring the quality priorities is the Quality Committee. This committee, which meets six times per year, received during 2017/18 regular reports on progress with our ambition for each priority. These monitoring arrangements will continue in 2018/19.

The reports identify actual and potential underperformance to act as a trigger to ensure action is taken to improve performance against agreed trajectories. The Board of Directors also regularly monitors key performance indicators through the monthly Integrated Performance Report. This will include quality priority-related information such as incidents, CQC inspections, patient experience, quality impact of cost improvement programmes (CIPs) and workforce indicators such as safe staffing levels and sickness. The Board also receives regular service user and carer experience (SUCE) reports.

Care Quality Commission Registration

Nottinghamshire Healthcare NHS Foundation Trust was first registered with the CQC on 1 April 2010. The Trust is currently registered to provide regulated activities from 32 separate locations. During registration the CQC implement routine conditions

which define the regulated activities the Trust can provide at agreed locations. The Trust does not have any non-routine conditions of registration.

The Trust has not been required to participate in any special reviews or investigations by the CQC in 2017/18 but has been inspected under the CQC's routine inspection programme.

On 15 June 2017, the CQC published their report of the inspection they undertook of Rampton Hospital during March 2017. The CQC made six compliance actions for breaches of the Fundamental Standards. A planned inspection in March 2018 will check if the actions the Trust has put in place have brought about compliance.

During 2017/18, the CQC has undertaken a series of inspections of services provided by the Trust. In England, all inspections of prisons are conducted jointly with the Care Quality Commission. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits by different regulators. The CQC reviewed four of the Trust's prison healthcare services during 2017/18 as follows:

> 03 – 13 July 2017 – HMP North Sea Camp: The CQC found no breaches of the relevant regulations.
>
> 10 – 21 July 2017 – HMP & YOI Doncaster: The CQC found no breaches of the relevant regulations.
>
> 24 October 2017 – HMP Ranby: The CQC carried out an announced focussed inspection to follow up on concerns raised during a previous focussed inspection in December 2016. The CQC inspected only those aspects detailed in the Requirement Notice dated 5 July 2017 and found no breaches of the relevant regulations.
>
> 08 – 11 January 2018 – HMP & YOI Nottingham. The CQC found no breaches of the relevant regulations.

The CQC's annual core inspection of the Trust took place from 9th to 16th November 2017. The CQC inspected five complete core services and assessed the Trust against the Well-led key line of enquiry. The outcome was that Effective, Caring, Responsive, and Well-led was rated as 'Good' and 'Safe' was rated as 'Requires Improvement'. The CQC's aggregated rating for the Trust overall was 'Good'.

At this inspection, the CQC issued eight requirement notices which related to 25 breaches of legal requirement in four of the five core services they inspected. In addition, the CQC advised the Trust to make a further 48 improvements to comply with minor breaches which did not justify regulatory action or to improve services.

The CQC also issued one warning notice during 2017/18 in respect of medicine management in Local Mental Health Teams. The Trust took prompt action to bring about the improvements required. The CQC has not yet undertaken follow up inspections for assurance that the warning notice and requirement notices have been addressed.

In addition to compliance inspections, the CQC's Mental Health Act Reviewers also undertake visits to services where patients are detained to ensure their rights under the Act are protected and that the powers of the Mental Health Act are used properly. Reviewers visited 12 services and made 76 recommendations to improve practice overall. The Mental Health Legislation Operation Group (LOG) will oversee the Trust's response to the improvements which are required and will report on progress to the Mental Health Legislation Committee which in turn reports directly to the Board of Directors.

The outcome of the CQC inspections found that the Trust was not fully compliant with registration requirements and expects further inspections to test the improvements which have been made.

The Trust has developed a comprehensive improvement plan in response to the must and should do actions identified from the CQC Inspection. The aim of the plan is to ensure that the Trust becomes compliant with the breaches in legislation which resulted in the 25 must do actions. The aim is also to ensure that action is taken for the 48 should do actions to prevent future breaches in legislation and improve the quality of services for our patients. The plan has been in development since receipt of the draft report and some of the improvement actions have been completed.

Implementation of the improvement plan and evidence to demonstrate compliance will be monitored by the Local Partnerships Divisional Leadership Team and the Trust's Executive Leadership Team with oversight by the Quality Committee and Board of Directors

In addition to the improvement plan to address the individual issues to bring about compliance, the improvements need to be embedded into practice to ensure any change in practice is sustained over time. Therefore, the themes from the inspection report are being used to inform the quality priorities the Trust is required to develop each year.

In addition, there will be other quality improvement projects, one being Back to Basics. Using quality improvement methodologies, which will include human factors, the Trust will start to understand why some of the fundamental issues identified in the inspection occur and develop the right solutions with our staff.

Risks to Data Security
Responsibility for Information Governance and information security within the Trust rests with the Executive Director of Finance who undertakes the designated role of Senior Information Risk Owner (SIRO). Policies are in place which are compliant with NHS guidelines, and incident reporting procedures are in place and utilised by staff.

The Trust policies are based on and designed to meet the ISO 27001:2013 standard where required across the organisation. This standard splits information security policies and procedures into two sets of documents:

- an Information Security management systems (ISMS) framework based on a continuous cycle of risk assessment; and

- separate “Codes of practice and procedures” based on the ISO 27002 standard.

The Trust’s Information Security Policy consists of four layers:

Layer 1 - Information Security Management system (ISMS).
The ISMS is a documented model for establishing, implementing, operating, monitoring and improving the effectiveness of information security management within the organisation. For the NHS, the NHS IG toolkit provides the basis of an ISMS that supports a basic but acceptable level of information security. For those organisations with special or advanced information security needs, the ISMS ensures a flexible approach that may be expanded in scope and content over time.

Layer 2 - Information Governance Toolkit
This is the NHS annual audit standard based on the ISO 27001:2013 standard. The NHS IG Toolkit will be used as the basis for evaluating the effectiveness of the ISMS. This provides the “Check” part of the Plan-Do-check-Act (PDCA model described within the ISO 27001:2013 standard)

- **Plan :** Establishing the ISMS
- **Do:** Implementing the ISMS
- **Check:** monitoring and reviewing the ISMS through the annual IG Toolkit audit
- **Act:** maintain and improve the ISMS based on outcomes from the annual IG toolkit audit. The Trust again achieved Level 2 (satisfactory) in submission of the Toolkit in March 2018.
- From April the Data Security and Protection Toolkit replaces the IG Toolkit, and this forms part of a new framework for assuring that organisations are implementing the ten data security standards as set out in the DH/NHSE document ‘2017/18 Data Security and Protection Requirements’.

Layer 3 -Trust Information Security Codes of practice

Codes of practice based on ISO 27002 which set the principles to be followed by the operating guides and procedures, it covers the following areas:

Code of Practice	Target Audience
Organisation of information security	All managers with responsibility for information assets
Human Resources	Human Resources and Service managers
Asset management	Health Informatics managers
Communications Security	Health Informatics managers
Cryptography	Health Informatics managers
Physical & Environmental security	All managers with responsibility for information assets
Operations Security	Health Informatics managers
Access Control	All managers with responsibility for information assets
Information Security Incident Management	Health Informatics managers
Business Continuity management	All managers with responsibility for information systems
Supplier Relationships	Health Informatics managers

Layer 4 - Trust Information security operational guides, policies and standards

Operational guides based on the Codes of practice principles, targeted at specific groups as follows:

Guide	Target Audience
Information Asset Owner guide	Information Asset Owners and Information Asset Administrators.
Networks Security Manual	I.T. Data communications staff
Systems Security manual	I.T. Systems staff
Desktop Security Manual	Service Desk and Technical Support
Policy on encryption of data and use of mobile media.	All staff

The Trust's information security status is the subject of ongoing review by the Information Security Forum (chaired by the SIRO) and the Finance & Performance Committee. In March 2018 the Finance and Performance Committee received a paper 'update on Data Security and Protection Standards' to provide the Committee with assurance that the Trust would be compliant with the ten data security standards referred to above. During the year the Committee received regular reports on the Trust's lessons learned from the 12 May 2017 WannaCry (WCry) 'ransomware' malware attack. Although the Trust had no devices that were infected by the malware, many of the Trust's staff work in buildings that are not on the Trust network, using devices that have been configured and are managed by other parties; some of these were affected. The Trust had to close network links to such locations and staff had to move to buildings that were on the Trust network in order for them to obtain access to their usual systems. Business Continuity processes worked satisfactorily with a limited number of patient appointments being affected. Many of the lessons learned from this experience have been used in influencing several investments in both the 2017/18 and 2018/19 capital programmes. During the year work has been undertaken on the General Data Protection Regulation and the first action plan was approved by the Information Security Forum in August 2017. An audit of our readiness for GDPR was conducted by 360 Assurance and presented to the Audit Committee in January 2018, who were assured of progress, with a follow up audit in April 2018.

Information security incidents are managed as part of the Trust's information governance processes and all incidents which have a data protection element are investigated with lessons learnt shared through the Information Security Forum.

NHS Improvement's Well-Led Framework

Foundation Trusts are required to undertake a Well-Led Governance Review every three years. The Trust commissioned a well-led review which was undertaken between September and October 2017. This commenced with a self-assessment against the ten questions set out under the four domains of the well-led review. The reviewers undertook extensive visits, document review and observations and

interviews with a range of directors, commissioners, service users and staff. This review determined that the Trust had conducted an accurate self-assessment and set out 9 developmental recommendations to assist the Trust in further developing its leadership. The Board of Directors has remained sighted on progress in implementing the recommendations. The high level findings from the review were:

- The Trust operates with a relatively mature and effective model of devolved leadership and management. Service teams are empowered and supported to lead and make decisions in the best interests of delivering high quality, sustainable services.
- The Board has a good mix of skills and experience. Board meetings function effectively, and sub-committees are leveraged to provide scrutiny and obtain assurance over performance, risk and delivery of plans.
- The Trust has a clear vision, set of values and credible strategy. The strategy and values are well understood and resonate with the staff at Divisional and Directorate levels.
- The culture of the Trust is open and supportive. Staff PwC met consider the Trust leadership approachable and to have the best intentions for patients, service users and staff.
- Trust and Divisional leadership have a clear understanding of service performance and challenges. More consistent focus on taking action to address risks should be considered.
- Governance, risk and quality is prioritised and actively engaged in. More systematic reporting from Directorates, recording and monitoring actions would further strengthen its impact.
- The Board is well sighted on risks and risk management is a core focus of Divisional and Service governance. Risk reports should be developed further to provide more detail on mitigation and how this is assured.
- The Trust is patient centred and prides itself on high levels of engagement with those who use the services. This supports a culture of learning and improvement, with the Trust clearly focused on quality improvement.
- The supportive culture at the Trust and investment in leadership development needs to be balanced with the need for rigorous and consistent performance management.

Trust Risk Profile

The Trust has a unique risk profile given the diversity of services provided ranging from community based physical health care services through to high secure forensic services and prison based offender health services.

During 2017/18 the Trust maintained a close and robust review of its key strategic risks and put in place robust mitigating actions to ensure the potential operational, financial and reputational impact was mitigated as far as possible.
The Trust's High Scoring (12+) and High Impact (score 5) organisational risks are summarised in the following tables.

Organisational Risks Scoring 12+

Risk Reference Number	Risk Description	Owner & Committee	Risk score	Actions
ORG0000091	If recruitment and retention issues are not resolved at High Secure services, then wards might not be appropriately staffed leading to lone working at night and/or the cancellation of patient day time activities with consequences for patient and staff safety, security and regulation.	Executive Director of Forensic Services Quality	20	• Fortnightly report on Lone Working/activities to Executive Leadership Team • Implement High Secure Services Workforce Strategy (new recruitment process) & Retention actions (including Just Culture) • Daily operational oversight and deployment of resources by site manager. Monitor turnover KPIs. • Implement contingency plan
ORG0000097	Failure to maintain quality and compliance standards leading to deteriorating safety and quality of services and loss of licence.	Executive Director of Nursing Quality	16	• Respond to CQC Core Inspection/Well Led review • Implement Quality Improvement Plan • Review Patient Experience processes • Refresh Never Events Framework • Review Professional leadership structure
ORG0000020	System wide pressures and regulation regimes impact on the delivery of the financial strategy and lead to a lack of long term financial sustainability.	Executive Director of Finance Finance	16	• Full participation in local health economy • Scrutiny of contract risk • Ongoing review of financial position • Develop QIPP plans
ORG0000071	Inability to recruit and retain an engaged and appropriately skilled and motivated workforce, with the right behaviours and leadership capacity while addressing unacceptable variance across the Trust.	Director of Human Resources Workforce, Equality & Diversity	16	• Staff bank, reward/recognition, workforce plans, e-rostering, staff survey actions, workstream 5, executive-led conversations, quality improvement approach, collaboration, bespoke training for recruiters, Review IT support for recruitment, review IT enablers.
ORG0000079	If the health, wellbeing and resilience of the workforce is not effectively supported and managed, then there will be adverse impacts on patient care and patient and staff experience.	Director of Human Resources Workforce, Equality & Diversity	16	• Implement well-being at work plan • Fulfil pledges in Public Health Responsibility Deal • Explore management of trauma and out of area support • Explore external support for staff
ORG0000014	Trust systems and processes fail to support personalised care and fail to protect vulnerable people (Children, Adults, Carers and Families)	Executive Director of Nursing Quality	12	• Implement new Quality Monitoring Framework • Develop and implement Quality Improvement approach • Produce Annual Safeguarding Report
ORG0000054	Failure to identify, monitor and mitigate the impact of clinical quality as part of CIP could result in the transformation, development and delivery of services which are not safe or clinically effective.	Executive Director of Nursing Quality	12	• Carry out longitudinal review of services that the Trust is disinvesting from. • Current review of CIP QIAs by EDoN and EMD

Risk Reference Number	Risk Description	Owner & Committee	Risk score	Actions
ORG0000025	Failure to deliver and transform services to be highly efficient and provide best value may lead to an inability to meet financial control totals.	Executive Director of Finance Finance	12	• Review of on-going mitigations to the financial position by a Best Value & financial Improvement Work stream to inform financial recovery and planning • Review of medium term financial strategy • Progress Carter programme on operational productivity (confirmed national pilot Trust for Mental Health and Community trusts). To inform financial planning
ORG0000064	Failure to develop and deliver an effective HIS Strategy could affect the delivery of current services and future new business	Executive Director of Finance Finance	12	• Work plan to deliver HIS Strategy to be fully developed by ISG
ORG0000098	Failure to be able to determine statutory estates compliance in buildings not owned by the Trust in which Trust staff operate and services are delivered	Director of Business Development and Marketing Quality	12	• Audit Plan in place for desk top, unannounced site visits
ORG0000080	Inability to recruit, retain and motivate a diverse workforce that is reflective of the diverse communities we serve.	Director of Human Resources Workforce, Equality & Diversity	12	• Implement and monitor Strategic Equality & Diversity Action Plan, Stonewall Action Plan, BSL Action Plan, WRES priority actions, • Report on Workforce disability equality standard • Develop Working Longer Toolkit • Provide training support and instruction to ensure that staff collect and process patient demographic data (both divisions)
ORG0000096	Failure to have robust arrangements in place regarding compliance with the Mental Capacity Act 2005 may result in patients' rights under the Act not being upheld which in turn may result in legal or regulatory enforcement and reputational damage	Executive Medical Director Mental Health Legislation	12	• Approve comprehensive MHL Operational Group workplan • Improve clinical divisional representational MHLOG, monitor attendance and escalate when required. • Agree an overarching audit plan
ORG0000042	If violent or aggressive incidents take place then patients/staff/visitors could be subject to physical and psychological harm (including serious injury and fatality) leading to: patient recovery being undermined, increased staff sickness, litigation claims, low staff morale and negative impact on staff retention.	Executive Director of Forensic Services Quality	12	• Implement DOPACT • Implement Mechanical restraint action plan • Discuss violence issues from staff survey and agree next steps
ORG0000090	If RIO progress notes and accompanying paper documentation are not viewed contemporaneously then high quality and safe patient care could be compromised.	Executive Director of Finance Finance	12	• Complete document management roll out of using RIO (Local Partnerships RIO only). • Improve and streamline CESA document management/storage/classification process (Forensic services only)

Organisational Risks – Impact level 5

Risk Reference Number	Risk Description	Owner & Committee	Risk score	Actions
ORG0000061	If we fail to assure NHS England of effective leadership of Rampton Hospital, then it could lead to the removal of high security services and threatened the financial viability of the Trust.	Executive Director of Forensic Services Quality	5	• Reauthorisation of Trust to deliver High Secure Services - submission required to NHS England. • Review of the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013 • Audit baselines
ORG0000085	If a known ligature anchor point risk or yet to be established ligature anchor point risk are not eliminated or mitigated through an individual patient risk assessment that identifies issues of self-harm/suicide that are not effectively clinically managed and supported, then there could be a patient death.	Executive Director of Local Partnerships Quality	10	• Survey of all curved curtain track, removed when not bespoke anti-ligature or reduced risk product. • Implement Local Partnerships Action Plan (includes resourcing, timeframe). • Development of training structure and materials for ligature risks and ligature risk reduction.

Current and future (new and emerging) risks are considered in line with the Trust's RMS and the current governance structure. The Board of Directors reviews the risks captured on the BAF on a quarterly basis. An Executive Summary report details the actions taken to mitigate each risk and also indicates the extent to which assurance is provided. Each of the Board's Committees has a duty to monitor the risks relevant to their remit, undertaking 'deep dives' when required. The Executive Leadership Team monitors and reviews BAF risks on a monthly basis and takes action as required. The ELT considers new and future risks to the organisation and Executive Directors/Directors escalate/progress as required.

Principal risks to compliance with the NHS Foundation Trust licence condition 4 (FT governance)

The Board of Director, supported by the Audit Committee, undertook an assessment against NHS Foundation Trust licence condition 4: the provider has complied with required governance arrangements, and were assured that there are no material risks to compliance. This determination is based on:

- The external PwC review of the Trust against the well-led framework rated the organisation as 'Good'.
- The consistent review of the Board Assurance Framework and consideration of organisational risks at the Board of Directors, its committees and deep dives in Board development sessions and the audit committee.
- Internal audit reports to the audit committee on matters relating to governance, financial control and risk management.
- The review and approval of the Trust Scheme of Delegation and Standing Financial Instructions.

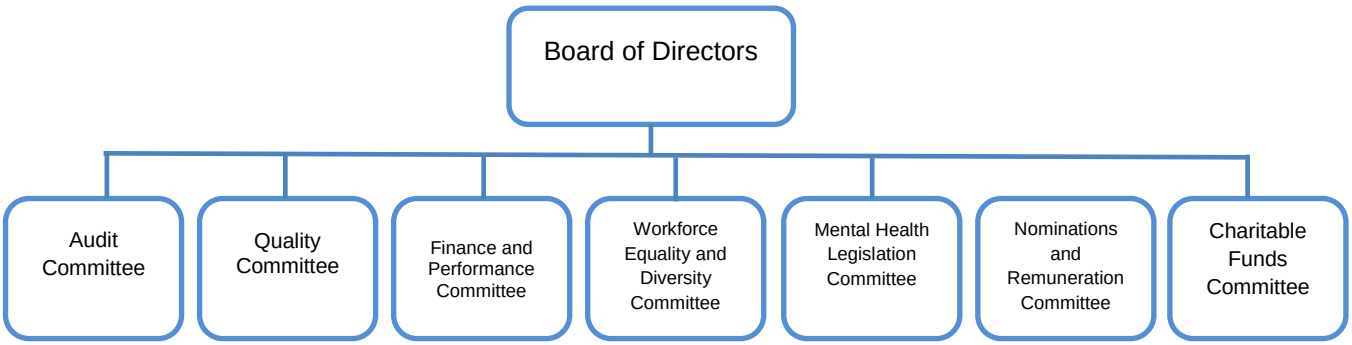
- Continuous reporting in accordance with the Single Oversight Framework to the Board of Directors – Integrated Performance Report – and the Trust's regulators eg NHSI, CQC.

Board of Directors and Supporting Committees
The Board of Directors comprises of a Chair plus six Non-Executive Directors (NEDs), a Chief Executive Officer and five voting Executive Directors. Two non-voting Directors also attend meetings of the Board together with the Trust Secretary.

The Board meets monthly and as such held 12 meetings during 2017/18.

The Board continues to focus both strategically and in assuring itself of the performance of the whole of the organisation. Standing items on the meeting agenda are an external and internal environmental scan, patient voice and service user feedback, staff voice, integrated performance reports and summary reports of meetings of the Board committees. The Board Assurance Framework and high level risk registers are reported on a quarterly basis. Detailed reports have been received on a broad range of strategic and governance issues.

To support the Board of Directors in fulfilling its duties effectively, committees are formally established with Board approved terms of reference. The remit and terms of reference of these Committees were reviewed during 2017/18 to ensure continued robust governance and assurance. The importance of the triangulation of understanding, challenge and assurance between committee's is recognised and reflected through cross-membership and reporting between committees and through the receipt of summary reports to the Board of Directors.



The following provides a brief overview of the remit of each of the prime scrutiny and assurance committees:

- **Audit Committee**: the prime purpose of the Committee is to provide assurance to the Board of Directors with regard to the continued effectiveness of the Trust's system of integrated governance, risk management, financial reporting and internal control. The Committee receives reports from the Trust's internal and external auditors and from the counter fraud service. The Board of Directors delegates responsibility to the Committee for the review and approval of the Trust's annual report and accounts. The Committee reviews the Trust's

compliance with the Code of Governance and has confirmed for 2017/18 there to be no significant breaches thereof.

The Committee met 5 times in 2017/18.

- **Quality Committee:** the Committee's prime purpose is, through a strategic approach, to maintain oversight and undertake scrutiny in order to inform the Board of the level of assurance identified that robust quality governance arrangements are in place throughout the Trust and that these are working effectively.

  The Committee met 6 times in 2017/18.

- **Finance and Performance Committee**: the Committee's prime purpose is to oversee and give detailed consideration to all aspects of the financial arrangements of the Trust, providing the Board with assurance that the financial issues of the organisation including capital expenditure are being appropriately addressed. The Committee also has oversight of the Trust's performance management framework, including the incorporation of quality metrics, undertaking detailed consideration of specific issues where performance is showing deterioration or there are issues of concern.

  The Committee met 5 times in 2017/18.

- **Workforce, Equality & Diversity Committee:** the Workforce, Equality and Diversity Committee is tasked through a strategic approach, to gain and provide assurance to the Board that robust Workforce and Equality and Diversity arrangements are in place throughout the Trust and that these are working effectively. In addition, the Committee receives and provides comment on workforce matters which are part of a regional and national agenda. Key areas of Committee oversight include:

  • Delivery of the People and Culture Strategy
  • Robust strategic workforce plans
  • Implementation and review of responsible strategies
  • Cost Improvement Programmes
  • Staff engagement, staff survey and Freedom to Speak Up
  • Whistleblowing
  • Board Assurance Framework and responsible risk management

  The Committee met 5 times in 2017/18.

- **Mental Health Legislation Committee:** the Committee's purpose is to consider policy, practice and procedures in relation to the Trust's management and administration of its responsibilities under the Mental Health Act 1983 and associated legislation, providing assurance that responsibilities, functions and duties are appropriately undertaken in accordance with legislation.

  The Committee met 4 times in 2017/18.

As well as the above key Committees for scrutiny and assurance, the Board of Directors is also supported by the:

- **Nominations & Remuneration Committee:** the Committee has responsibility for the review and evaluation of the structure, size and composition of the Board; to oversee talent management and succession planning arrangements and to consider and determine on matters of executive remuneration.

- **Charitable Funds Committee:** the Committee has delegated responsibility for ensuring the control and management of the Trust's charitable funds in accordance with statutory requirements.

In addition, the **Executive Leadership Team**, the most senior executive decision making body in the Trust, is responsible for ensuring that strategies approved by the Board of Directors are implemented with collective accountability for delivery, shaping and placing tactical and strategic responses, oversight of risk management, oversight of the Board Assurance Framework, oversight of the implementation of internal audit recommendations and serve a route of escalation.

During 2017-18, the Trust has continued to develop its **Council of Governors**, an integral element of the overall governance structure of the organisation, to enable the Council to fulfil its prime statutory duties:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and
- to represent the interests of the members of the Trust as a whole and the interests of the public.

Corporate Governance Statement
The Board of Directors, through the established governance assurance processes of the organisation, maintains on-going oversight of compliance with those principles, systems and standards of good corporate governance which would reasonably be regarded as appropriate for a supplier of health care services to the NHS.

To maintain ongoing compliance the Board of Directors has continued to review the effectiveness of its internal control systems including compliance with the Code of Governance. The Audit Committee has a key role to play in this process, receiving detailed reports to support positive declarations of compliance which are triangulated against internal performance and assurance reporting, internal audit reports and the Board Assurance Framework, with any deviations of risks escalated to the Board of Directors.

Guidance issued by the Care Quality Commission emphasises the importance of the Fit and Proper Person Requirements in ensuring the accountability of Directors of NHS bodies. NHS bodies have a responsibility to ensure the requirements are met with the Care Quality Commission's role being to monitor and assess how well this responsibility is discharged. The purpose of the regulation is not only to hold Board members to account in relation to their conduct and performance, but also to instil confidence in the public that the individuals leading NHS organisations are suitable to hold their positions. The Trust has recognised systems and processes to ensure

each member of the Board of Directors is fit and proper to undertake their role of office, including determining the independence of the Non-Executive Directors. The systems and processes were audited by CQC inspectors in November 2017. The inspectors were assured that the Trust was meeting the regulations, although there was verbal advice to the Trust Secretary to develop a Fit and Proper Persons Policy.

Single Oversight Framework
Compliance with NHSI's Single Oversight Framework is subject to on-going monitoring and reporting and is reported and scrutinised through the organisations governance structures on a monthly basis.

Through the above arrangements the Trust reports each month to the Board of Directors the compliance risk against the Single Oversight Framework and ultimately its score for 'segmentation'; defined categories identified by NHSI depending on performance against key metrics. The Trust ends the year in segment 2.

Management of Incidents
Robust systems are in place to manage and learn from patient safety incidents. The Board of Directors recognises the importance of ensuring an organisational culture which encourages and supports the reporting of incidents and near misses, the thorough and proportionate investigation thereof and the identification and dissemination of learning across the organisation.

The Board of Director's Integrated Performance Report continues to incorporate information on harm caused by incidents and detailed information on high risk incidents such as violence, using Statistical Process Control (SPC) which is based on plotting data over time. These are referred to as the 'Quality of Care' information.

The Trust reports and manages serious incidents in accordance with the NHS England Serious Incident Framework. The Trust has reported two Never Events during 2017/18. Full investigations have been carried out with support provided to the families involved and learning disseminated as part of the Trust's quality governance process. Other serious incidents have been reported and investigated and no significant control issues have been identified. The Trust responds quickly to incidents ensuring that lessons learned from them are implemented swiftly across the organisation. The processes for these continue to be reviewed and developed to ensure they are embedded in the culture of the organisation. The Trust has embarked on a new initiative known as the Quality Reporting Framework. The framework ensures the right information is received in the right sub-committees and groups and where issues are identified, ensures appropriate, sustainable improvements are made.

Sharing the learning through risk related issues, incidents, complaints and claims is an essential component to maintaining the risk management culture within the Trust. Learning is shared through divisional governance structures and Trust wide forums including the Quality Committee, Trust CIRCLE (Critical Incident Reporting Creating a Learning Environment) Sub Committee and Health, Safety, Security and Emergency Preparedness Sub Committee. Learning is acquired from a variety of sources which include:

- Analysis of incidents, complaints, claims and acting on the findings of investigations.
- External Inspections.
- Internal and external audit reports.
- Clinical audits.
- Outcome of investigations and inspections relating to other organisations.

The Trust CIRCLE group maintains oversight of the Trust-wide reporting, investigation and monitoring of serious incidents, ensuring that appropriate learning is gained and reflected into practice. This is supported by a trust-wide Serious Incident/Significant Issues group which reviews serious incidents received in the preceding week; raises any queries and receives assurance that immediate risks are being managed. It ensures that the Duty of Candour is applied appropriately and staff are supported, agrees what level of investigation is required and identifies incidents which could result in a difficult inquest or claim. The Executive Medical Director chairs this group on a weekly basis.

In addition, in line with NHS England Learning from Deaths guidance, the Trust has established a Mortality Surveillance Group to provide corporate oversight of Trust systems to report, review, analyse and learn from deaths of service users. It also provides a framework for determining what level of review/investigation should be conducted following deaths of service users that meets national reporting requirements. As a result the Trust is improving its learning from deaths of service users by introducing the Initial Management Review (IMR) process which determines the level of investigation required.

The Trust continues to work through a review of all policies including understanding how robustly these are embedded in the culture and working practices.

Preventing Future Deaths

The Coroner's Regulation 28 Report is issued if any information is revealed as part of the Coroner's investigation or during the course of the evidence heard at the Inquest, which gives rise to 'a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future' and if the Coroner is of the opinion that action needs to be taken. These are often known as Preventing Future Deaths Reports (PFDs). The report will set out the concerns and request that action should be taken by the Trust. During 2017/18 the Trust received two PFDs. One was in regards to suicide by hanging and the Coroner raised concerns in regards to the effectiveness of the Crisis Team to ensure consistency and continuity of care, accurate record keeping and how the team escalate and report matters of concern to senior managers. The second was in regards to an incident where a patient fatally stabbed themselves. The Coroner felt that there was a lack of coordinated discharge from inpatient care to the community, in particular the failure of appropriate professionals from hospital and community to liaise and for family to be informed as a prerequisite for discharge. Action plans were agreed for these cases and sent to the Coroner.

The Never Events policy and framework supports the Trust in continuing efforts to build a learning culture and maximise opportunities to keep our patients safe. Never Events are defined as Serious Incidents that are wholly preventable because

guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. In 2017/18 the Trust reported two Never Events. During a paediatric general anaesthetic list at a local acute hospital, the dental trainee who was carrying out the dental treatment on the last patient on the list removed the lower left first permanent premolar in error. The tooth was re-implanted immediately and treatment given. This incident constituted a Never Event under wrong site surgery. The second incident was in regards to a misplaced naso-gastric (NG) tube. The Trust member of staff was supporting the family of the patient to insert a NG tube for feeding. The tube was inserted but the patient became rapidly unwell. Feed was stopped and ambulance contacted and the patient taken to hospital, however the patient tragically died. Support was given to the families involved.

Public Stakeholders
The Trust proactively seeks and welcomes feedback from and involvement of stakeholders in relation to the provision of services and the management of risk. Key ways by which public stakeholders are involved in managing risks which have potential to impact on them include:

- Well established processes for patient, service user and carer feedback
- Through the Council of Governors
- The Trust's engagement with commissioners, the Joint Health Scrutiny Committee and Healthwatch
- Consultation on the Quality Account
- Consultation on transformational plans.

Compliance Statements
The Foundation Trust is not-fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pensions 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 update in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation`s obligations under equality, diversity and human rights legislation are monitored with a view to measuring compliance. Training in equality and diversity is mandatory for all staff and a key component of our new staff induction process. This aims to ensure that all employees are equipped with the appropriate knowledge and awareness to provide consistently fair treatment towards both colleagues and patients/service users alike.

Attendance at any of the equality and diversity conferences that the Trust has hosted is also counted as mandatory training. In addition to this, team sessions are being offered by the equality and diversity lead for any teams who would like further information and training around equality and diversity.

In accordance with the Modern Slavery Act 2015, the Trust ensures that Modern Slavery i.e. slavery and human trafficking, is not taking place in any part of its own business or any of its supply chains. This is achieved through ensuring that services are procured through approved providers only or tendered through robust procurement processes.

The foundation trust had 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 Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources
The Board takes responsibility for oversight and risk management assurance throughout the trust and receives the Board assurance framework at its formal meetings.

The trust's strategic objectives form the basis of the Board assurance framework. The strategic objectives are linked to key risks, internal controls and assurance sources. Mitigating controls and assurances are recorded and monitored to deliver reasonable assurance for prevention of risks, deterrent to risks arising and management of current risks. The control mechanisms in place are designed to minimise or eliminate the risk of failure to deliver objectives, including robust corporate and performance management frameworks, service level agreements and contract monitoring, policies and procedures.

The Board delegated detailed oversight of the Board assurance framework to the Audit Committee. This Committee assesses the effectiveness of risk management by: managing and monitoring the implementation of the Risk Management Strategy; considering findings from internal and external audit reviews; calling Executive Directors to account for their risk portfolios and monitoring the Board Assurance Framework at each of its meetings. The end of year review of the Board Assurance Framework by the Head of Internal Audit has resulted in an opinion of reasonable assurance that the Board Assurance Framework is effective.

Overall performance is monitored at meetings of the Board of Directors and the Finance and Performance Committee. Performance reports provide data in respect of financial, clinical and workforce together with national targets and objectives. Any areas of concern are highlighted and mitigating actions taken where deemed necessary. The Finance and Performance Committee is also responsible for the consideration of investment risk.

Achievement of efficiency, effectiveness and value for money is central to the Trust's organisational strategy and is one of four key objectives that underpin the Trust's approach to governance. The Trust has an overarching programme executive to maintain focus and pace on delivery of key objectives which includes a work stream specifically dedicated to this area.

Clinical risk and patient safety are overseen by the Quality Committee, the Director of Nursing, the Medical Director and the Operational Directors. The Board receives

monthly reports encompassing the quality and patient safety aspects for the trust. The Quality Committee has focused on assurance that the trust is embedding the lessons learned from inspections. This assurance is reported to the Board.

The Audit Committee received regular reports from the local counter fraud specialists which identified specific fraud risks and investigated whether there was evidence of those being exploited. No significant risks, classes of transactions or account balances were identified. The Committee has focused some attention on the relationship between committees, ensuring triangulation of risk and performance data to ensure assurances are considered and robustly tested.

The Trust remains a key partner in the local health economy and is central to the Sustainability and Transformation Partnerships (STPs) developed in both Nottinghamshire and South Yorkshire. Reducing inefficiencies and mitigating financial risks are core to both STPs.

All of the above arrangements are subject to and supported by Internal and External Audit reviews. Any findings and recommended actions are implemented, monitored and reported through to the Audit Committee. External Auditors are also required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in how its uses its resources.

Information Governance

Responsibility for Information Governance in the Trust rests with the Executive Director of Finance who undertakes the designated role of Senior Information Risk Owner. Policies are in place which are compliant with NHS guidelines, and incident reporting procedures are in place and utilised by staff.

During 2017/18 there were five HSCIC Information Governance Toolkit defined Level 2 Serious Incidents. Four further incidents were recorded on the Toolkit as initially meeting the requirements for reporting, however on investigation, were re-graded.

Date of Incident	IG SIRI Level	Breach Type	Summary of Incident	Reported to ICO	ICO Action
15-Dec-17	2	Disclosed in Error	Patient assessment followed admission via A&E; urgent letter was typed by admin at the request of HCP. Letter included sensitive, confidential information about the patient and seven (possibly eight) other individuals. HCP asked for the letter to be sent to third party agencies who were also involved in providing support to the patient, one of whom was a Social Worker with County Council. Letter incorrectly addressed to a private SW training provider.	Yes	Awaiting Feedback
23-Nov-17	2	Non-secure Disposal of paperwork	Documents containing sensitive, confidential information were found in a waste area at a Trust site.	Yes	No Action
20-Sep-17	2	Unauthorised Access/Disclosure	Complaint received from family member of a patient that a member of staff alleged to have accessed the patient electronic record on more than one occasion. According to the family member, the member of staff apparently known to the patient. Safeguarding referral made due to the risks and wellbeing of both patient and member of staff concerned.	Yes	Ongoing
11-Sep-17	2	Unauthorised Access/Disclosure	Locum Consultant Psychiatrist emailing documents containing personal data (patient) to unsecure email accounts from Trust email account. The email accounts include Hotmail and St Andrews (private provider). Documents emailed were to enable Locum to complete registration requirements. Some had been redacted, others had not.	Yes	No Action
29-Aug-17	2	Lost or stolen paperwork	Laptop bag containing laptop, mifi, 1 set of patient nursing records and print-outs from patient information system containing information relating to 3 patients, left in a car boot of Trust employee. Bag and contents have been stolen from car at some point during a 4 day period. Laptop bag was found in an alleyway by a neighbour and all patient information was recovered. Laptop and mifi were gone.	Yes	No Action

Date of Incident	IG SIRI Level	Breach Type	Summary of Incident	Reported to ICO	ICO Action
05-Jan-18	1	Unauthorised Access/Disclosure	An employee of County Council used the RiO log in details of a Trust HCP to review two sets of patient records. Also alleged to have taken copies of RiO notes for both patients and emailed them to their NCC account as unprotected word documents using the Trust email account. Whilst the access to the information was for legitimate reasons, the process of access and sharing was not in line with either organisational policy. Matter also reported to the County Council.	No	N/A
05-Dec-17	1	Disclosed in Error	Medical Report for a CPA Meeting written by Ward Doctor presented to the Care and Treatment Review (CTR) Team. The external CTR team were all visitors to the hospital and were due to review patient's current care and treatment. Some pages of the report related to a different patient. Information in this section of the report relates to several instances of seclusion and disruptive behaviour.	No	N/A
06-Nov-17	1	Lost In Transit	Numerous prescriptions issued via fax and/or post by the Continence Advisory Service has not been received by the intended recipients.	No	N/A
15-May-17	1	Unauthorised Access/Disclosure	Two emails were sent from a staff member from personal email accounts to another staff member's Trust email account, which contained staff, patient and relative's information relating to Care Programme Approach (CPA) meetings. One of the emails was sent to Trust employee's family member, from employee's email address.	No	N/A

Annual Quality Report

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. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Annual Quality Report is published as part of the Trust's Annual Report. The Annual Quality Report for 2017/18 has been developed in accordance with national guidance with its development being led by the Executive Director of Nursing.

Stakeholders receive a draft version of the report for comment, with feedback received reflected within the final version. The Council of Governors and lead commissioner are also consulted on the report's content.

Data included within the report is based on the descriptors set out in national guidance and is subject to data quality checks as part of the Trust's Performance Indicator Assurance Process.

The Quality Committee has a key role in monitoring the report's content, the determination of Quality Priorities, the ongoing monitoring thereof and for providing assurance to the Board of Directors.

The completed Quality Report, including two mandatory indicators and one local indicator and comments received from our stakeholders is subject to review by the Trust's external auditors.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to 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 the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The internal audit opinion for 2017/18 provided by 360 Assurance, is as follows:
'I am providing an opinion of Significant Assurance, that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently. This opinion is based on my review of your systems of internal control, primarily through the operation of your Board Assurance Framework in the year to date, the outcome of individual assignments completed and your response to recommendations made.
I have reflected on the context in which the Trust operates, as well as the significant challenges currently facing many organisations operating in the NHS, and my Opinion recognises that the system of internal control is designed to manage risk to a reasonable level, rather than eliminate all risk of failure to the achievement of strategic objectives'.
The internal audit reports which received limited assurance were:

- Preparedness for the General Data Protection Regulations (GDPR)
- Early Intervention in Psychosis
- Organisational Ethics and Values: Conflicts of Interest
- Bank Staffing

- Medical Devices
- Review of Strategic Workforce: Local Partnerships and Forensic Divisions

There is a clear, dynamic process for monitoring progress against audit recommendations with oversight by the Audit Committee. Recommendations from any reports providing limited assurance are prioritised.

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

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, supported by the Audit and Quality Committees' regular reports to the Board. Processes are in place to maintain and review the effectiveness of the system of internal control by:

- the Board providing overall leadership for the management of risk against the achievement of organisational objectives
- the Board's receipt of the Board assurance framework at its meetings
- the Audit Committee assurance on the effective operation of the risk management system
- each level of management being responsible for the risks in their areas, regularly reviewing them and the controls in place to mitigate them
- the internal assurance process used to monitor compliance with the Care Quality Commission essential standards.

Conclusion

There have been no significant internal control issues identified in the Trust in 2017/18. However, weaknesses in quality governance process were identified which resulted in non-compliance against certain fundamental standards of care as identified by the Care Quality Commission. Initial remedial action has been taken, but there remains work to do to deliver the action plan in response to the Care Quality Commission findings, which will continue in 2018/19, closely monitored by the Board of Directors and the Quality Committee.

The Head of Internal Audit confirms that Nottinghamshire Healthcare NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. The Trust recognises though that the internal control environment can always be strengthened and this work will continue in 2018/19.

Ruth Hawkins
Chief Executive
24 May 2018

VOLUNTARY DISCLOSURES

Equality and Diversity

As a Trust we are passionate about championing a culture of Equality, Diversity and Inclusion where people are able to be themselves in the workplace and in our services should they choose to do so. Consequently we strive to not only meet but surpass our legal duties and do this through working in partnership with our staff and those members of our diverse communities who use our services. Together we determine our priorities, which the Trust then action and report to our stakeholders so that we are held accountable.

The Trust's Strategy for Equality, Diversity and Inclusion is contained in our Single Equality Scheme for 2016-2021 (the Scheme). The Scheme is published on the Trust's Equality and Diversity webpage at: https://www.nottinghamshirehealthcare.nhs.uk/equality-and-diversity-reports accompanied by its Action Plan. This strategic Equality and Diversity Action Plan is the Trust's delivery mechanism for the Scheme, which has embedded within it our Equality Delivery System 2 (EDS2).

Over the last year we have continued to strengthen our Equality and Diversity governance within the Trust and the work of our Equality and Diversity Subcommittee has progressed well, with clear evidence demonstrated of strong partnership working to meet strategic and operational aims. This Subcommittee provides assurance to the Workforce, Equality and Diversity Committee, a committee of the Trust Board, that we are meeting our statutory and public responsibilities. This is also assured via a 360 Assurance audit of our equality and diversity practices and processes, which we commissioned in 2016, to ensure that our robust governance objectives were being met. It is also noteworthy that Board Champions, that support each of the Equality and Diversity strands, are now in place. This sponsorship has already proved to be a very valuable support and resource for the strand steering groups and the wider Equality and Diversity agenda.

Closely aligned to the Trust's Vision, Values and Five Year Strategy (2016-2021) we actively champion three overarching objectives, enabling us to measure our performance and identify how good we are at achieving our goals. The three objectives are:

- services which meet the diverse needs of our communities;
- recruiting and retaining a diverse workforce which is inclusive of and reflects the diverse communities it serves;
- understanding and engaging with our communities.

Progress on Equality, Diversity and Inclusion has been swift over the last few years and our accomplishments many. We do however acknowledge that there is still work to be done and are committed to ensuring this continues with the same passion and determination as before. It is therefore important that we acknowledge and celebrate the accomplishments we have made, which are not only those of Trust staff, but its service users, carers, partner organisations, governors and community members.

Noteworthy progress:

- As part of our commitment to improve staff voice we have established a BME (Black and Minority Ethnic) Staff Network. The Network, which had its first meeting in June 2017, has an agreed Terms of Reference and following a democratic election process a leadership group that will champion and drive the Network forward. This will ensure that the voice of BME staff is clearly heard and acted upon within the organisation and that BME staff are actively engaged in the decision making process.
- We have launched our Race, Religion and Belief Equality Steering Group, which is supported by our 'Race, Religion and Belief Board Champion' Simon Crowther, Director of Finance and our 'Senior BME Champion' Dr Itai Matumbike, Associate Medical Director (Medical).
- Work on the Workforce Race Equality Standard (WRES) is progressing well. Following consultation with our key stakeholders, including members of our Race Religion and Belief Equality Steering Group and BME Staff Network we continue to focus on two main objectives namely the bullying and harassment of BME staff, and BME recruitment and retention. Key successes over the last year in this respect include:
    - establishment of the aforementioned BME Staff Network;
    - launch of a new Respect At Work Policy, which clearly addresses tackling bullying and harassment;
    - development of a Trust wide Resourcing and Retention plan;
    - a review of the Trust induction;
    - additional learning and development/ leadership development offers for BME staff;
    - promoting career opportunities within our diverse communities via open days, community media and an active presence at community events;
    - promoting positive role models within schools via the Health Ambassadors Scheme, supported by Health Education England;
    - delivery of Unconscious Bias training to 190 senior colleagues at the Trust's Leadership Council;
    - participation in NHS Improvement's Non-Executive Director Board Development Programme;
    - launch of an anonymous reporting system and two-way dialogue to ensure the mechanisms for staff to report issues of bullying, harassment, discrimination and victimisation are accessible, quick and simple to use;
    - development of a BME role model DVD in partnership with other BME networks from the public and educational sectors in Nottinghamshire;
    - additional training and support to ensure that line managers have the right skills in place to effectively support staff and deal with bullying and harassment issues as an integral part of the Trust's Vision 21 and Aspire management development programmes.
- A Trust sponsored WRES/ Black History Month celebration event was held in October 2017 and well-attended by staff, service users, volunteers, partner organisations and community members. The aim of the event was to celebrate BME identities, showcase and promote BME role models and help build community relations and evaluation suggests that it achieved all of these

aims and more. All of the BME role models who shared their inspirational journeys touched and motivated others.

- We have developed and implemented our Developing Our People and Culture Strategy, the purpose of which is to develop and encourage real and meaningful cultural change within the organisation, thereby helping make Nottinghamshire Healthcare a Great Place to Work and a service provider of choice.
- Our work as a Stonewall Star Performer continues and during the last year we continued to provide advice to the NHS Equality and Diversity Council on its Lesbian, Gay, Bisexual and Trans (LGBT) Action Plan via a working group, which has since been disbanded. In February 2018, as part of LGBT+ History Month celebrations we held a partnership conference with a number of organisations who identify as the Nottinghamshire Diversity Champions Partnership. This conference, which involved staff, service users and carers, focused on Bisexuality and the varying identities within. The Partnership continues to work collectively to share expertise, resources and training to further advance equality and diversity within our workplaces. Following on from the LGBT+ Role Models DVD we produced in 2016/17 we have been involved in producing DVDs looking at mental health role models and BME role models within each of our respective organisations.
- Trans Awareness Training continues to be delivered across the Trust via standard and bespoke courses. We continue to share good practice and support other organisations to develop Trans equality and freely share our Trans Awareness Training package to other employers and providers to help inform and achieve their goals.
- Engagement and partnership working with Nottinghamshire's Deaf Communities has continued to develop through collaboration with other public sector organisations in the City and County. Our comprehensive action plan, developed in consultation with the Nottinghamshire Deaf Wellbeing Action Group, continues to progress well and is embedded within the Strategic Equality and Diversity Action Plan. We continue to engage in community listening events and ensure the involvement of Deaf community members in our work e.g. our Annual General Meeting and Annual Members' Meeting. Short films have been produced which focus on two of the most important areas identified by Deaf patients and carers and are available on the Trust website at https://www.nottinghamshirehealthcare.nhs.uk/british-sign-language We continue to update a comprehensive BSL Community Web Resource Library, initially developed in 2016, to enable Trust staff and partners to signpost Deaf people to signed and subtitled health information videos.
- In order to ensure that the Trust met the requirements of the Accessible Information Standard a Trustwide working group was set up to lead on this work. As part of its work the following processes are now in place:
    - An Inclusive Communication Needs form is now available on both RiO and SystmOne patient information systems;
    - an E-learning package has been developed to raise awareness of staff and help develop skills and knowledge in this area;
    - a ward resource pack has been developed and circulated to all services;

    - a DVD has been produced and is being used in staff training. It was launched at Trust Leadership Council in February 2017.
- The Trust website has been updated to improve accessibility, ensuring that navigation is simple and easy to use, with easy to find contrast buttons, which improve the browsing experience.
- Training for staff in Mental Health Services for Older People (MHSOP) on progressive hearing loss has been designed and delivered in partnership with The Nottingham University Hospitals (NUH).
- Safeguarding adults and children has been added to the Equality Impact Assessment template and associated guidance as a subsection within Human Rights. In order to ensure adherence this has been replicated within the Quality Impact Assessment Framework.
- Equality, Diversity and Inclusion training is a mandatory requirement for all Trust staff. Current compliance is 93% across the organisation. A broad training offer is provided to meet staff needs, where possible, from generic Equality, Diversity and Inclusion training to strand specific. All new starters to the Trust currently receive 90 minutes training on the first day of their induction. We also, where at all possible, try to ensure we commission training for staff using 'authentic' trainers from our diverse communities.
- The Trust's award winning Wellbeing at Work Scheme (bronze level) is now embedded in the organisation and is supported by around 84 Health and Wellbeing Champions within services. A wide variety of activities, training courses; tips for healthy living etc. are easily accessible on the Staff Health and Wellbeing intranet pages.
- A Working Life and the Menopause Seminar was held in June 2017 to raise awareness of the issues that affect women (and some men) during this time of life, share good practice, including hints and tips, and to learn valuable skills to support self and/or others. Presentations from the event have been uploaded onto the Staff Health and Wellbeing intranet pages to share learning. Guidance for staff and managers on Work and the Menopause has been developed by Human Resources, with the support of the Gender Equality Steering Group.
- Guidance for staff on recording and reporting hate crime has been developed and distributed, supported by advice and guidance on the Trust intranet site. Trust staff attend meetings of the Nottinghamshire Hate Crime Steering Group to engage in joint work with partners to tackle and respond to hate crime.
- Trust services continue to participate in culturally and socially diverse community events to consult and engage 'seldom hear' communities e.g. Gypsies and Travellers, Asylum Seekers and Refugees, LGBT+ people, faith communities etc. These include the Robin Hood Marathon, Nottinghamshire Pride, Splendour, faith meetings, disability community roadshows etc. In October 2017 a recruitment and community engagement stall was staff at a local BME community event in celebration of World Mental Health Day 2017, organised by Awaaz. A 'Working With and Involving Our Communities Group' has been established to lead on this work.
- Examples of engaging internal communities in the developments of services can be evidenced in the Forensic Services Division via the £10m refurbishment of the C&D Blocks at Rampton Hospital and the developments at Arnold lodge. Furthermore the rollout of the Sense of Community CQUIN in high secure services will further enhance patient and carer engagement.

- The Trust published its first Gender Pay Gap report by the statutory deadline of 30 March 2018. The findings in this report have been discussed by the Trust's Executive Leadership Team and will inform our Strategic Equality and Diversity Action Plan. This will be monitored by the Workforce, Equality and Diversity Committee of the Trust Board.
- The Trust's Transcultural Cognitive Stimulation Therapy Project within Mental Health Services for Older People continues to be recognised nationally for its ingenuity and innovation and for improving patient outcomes.
- The Trust's Apprenticeship Scheme continues to grow and develop with increasing numbers of apprentices being recruited, trained and supported 80% of whom achieve a positive outcome of employment or progress onto further training at the end of the Scheme.
- The innovative Children, Young People and Families Project progresses well with the building work for a brand new, purpose built 'Hopewood' facility for children, young people and families, which is due for completion and occupation in 2018/19.

Conclusion
Activities during 2017/18 have supported this agenda, developing it further and preparing for the next steps, as outlined in our Strategic Equality and Diversity Action Plan.

Environment and Sustainability Report 2017/18

Sustainability Leadership and Vision
The Trust's current Sustainable Development Management Plan (SDMP) was approved by the Trust Board back in 2015. Due to the progress that has already been made and in response to changing guidance and best practice issued by the NHS Sustainable Development Unit (NHS SDU), this is now being reviewed and updated. The objectives and targets contained within the revised SDMP, due to be presented to the Board for approval in June 2018; will be aligned to the new Sustainable Development Assessment Tool (SDAT) issued by the NHS SDU.
The key areas are detailed below:

- Corporate Approach
- Asset Management and Utilities
- Travel and Logistics
- Climate Adaptation
- Capital Projects
- Green Space and Biodiversity
- Sustainable Care Models
- Our People
- Resources
- Carbon and Greenhouse Gases

Currently meetings are being held with senior managers from each area to agree new objectives and targets so they are relevant, achievable, patient focused and deliverable.

To ensure continual improvement is made and that the Trust remains on target to achieve the objectives set, each area has a nominated/responsible lead. Under the proposed reporting process the lead will report progress every six months to the Board via the Sustainability Steering Group.

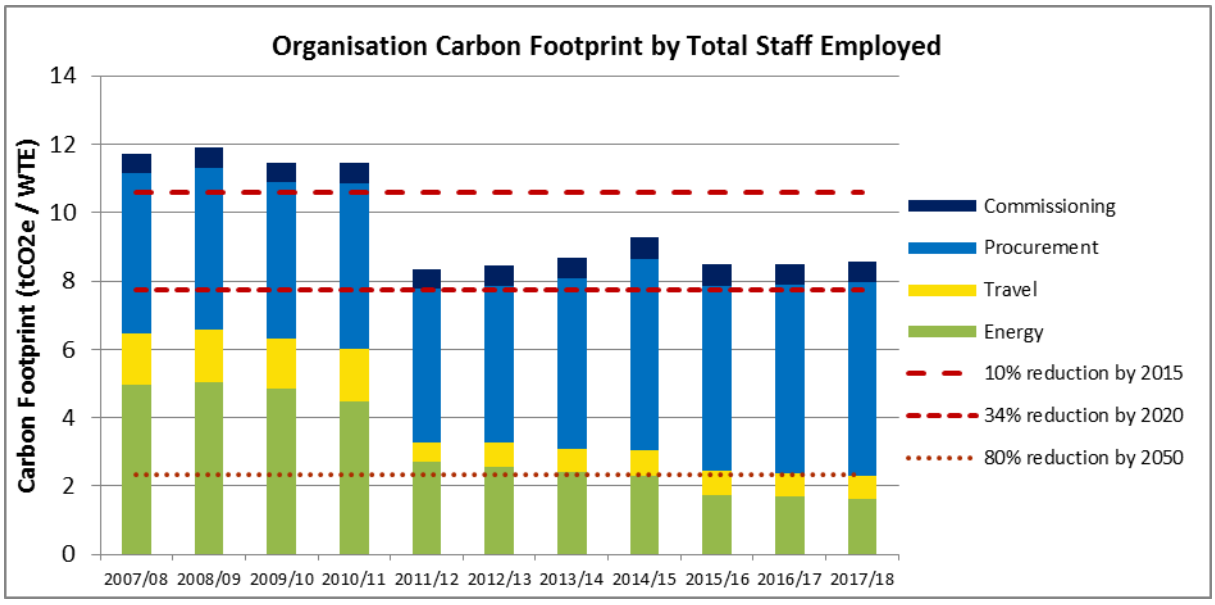
The overarching vision of the new SDMP is to *'ensure that the Trust works within its available environmental and social resources to protect and improve health both now and for future generations*'.

Our goals are to ensure:

1: A healthier environment
2: Communities and services are ready and resilient for changing times and climates
3: Every opportunity contributes to healthy lives, healthy communities and healthy environments
The current SDMP dated 2015 can be found on the Trust website at https://www.nottinghamshirehealthcare.nhs.uk/what-are-our-priorities-and-how-are-we-doing. Once the revised plan has been approved by the Board in June 2018, this will be made accessible for all relevant stakeholders both within and outside of the Trust.

Carbon Reduction
The Trust aims to reduce its carbon footprint in tonnes of carbon dioxide equivalent (tCO_2e) per whole time equivalent (WTE) against a 2007/08 baseline by 34% by 2020, and 80% by 2050, in line with the requirements of the Climate Change Act 2008.

The Climate Change Act 2008 outlines the UK's approach to tackling and responding to climate change. It requires a reduction in emissions of carbon dioxide and other greenhouse gases and that climate change risks are prepared for. The revised SDMP will set objectives to ensure both of these requirements are addressed.
The graph below outlines our past and projected progress against this target.

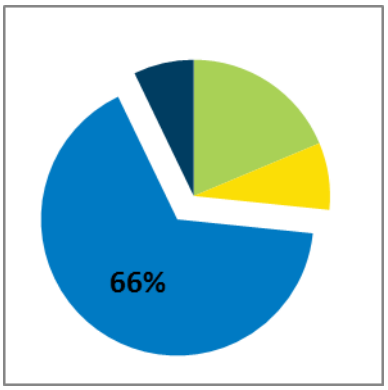


There are four main categories which make up the carbon footprint of the Trust. These are Procurement, Energy, Commissioning and Travel. The actions taken and progress made during 2017/18 in each of these areas is detailed in the following section.

2.1 Procurement

Carbon emissions associated with procurement still remain the greatest contributor to our carbon footprint accounting for 66% of the total.

Although carbon emissions associated with procurement have remained consistent to those recorded last year, considerable progress has been made in terms of procurement practice over the last year.



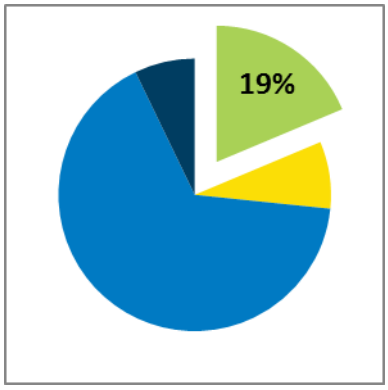
The Trust has developed and successfully implemented procedures to demonstrate how it complies with the Public Services (Social Value) Act 2012. It is now standard practice at the outset of each procurement project for the procurement lead and project sourcing group to consider how the Social Value Act applies to that particular project and detail the measures that will be put in place to support it. An example of this is breaking larger tenders into geographical lots to support small and medium sized enterprises.

Whole lifecycle costing for procurement contracts has been introduced and during the last year, high expenditure goods and services were reviewed to identify priority areas for action.

Perhaps one for the most successful procurement initiatives was the Mono Printing Project, an idea which targeted the reduction of colour printing. In 2016, it was calculated that the Trust printed 12.5 million colour pages costing a staggering £450,000. A number of measures were introduced in 2017, including identifying and monitoring high users, and the results were remarkable. There was a 46% reduction in colour printing and total printing was reduced by 20%. Clearly this initiative delivered a financial saving, but also improved resource efficiency too.

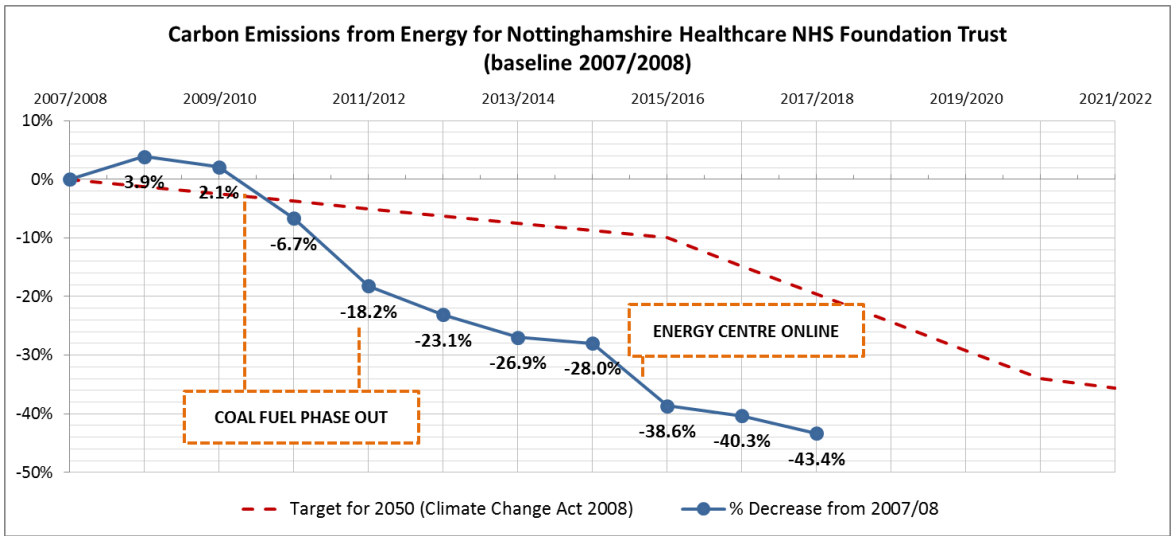
In 2017 the Trust's Procurement Department continued to work towards achieving Level 2 Accreditation of the Department of Health's NHS Standards in Procurement. The standards set out a framework for assessing and benchmarking procurement performance.

2.2 Energy

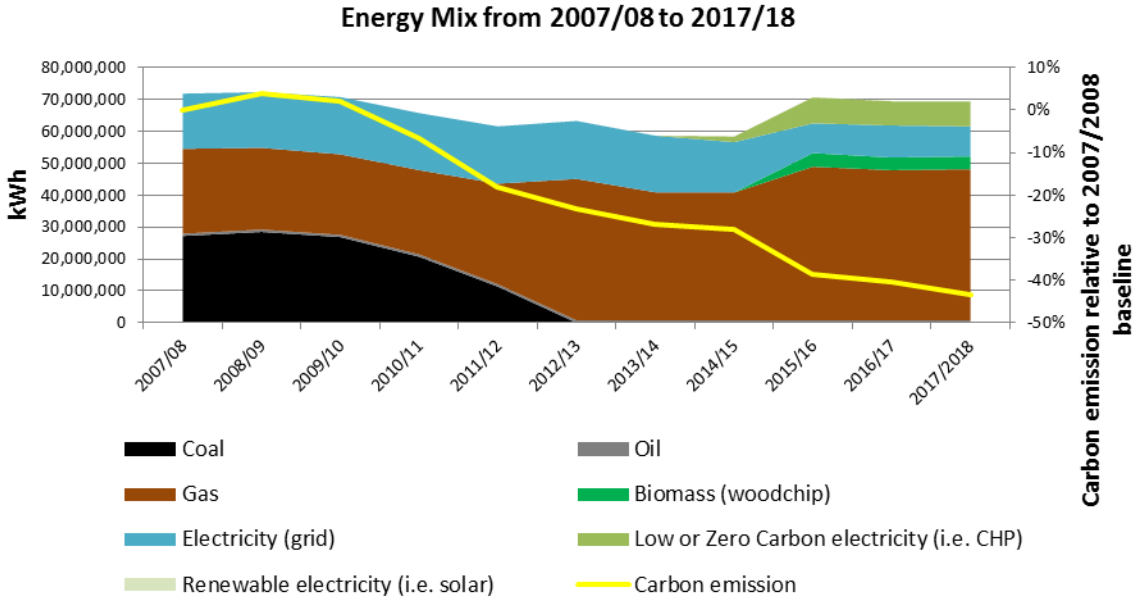


Carbon emissions associated with building energy account for approximately 19% of the Trust's overall carbon footprint. This comprises all Forensic Services and Local Partnerships properties.

In the baseline year 2007/08, the reported emissions were 25,575 tCO_2e. During 2017/18 the emissions were 14,484 tCO_2e a reduction against baseline of 43%. The carbon emissions monitoring is in line with the reporting guidelines of the NHS SDU.

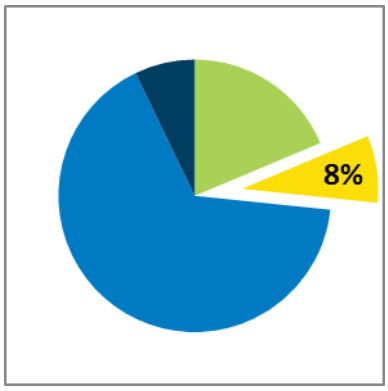


Since 2007/08 there has been significant investment into energy efficiency and renewable energy as a strategic move to reduce the Trust's carbon footprint, enhance its environmental sustainability, reduce operational and maintenance costs, and to improve resilience.



Purchasing

The Trust's spend on utilities in 2017/18 was £3 million. During 2016 the Trust's energy purchasing strategy was reviewed. Following on from this in 2017, to ensure operational effectiveness and efficiency, a review of alternative framework providers was undertaken to ensure that the Trust was achieving best value. We were assured after this benchmarking exercise that our current purchasing strategy and provider delivers financial sustainability.



Compliance

As required by UK law the Trust is part of the Carbon Reduction Commitment (CRC) Scheme. The carbon emissions associated with our energy use is externally audited by independent assessors on an annual basis. In 2017, as all previous years, we were fully compliant with the legal requirements. The next CRC audit will take place in June 2018. The reported carbon emissions under CRC are different to those stated in this report, due to differences in the calculation methodologies.

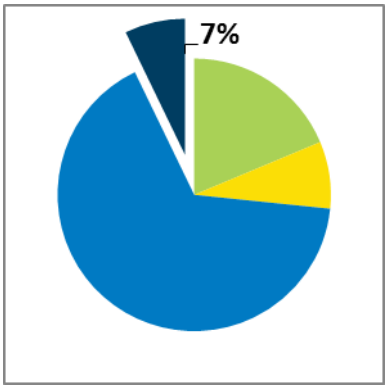
The cost of CRC compliance in 2017/18 was £186,000 with a cost of £16.60 per tCO_2e. The unit price of carbon will increase to £17.20/tCO_2e in 2018/2019. The Trust has compensated for this increase by successfully implementing energy efficiency measures and on-site energy generation, i.e. solar panels, combined heat and power (CHP), which has resulted in a saving on this environmental tax.

Projects

The replacement of the coal fired boilers at Rampton Hospital with the biomass boiler and CHP system continues to provide significant carbon and financial savings. Work is underway to determine if the system can be expanded to include other areas of the Hospital. Additionally enquiries are being made into the opportunities available to the Trust to export electricity generated to the national grid.

In 2017 the Energy and Environmental Team co-ordinated for the third year running its 'Energy Challenge' which saw 19 sites compete with each other to reduce electricity and gas consumption. This was achieved through encouraging building occupiers to report faults and raise awareness about energy efficiency. The project was again a great success and highlights the importance of involving stakeholders in environmental initiatives. Engaging with our staff is essential to encourage behaviour change which will help to deliver financial as well as carbon savings. The Energy and Environmental Team has continued to support the development of Hopewood, the new Children, Young People and Families Unit in Arnold, Nottingham to ensure that energy efficient behaviours are adopted by building occupiers. The new site will also benefit from LED lighting, a CHP plant providing power across all three buildings and efficient underfloor heating in patient areas.

Commissioning
Based on the model provided by the NHS SDU there has been little change in the carbon emissions associated with commissioned health and social care services. As previously identified this is an area that requires further understanding and development. Commissioning currently is estimated to represent 7% of the Trust carbon footprint.

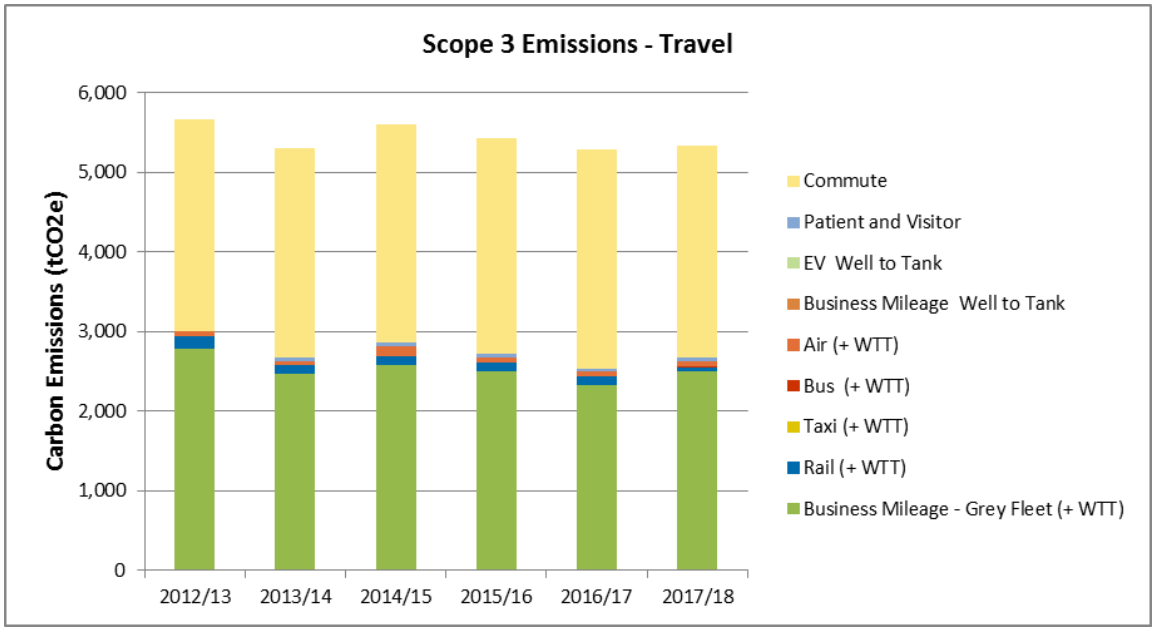


Travel
Business travel miles travelled (including road, rail and air travel) represents 8% of the Trust's carbon footprint. In 2017/18 7 million business miles were travelled, a slight increase when compared with the previous year. The composition of air travel has changed during the reporting year with an increase in long haul flights but a decrease in short haul and domestic flight mileage.

During 2017 there were a number of changes to sustainable travel options within the Trust. Due to limited uptake by staff of our Liftshare webpage, the subscription for this service was not renewed. It is understood that this had minimal impact due to the limited number of staff signed up to the scheme in the first instance and also due to the fact that staff could still access the Liftshare database, the only difference being the potential for finding someone to share with was based on region not employer.

Additionally the contract for the Trust's Pool Cars expired and was not at this time renewed or retendered. The next steps for pool car provision will be decided once data from the Trust's first ever all staff travel survey issued in February 2018, has been analysed.

Despite the reported changes to travel options, the Trust was one of many organisations within the region that promoted the first ever National Clean Air Day Campaign in June 2017. Using Connect (the Trust intranet) to raise awareness, we were able to engage and inform our workforce about the causes and impact of air pollution, a topic of importance regionally given that Nottingham City Centre will, by law, be required to have a Clean Air Zone by 2020. The Trust is an active member of a working group established by the Council in Nottingham to tackle air quality.



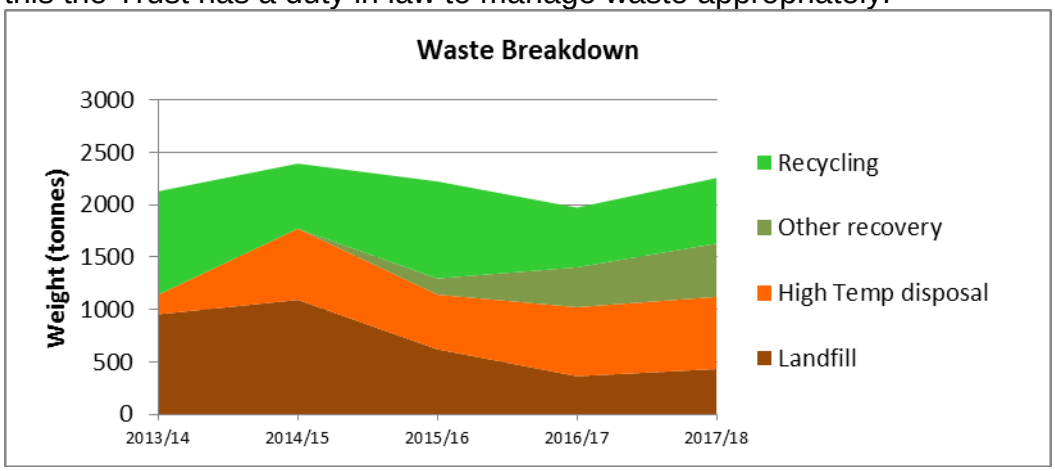
(* Note: WTT in graph means Well to Tank – emissions associated with extracting, producing and transporting fuel)

Currently there isn't a Trustwide Travel Strategy or Plan which would detail reduction targets. However, site specific travel plans exist for some sites where these have been a specific requirement of planning for example the new Hopewood site.
As mentioned previously, in February 2018 the Energy and Environmental Team launched the first ever Trustwide Travel Survey to better understand the travel habits of our staff. The survey was available via the Trust's Connect homepage (and via paper copy if requested) for a month and in total, 420 members of staff completed the survey which represents approximately 5% of the Trust's staff.

It is hoped that the output of the travel survey will highlight areas for development and influence the scope and shape of sustainable travel options for the Trust going forward. The information from this survey will also be used to determine if the Trust is eligible for grant funding from Nottingham City Council which has been made available to help encourage and support healthy and active travel with the city.

Waste

Waste has the potential to cause significant environmental harm, and as a result of this the Trust has a duty in law to manage waste appropriately.



There are a number of reasons why the confidence levels in our waste data reporting is lower than in previous years and why there may be areas of duplication and/or under reporting.

In 2017 we terminated the services of SUEZ before the end of the contract due to repeated poor performance. We also experienced significant issues in relation to both invoicing and the quality of data from our healthcare waste contractor Stericycle (formerly SRCL). The situation has been managed with support from Procurement and Finance colleagues but the latter issue is yet to be fully resolved and as such, there are concerns around the accuracy of the data obtained.

It should also be noted that more than half of the Trust's waste is produced in premises managed by NHS Property Services, and given the limited data provided; it is possible that this has been overestimated.

We are able to accurately report on re-use tonnages achieved through Warp-it and can report that since the system was implemented, we have saved £52,582, 21 tonnes of carbon and avoided 7.8 tonnes of waste.

Work is currently underway to write the specification for a Trust wide general waste and recycling tender which will be awarded in summer 2018. It is hoped one supplier will be able to provide a service Trust wide to enable consistency in messages, financial savings and improvements in data quality.

Stakeholder Engagement

As a team our main mechanism for engaging with staff is the Green Champion Network which now has over 325 members. Each month an e-bulletin is produced which outlines key focus areas, news on awards, hot topics and ideas for being more sustainable both at work and at home. Regular articles in the Trust's magazine, Positive, also helps to raise our profile and highlight the work we do and the successes we have had.

Engagement with patients is mainly face to face with project work being undertaken with support from both clinical and non-clinical teams. Engagement with our patients in relation to green space is very important, particularly within our secure hospitals, as many patients will stay within the same environment for a considerable number of years. Encouraging connectedness with nature and being outside in the fresh air is good for wellbeing and social integration.

The Team were delighted to be asked to take part in a clinically led environmental education project in July 2017 with patients at Arnold Lodge in Leicester, one of the Trust's Medium Secure Units. The '*Creative Upcycling'* project was established to educate patients about waste reduction, particularly re-use, by using everyday waste items such as crisp packets to craft new useful items such as coasters. This was a great way to engage patients with the sustainability agenda.

The Trust Board is kept updated on the sustainability performance of the Trust via reports from the Sustainability Steering Group. These will be produced 6 monthly. The NHS SDU has recently re-launched the Good Corporate Citizen benchmarking

tool as the Sustainable Development Assessment Tool (SDAT). The new SDMP will make a commitment to completing the tool on an annual basis to enable us to benchmark our own improvement year on year but also how we compare against other healthcare providers in the sector.

Members of the public are able to access information about the environmental performance of the Trust from the Annual Report and also via the Trust website.

Awards and Successes

Our success was recognised for the third year running at the Annual NHS Sustainability Day Awards ceremony in May 2017. The Adiabatic Cooling System at Rampton Hospital was Highly Commended in both the Innovation and the Finance Categories and in addition, the Sustainable Food Project was Highly Commended in the Procurement Category. The Sustainable Food Project was also shortlisted for a HSJ Award in November 2017, which was a fantastic achievement and one which we are very proud of. Despite being unsuccessful on the night, the Trust's profile has been raised within and potentially beyond the health and social care sector.

Each year, the NHS SDU undertakes an analysis of all provider and clinical commissioning group (CCG) annual reports to evaluate the sustainability sections. In February 2018 the Trust was awarded a Certificate of Excellence for our 2016/17 Annual Report, which was granted on behalf of the Sustainable Development Unit (SDU), NHS Improvement (NHSI) and the Healthcare Financial Management Association (HFMA). This score placed the Trust in 6th place overall out of the 472 providers and CCGs in the UK.

For a number of years the Estates and Facilities Department of the former Local Services Division operated a certified management system to the internationally recognised environmental standard ISO14001. Following the recent restructure of the Estates and Facilities, and the decision for this to become a Corporate Service, approval was granted by the Trust Board in January 2018 to extend the scope and remit of the system to include Forensic Services. The team is excited about the opportunities that this will present and is keen to begin revising and updating the system to include these sites and operations over the coming year.

Based on the work that has been achieved over the last few years in relation to the sustainability agenda and our progress in this area, the Trust was asked in July 2017 by the organisers of the NHS Sustainability Day programme to speak about its approach to Corporate Social Responsibility on a webinar, which was made available to fellow practitioners both within and outside of the sector. The webinar content was very well received and helped showcase the Trust and its achievements.

Early in 2017, a representative from the Energy and Environmental Team was asked by the Director of the NHS SDU to become a Local Ambassador for the East Midlands Region as part of a wider sustainability programme aimed at sharing best practice within the region and the health and social care sector. Although early in to the process of establishing the network, initial meetings have proved beneficial. During 2017 Energy Analyst, Istvan Sereg received his MSc in Energy and Sustainable Development from De Montfort University and Lynn Richards, Energy

and Environmental Manager and Sustainability Advisor became a Full Member of IEMA (Institute of Environmental Management and Assessment) and a Chartered Environmentalist (Society for the Environment). This was a great achievement for both team members.

Barriers and Challenges

Delivering services under increased cost pressure is a challenge faced by the whole of the NHS. Without significant investment in new technologies and energy efficient practices, and adequate resourcing to manage the delivery, achieving the 2020 and 2050 goals for carbon reduction will remain significantly challenging.

Behaviour change relating to staff will be a contributing factor to any further success associated with sustainability and there will be the need to direct resources and commitment into this area of work. Regardless of how messages are delivered, the emphasis should be on creating a more sustainable workforce and workplace, making the right choices for both the Trust and the environment.

A summary of 2017/18 Sustainability Achievements

The sustainability agenda is much wider than just carbon reduction and for the Trust to be a sustainable service provider of choice; it must continue to work towards integrating the economic and social elements into service delivery and the day to day operations of all Trust employees.

The following table outlines the key themes and initiatives led and developed by the Energy and Environmental Team during 2017/18 with both patients and staff to reduce our environmental impact, raise awareness and share learning within the Trust.

Engagement and Communication	• Attend monthly induction at DMH and Rampton Hospital to speak to new staff • Produced monthly Green Champion bulletins throughout 2017/18
Sustainable Food	• Sustainable food event held with patients at Wells Road on two separate occasions, each one with a different theme, the first was using food waste as a resource, the second focused on meat and fish accreditations such as Red Tractor. • The Trust became a Board Member of Good Food East Midlands, an initiative linking schools, hospitals, charities and other organisations to work towards the East Midlands becoming the first accredited Sustainable Food Region.
NHS Sustainability Day	• Awareness raising about the day. Later in the year Awards ceremony attended.
Biodiversity and Green Space	• Supported and advised on a variety of biodiversity and green space patient-focused projects across the Trust
Water	• Promoted water saving across the Trust
Travel	• 78 staff joined the cycle to work scheme • Raised awareness of the first ever National Clean Air Day • First annual All Staff Travel Survey launched in February 2018.
Energy	• Energy Challenge held for the third year running.
Waste	• Clinical waste contract tendered and awarded. • Currently tendering for the Trust's general waste and recycling contract

Procurement	• Warp-it furniture re-use system delivered over £50,000 savings in total since implementation
Community	• Co-ordinated food donation points at multiple Trust sites to support local food banks.
Workforce	• Work on-going to improve and co-ordinate the Trust Staff Induction content. • Sustainability will be considered within staff annual appraisals from 2018.

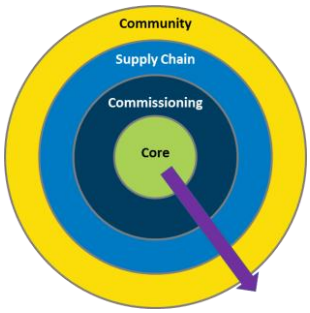
Future Plans

It is imperative that all stakeholders involved in the revised SDMP develop and implement action plans to ensure that the sustainability objectives and targets included are integrated into service delivery.

Travel will remain a priority for the Trust and key to this will be the recommendation that a Trustwide Travel and Transport Plan be developed to help monitor and reduce carbon emissions associated with the delivery of our services. To help provide further understanding and support in this area, the Energy and Environment Team plan to use the NHS SDU Healthy Outcomes Travel Tool (HOTT) to model different service delivery designs. The Procurement Team is also investigating whether this tool can be used with logistics partners to reduce carbon emissions associated with deliveries. To broaden the effectiveness of the SDMP it is important that the Trust develop frameworks which support programs for the local community, engaging with them and sharing resources where practicable.

The Energy and Environment Team has taken the decision this year to produce the annual report in the same format as the 2016/2017 report to ensure consistency, but it is worth noting that the format of the report next year may look quite different if NHS SDU reporting guidelines are followed.

The SDU has developed a new functional framework for carbon emissions, where the primary driver is around the level of control and/or influence the organisation may have. The further from the centre the less control the organisation has but the more value/impact can be achieved in supporting individuals, patients and community to support their health through healthy lifestyles and choices.



Area of influence	Level of control	Description / Scope
Core	High	Scope 1, 2, 3 emissions from energy, waste, water, business travel and transport and fugitive GHGs (e.g. anaesthetic gases) These impacts cover the energy, travel and fugitive emissions captured within ERIC and other central processes that a Trust or CCG will have significant control over.
Commissioned Healthcare	High	Scope 3 impacts of commissioned healthcare. For providers this may be where healthcare is commissioned from NHS providers.
Supply chain	Medium	All scope 3 emissions from the goods, services and buildings procured – this includes the extraction of raw materials, their transport and processing in usable items used by the NHS organisation, e.g. oil transported and processed into plastics and provided to the NHS such as syringes and their packaging.

Community	Low	All emissions (Scope 1, 2, 3) from staff commute, patient and visitor travel. This is the travel NHS organisations can influence through healthy travel planning, site locations and partnership working with the local authority for instance but are not in a position to dictate the mode of transport these individuals choose.

Clarifications

Note 1: All information contained within this report is based on NHS SDU reporting guidelines and template, which have been created in accordance with HM Treasury and DEFRA guidance on carbon reporting.

Note 2: Data for travel, energy, waste and procurement is estimated for March 2018.

Note 3: There are some limitations to the data provided for leased properties and services. Specifically this will include some estimated data for utilities and waste within NHS Property Services premises.

Note 4: Procurement, business travel, and healthcare waste are included for Offender Health portfolio only. No data is included for utilities or other wastes.

Note 5: All Commissioning data is estimated based on the model provided by the NHS SDU.

Table 1: Carbon Emissions from Energy (2007/8-2017/18)

Resource		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018
Gas	Use (kWh)	26,591,101	25,603,560	25,233,365	26,422,296	31,531,168	44,317,576	40,151,517	40,054,619	48,137,865	47,062,827	47,406,183
	tCO2e	5,434	5,232	5,156	5,399	6,443	9,056	8,518	8,404	10,099	9,836	10,051
Oil	Use (kWh)	714,158	714,158	714,158	737,901	728,152	763,027	729,522	739,522	739,522	739,522	739,522
	tCO2e	228	228	228	235	232	243	233	237	236	234	242
Coal	Use (kWh)	27,196,924	28,486,208	26,839,757	20,680,813	11,333,503	0	0	0	0	0	0
	tCO2e	10,011	10,485	9,879	7,612	4,172	0	0	0	0	0	0
Electricity (grid)	Use (kWh)	17,316,653	17,456,830	17,933,711	17,865,429	17,959,075	18,163,431	17,747,058	15,798,974	9,317,439	10,038,825	9,405,093
	tCO2e	9,903	10,629	10,853	10,622	10,064	10,368	9,937	9,785	5,357	5,188	4,192
Low or Zero Carbon electricity (i.e. CHP)	Use (kWh)	0	0	0	0	0	0	0	1,747,896	8,133,875	7,612,851	7,826,171
	tCO2e[1]	0	0	0	0	0	0	0	0	0	0	0
Renewable electricity (i.e. solar)	Use (kWh)	0	0	0	0	1,213	35,463	38,348	73,577	60,853	68,185	66,339
	tCO2e	0	0	0	0	0	0	0	0	0	0	0
Biomass (woodchip)	Use (kWh)									4,304,340	3,977,248	3,989,242
	tCO2e	0	0	0	0	0	0	0	0	0	0	0
Total energy CO2e	tCO2e	25,575	26,574	26,116	23,869	20,911	19,667	18,687	18,425	15,692	15,258	14,484
Total energy spend	£	2,184,060	3,173,702	3,018,944	2,566,151	2,862,578	3,215,780	3,238,730	3,014,066	2,402,362	2,026,048	£2,222,562
Diff to 2007/08			1,000	541	-1,706	-4,663	-5,907	-6,887	-7,150	-9,882	-10,317	-11,090
%Diff			3.91%	2.12%	-6.67%	-18.23%	-23.10%	-26.93%	-27.96%	-38.64%	-40.34%	-43.36%

[1] The carbon associated with the electrical energy output of the CHP system is considered as 0 in line with the SDU reporting template. No export.

Table 2: Carbon Emissions from Procurement in tCO_2e (2007/08-2017/18)

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Business services	5,806	6,008	5,880	6,164	8,337	8,456	8,557	9,377	9,439	9,327	9,230
Capital spend / Construction	2,472	2,558	2,504	2,625	3,550	3,601	6,780	8,556	6,886	8,720	9,349
Food and catering	2,716	2,810	2,750	2,883	3,900	3,956	4,003	4,386	4,415	4,363	4,317
Freight transport	2,982	3,086	3,020	3,166	4,282	4,344	4,395	4,816	4,848	4,791	4,741
Information and communication technologies	1,540	1,593	1,559	1,634	2,211	2,242	2,269	2,486	2,503	2,473	2,447
Manufactured fuels chemicals and gases	2,560	2,650	2,593	2,718	3,677	3,729	3,773	4,135	4,162	4,113	4,070
Medical Instruments /equipment	3,527	3,650	3,572	3,744	5,065	5,137	5,198	5,696	5,734	5,666	5,607
Other manufactured products	477	494	483	507	685	695	703	771	776	767	759
Other procurement	0	0	0	0	0	0	0	0	0	0	0
Paper products	936	969	948	994	1,344	1,364	1,380	1,512	1,522	1,504	1,488
Pharmaceuticals	1,170	1,211	1,185	1,242	1,680	1,704	1,724	1,890	1,902	1,880	1,860
Total	**24,186**	**25,029**	**24,495**	**25,678**	**34,732**	**35,229**	**38,782**	**43,625**	**42,188**	**43,604**	**43,868**

QUALITY REPORT 2017/18

PART ONE: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE FOUNDATION TRUST

On behalf of the Board of Directors of Nottinghamshire Healthcare, I am pleased to be able to present our Quality Report which covers the year April 2017 to March 2018. It focuses on the quality of the services we deliver and is a restatement of our wish to be publically accountable for the quality of the services we deliver.

The Trust is committed to delivering high quality care and the safety and wellbeing of all its patients, service users, carers, volunteers and staff. The Board of Directors approved a revised Quality Strategy in May 2017 which sets out our ambitions for quality, how we will achieve these and how and where we will measure progress. This included our quality priorities for 2017/18, encompassing our safety priorities which were aligned with our commitment to the national Sign up to Safety campaign. This campaign was launched in 2014 however the focus is now changing to provide ways to help people talk to each other about safety and provide on-line resources.

As part of the development of our overall quality priorities for 2018/19 we have reviewed our safety priorities and we have decided to end the specific safety campaign as this work has become embedded in practice. This will enable us to focus on a wider quality improvement programme, including safety, led by the Quality Committee. We have always had a quality priority relating to reducing the number our patients who commit suicide; however as part of our quality improvement programme we are aligning our work with that of the Zero Suicide Alliance. This means our previous ambition to reduce suicide by 50% has become an ambition to have zero suicides.

The Trust's Quality Improvement campaign was launched at the Leadership Council in September 2017. Our vision is that we will have an embedded culture of continuous quality improvement by 2022. This will be achieved through 4 key commitments 1) engaging with patients, carers, staff and stakeholders, 2) building QI capability throughout the workforce, 3) supporting teams to deliver quality improvement projects, and 4) embed the QI methodology. The QI strategy has been designed to make a significant contribution to the organisational strategic objectives of providing the best possible care and support, and being a great place to work. For 2018-19, the QI Hub will continue to develop, training and supporting staff in QI tools and techniques, whilst also driving key Trust quality priorities namely, reducing restrictive practice and violence reduction, a Quality First campaign around getting the basics right, and supporting the local implementation of the national Always Event programme.

Our People and Culture Strategy (2017-2022) describes our strategic workforce priorities for our staff as we recognise that ensuring we have good staff engagement and staff experience is integral to good patient experience and outcomes. Our overall workforce objective is to ensure the Trust is a Great place to work. We recognise that supporting staff health and wellbeing is essential in this, and as such we will focus our quality priority on staff health, wellbeing, recovery and resilience for 2018/19.

During 2016/17 we undertook a full review of our governance structures which resulted in some changes to the committee structure supporting the Board's Quality Committee. This was effective from 1st April 2017 and this revised structure was embedded during 2017/18.

Foundation trusts are required to undertake a Well-Led Governance Review every three years and therefore the Trust commissioned a well-led review which was undertaken between September and October 2017. This commenced with a self-assessment against the Well-Led Framework followed by an independent review which determined that the Trust had conducted an accurate self-assessment finding that overall the Trust has good governance systems and the Board functioned effectively. The report set out nine developmental recommendations to assist the Trust in further developing its leadership. The Board of Directors has remained sighted on progress in implementing these.

CQC is the independent regulator of health and adult social care in England which ensures that health and social care services provide people with safe, effective, compassionate, high-quality care. The CQC's annual core inspection of the Trust took place in November 2017. The CQC inspected five complete core services and assessed the Trust against the Well-led key line of enquiry. The outcome was that Effective, Caring, Responsive, and Well-Led were rated as 'Good' and 'Safe' was rated as 'Requires Improvement'. The CQC's aggregated rating for the Trust overall remained 'Good'. CQC issued eight requirement notices which related to 25 breaches of legal requirement in four of the five core services they inspected. An improvement plan to address the areas of non-compliance and other areas for improvement is currently being implemented and is overseen by the Quality Committee.

The CQC also issued one warning notice during 2017/18 in respect of medicine management in Local Mental Health Teams. The Trust took prompt action to bring about the improvements required. The CQC has not yet undertaken follow up inspections for assurance that the warning notice and requirement notices have been addressed.

In June 2017, the CQC published their report of the inspection they undertook of Rampton Hospital during March 2017. The CQC made six compliance actions for breaches of the Fundamental Standards. Action was taken during the year to address the concerns raised, however it is acknowledged that staffing continues to be a challenge to ensure there are sufficient numbers of suitably qualified staff. A planned inspection took place March 2018 which included checking whether the actions the Trust has put in place have brought about compliance. The report has not yet been received.

During 2017/18, The Lucy Wade Psychiatric Intensive Care Unit was used less for its intended purpose – providing intensive psychiatric care for women who need it for short periods of time when their mental health problems have severely deteriorated. As a result the service was being used to look after and care for women with personality disorders for lengthy periods of time, rather than the shorter intensive admissions it was designed for. Neither the environment nor the clinical model and interventions provided were appropriate for the needs of this group of patients. Following a clinical review it was also clear that the ward environment did not meet

the best standards for providing intensive care. Nottinghamshire Healthcare has now served notice to close the unit for psychiatric intensive care. Any female patients in need of psychiatric intensive care will be referred on an individual basis to other suitable units. Those patients who remain on the ward will continue to be cared for whilst appropriate placements are sought for them that will meet their therapeutic needs. The Trust has plans in place to refurbish and redevelop the unit and once this work is completed it will reopen as an acute admissions ward.

As a demonstration of our commitment to learn from deaths of patients using our services, this continued to be one of our quality priorities for 2017/18. Throughout the year the Trust has continued to build on previous improvements and we issued a new policy on learning from deaths in September 2017. A policy implementation plan was developed as it was recognised that some areas of the policy were developmental, for example the introduction of Case Note Reviews for deaths which are not serious incidents, but from which there is the potential to learn. Good progress has been made with meeting the national requirements which was acknowledged within the Trusts CQC well-led inspection in November 2017.

The Quality Committee asked for the issue of a number of deaths at HMP Nottingham, all of which happened in a short space of time, to be highlighted to the Board of Directors. The Committee was concerned that the prison was under pressure which may be impacting on the safety of inmates. The Board of Directors wrote to NHS Improvement raise concerns on the number of recent deaths and outlined the Trust's willingness to work in partnership with the system to support HMP Nottingham.

The Trust has continued to work in collaboration with other Trusts through workshops facilitated by Mazar's who conducted the investigation into deaths at Southern Healthcare which ultimately resulted in the publication of the national guidance. This has enabled us to learn from others and share best practice and we are planning a regional learning from deaths conference in 2018/19.

We continued to work with the Patient Safety Collaborative during the year to test the use of human factors in serious incident investigations and we have completed our first investigations. This has proved to be helpful in identifying systemic issues that may well be impacting on the delivery of safe services and creating a greater understanding of why issues often get repeated. In 2018/19 we will be reviewing our approach to investigations and we will be working with the Royal College of Psychiatrists through a Serious Incident Investigation Accreditation Peer Review Group to improve standards and consistency of internal investigations.

Furthermore, to deliver safe, quality care the Trust has been involved implementing the Keith Hurst Acuity tool and undertaking routine 6 monthly establishment reviews of all in-patient areas which has resulted in some increases to staffing establishments. In addition the roll out of the E-rostering and the Safe Care module is enabling staff to ensure that the correct skill mix and staffing levels are in place to meet the acuity of patient's clinical need. The Trust has worked with NHSI on a programme of quality improvement in the use of E-rostering to develop standard best practice and learn from the experience of other organisations.

Cost Improvements are important for every NHS organisation, making sure that public money is being invested in cost efficient and quality services. The impact of

those improvements on the quality of services we deliver is closely monitored by both our Medical Director and our Director of Nursing. We are determined to ensure financial challenges do not impact on patient safety and this continues to be an area of close scrutiny for our Quality Committee. In addition, the Trust has been part of a cohort of 23 trusts who have been part of Lord Carter's review to develop recommendations for improving productivity and efficiency and specifying the benchmarking criteria of an 'optimal delivery model' for NHS community and mental health trusts.

To the best of my knowledge the information contained in the Quality Account is accurate.

Ruth Hawkins

Chief Executive

Date: 24 May 2018

PART TWO: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Performance against Priorities for Quality Improvement 2017/18

This section reviews progress made against the Trust's 2017/18 quality priorities. These priorities were identified and developed in consultation with commissioners, the Council of Governors, clinical divisions, staff, service users, carers, the Joint Health Scrutiny Committee and HealthWatch. Page 149 to 163 provides an update of the Trust's quality priority performance.

Sign up to Safety

The Trust's quality priorities were aligned to the 3 year Sign up to Safety campaign. As the three years approaches its end Nottinghamshire Healthcare NHS Foundation Trust has continued to embed its learning from the improvement plans.The safety priorities were focused at the following:

- **Medication Errors** – Medicines Optimisation Group
- **Assaults** – Violence Reduction & Restrictive Practice Group
- **Restrictive Practice –** Violence Reduction & Restrictive Practice Group
- **Pressure ulcers** – Tissue Viability Group
- **Patient Falls** – Trust Falls Group
- **Suicide prevention and self-harm** – Trust Suicide and Self-harm Oversight Group

Each work stream continued to monitor progress against their quality and safety improvement plan, and provides a report outlining the key achievements and any issues or significant slippage against their plans. These plans were overseen by the Trust Clinical Incident Review Creating a Learning Environment (CIRCLE) Group. This sub-committee reports to the Board's Quality Committee and provides assurance and escalates any identified risks. Some key achievements from the Sign Up to Safety campaign can be found on pages 12 to 27.

Nationally, the Sign up to Safety Campaign is now focussing on helping people talk to each other, by which they mean conversations where people have a chance to speak, to be listened to, to feel heard and understood. There will also be on-line resources and 'matchmaking' to help connect with other organisations. As part of the development of our overall quality priorities for 2018/19 we have reviewed our safety priorities and we have decided to end the specific safety campaign as this work has become embedded in practice. This will enable us to focus on a wider quality improvement programme, including safety, led by the Quality Committee.

Learning from Deaths

In March 2017 the National Quality Board (NQB) published National Guidance on Learning from Deaths. This set out expectations for providers regarding engagement with bereaved families, improving data collection, case note reviews and trust governance arrangements including policy and Board reporting requirements.

Learning from Deaths was a quality priority for 2017/18 and further information is also included on pages 23 to 25.

The Trust had previously established a Mortality Surveillance Group and this Group led the development of a new policy on Learning from Deaths and Managing Serious Incidents which is compliant with all national requirements. The Trust continues to implement this policy and progress was reviewed by the Care Quality Commission as part of the Well-Led inspection which took place in November 2017. This reported that the Trust had set up robust processes that were fully compliant with the framework to investigate and learn from deaths. It is however recognised that some aspects of the revised policy are developmental nationally and therefore, a policy implementation plan has been developed. Progress with this is monitored monthly at Trust CIRCLE and the key areas of this plan are outlined below:

- Communication of Policy Requirements
- Notification of Serious Incidents and Triage of Deaths
- Serious Incident Investigations & Human Factors
- Case Note Reviews
- Support for Bereaved Families
- Quality Reporting Framework

Communication of Policy Requirements

Changes to processes in the revised policy, particularly relating to planned improvements relating to reporting and reviewing deaths were communicated to staff early in February when revised systems were live on the Ulysses risk management system.

Notification of Serious Incidents and Triage of Deaths

Since February 2018 staff now report all known deaths on Ulysses, all of which are reviewed (triaged) within three working days which has three possible outcomes:

- Outcome One - the death meets the criteria for reporting and managing as a serious incident
- Outcome Two – the death meets the criteria for consideration by the Mortality Surveillance Group to have a Case Note Review (see below)
- Outcome Three – no further investigation or review is required

If the outcome of the initial review (triage) is outcome one or two an Initial Management Review is conducted. This provides further information on the death and also ensures any immediate risks to patient safety have been managed, families are communicated with and the Duty of Candour applied if applicable.

Serious Incident Investigations and Human Factors

The current process for investigations and the subsequent written reports will be reviewed during 2018/19 to ensure there is a consistent Trust wide approach and also consider the implications of any amendments to current national policy which is

currently being consulted upon. Our review will also consider the resources and training required and consideration of the integration of human factors into the process. The Trust is also undertaking a retrospective review of the outcomes from Serious Case Reviews using human factors methodology.

In addition, the Trust is participating in a Serious Incident Investigation Accreditation Peer Group at the Royal College of Psychiatrists to agree principles for investigations to improve standards and consistency and to pilot an accreditation standard.

Case Note Reviews

The National Guidance on Learning from Deaths also defines the requirement to introduce Case Note Reviews using a structured approach. This is for some deaths that are not considered to be a serious incident and therefore do not require investigating in accordance with the NHS Serious Incident Reporting Framework, however there may be the potential to learn.

This process is well recognised within the acute trust sector but is developmental for providers of mental health and community services and there has been limited clarity on the development of national guidance. The Trust has adapted the tool developed by Humber NHS Foundation Trust in conjunction with the Academic Health Science Centre in Sheffield. The outcome of the review is a judgement on whether 'the death is thought to be more likely or not due to a problem in care'. As reviews are completed the Trust will be able to capture this outcome to enable reporting, identify the issues concerned and ensure appropriate action is taken. It is intended to also ask this question for deaths investigated under the serious incident framework.

The first phase of reviewers has been identified and nine cases have been identified for review, of which four have commenced in February 2018. The Trust allows 60 days for completion and therefore these have not yet concluded. This process will continue to develop during 2018/19.

Support for Bereaved Families

Engagement with bereaved families is a significant element within the national guidance and there is currently a review being undertaken of how the Trust supports all families who have suffered from a bereavement while their relative has been receiving care from the Trust. A workshop, to which families will be invited, is planned for April 2018 to inform this work. The Being Open (Incorporating the Duty of Candour) Policy is also in the process of being reviewed to incorporate bereavement support.

Quality Reporting Framework

The national guidance requires Boards to publish information on deaths, reviews and investigations quarterly through a paper to its public board meetings. This includes information on reviews of the care provided to those with severe mental health needs or learning disabilities from Quarter 3 2017 onwards. The Trust has been reporting mortality data to public Board meetings since February 2016. Following the review of

available mortality data in the Trust, reporting was compliant, as required by the guidance from Quarter 3.

The Trust will continue to endeavour to use appropriate benchmarking information, such as national mortality data. However, there is national agreement that data relating to deaths judged to be potentially due to problems in care will not be used for comparison due to the subjective nature of this information.

During the year the Trust continued to work in collaboration with other Trusts through workshops facilitated by Mazar's who conducted the investigation into deaths at Southern Healthcare which ultimately resulted in the publication of the national guidance. This has enabled us to learn from others and share best practice and we are planning a regional learning from deaths conference in 2018/19.

National Learning Disability Mortality Review Programme (LeDeR)

This programme was established as a response to the Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities. This found that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable. It also identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews and the HM Coroner.

The programme has been commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England and is being managed by Bristol University. Deaths of people with a learning disability are referred to the programme, following which a case note review will be undertaken by a professional from a regional pool of trained reviewers. The LeDeR Programme will collate and share anonymised information so common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

The Trust has started to refer deaths to the LeDeR Programme, however outcomes from these reviews have not yet been received by the Trust to act upon.

Monitoring Progress with Quality Priorities

The Board Committee with overall responsibility for monitoring the quality priorities is the Quality Committee. This committee, which meets six times per year, received during 2017/18 regular reports on progress with our ambition for each priority. These monitoring arrangements will continue in 2018/19.

The reports identify actual and potential underperformance to act as a trigger to ensure action is taken to improve performance against agreed trajectories. The Board of Directors also regularly monitors key performance indicators through the monthly Integrated Performance Report. This will include quality priority-related information such as incidents, CQC inspections, patient experience, quality impact of cost improvement programmes (CIPs) and workforce indicators such as safe staffing levels and sickness. The Board also receives regular service user and carer experience (SUCE) reports.

Progress with each of the 2017/18 quality priorities is outlined in the tables below.

2017/18 Priorities	Our Ambition	How we will Measure the Priority
1. Reduce avoidable harm, with clear focus on: **1.1. Physical assaults** **1.2. Pressure ulcers** **1.3. Medication errors** **1.4. Patient falls** **2. Suicide prevention and reducing self-harm** *Priorities 1 and 2 were chosen as monitoring has identified these incidents occur more frequently and potentially could cause significant harm. The Trust is also committed to reducing suicides* **3. Reduce restrictive practice to ensure the 'least restrictive' principle is applied for all patients** *This priority was chosen as we recognise that using restrictive interventions can delay recovery, and cause both physical and psychological trauma to both people who use services and staff* These are also the Trusts 'Sign up to Safety' priorities	Our ambition is to have no incidents causing severe harm or death and to reduce avoidable harm by 50%. Increase the reporting of these incidents	Effective delivery of Safety Improvement Plans for each work stream , including one key action to deliver maximum impact To assess the impact of implementation of the Safety Improvement Plans some key metrics will be monitored: • % incidents causing moderate harm or above (assaults, medication errors, falls, self-harm) • % incidents high volume/low number of patients (assaults, falls, self-harm) • Number of suicides potentially preventable • Restrictive Practice metrics such as restraint including - prone, medication and mechanical and seclusion and long-term segregation • Number of Stages 3 & 4 pressure ulcers • Number of repeated issues identified following investigations Analysis (RCA) that could have *Monitored by **Trust CIRCLE***

Progress to date:

Pages 12 to 19 provide an update to the Quality Priorities relating to patient safety and the Sign Up to Safety Campaign during 2017/18.

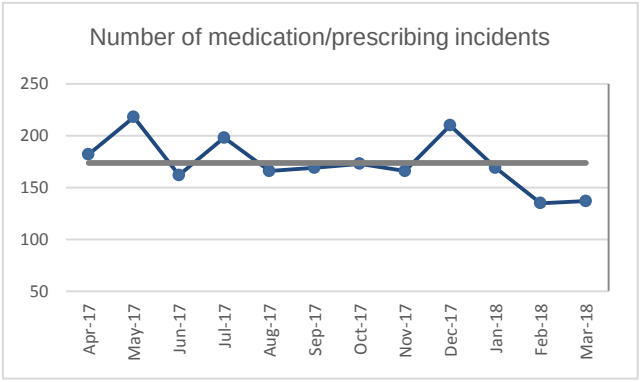
2017/18 Priorities	Our Ambition	How we will Measure the Priority

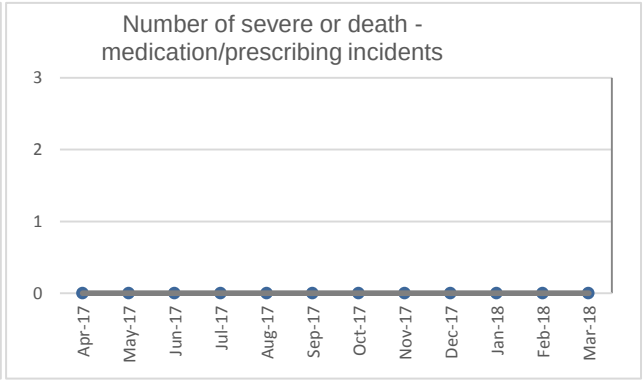
Medication Errors –

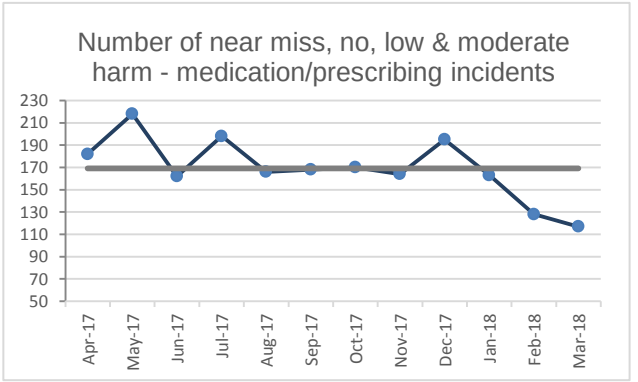
During 2017/18 the Medicines Optimisation Group assumed the responsibility of Medicines Safety across the Trust and superseded the Sign Up to Safety focus. Its core responsibility is to identify, develop and promote best practice for medication safety. This includes supporting the implementation of external patient safety guidance from NHS England, MHRA, NICE and other organisations. The core progress during the year are:

- Identification of themes relating to insulin incidents – this is leading to a deeper dive to identify further issues and training requirements.
- The Trust has created a formal link with Central and North West London Foundation Trust, to benchmark medicines safety parameters and share learning and good practice
- A Trust-wide pharmacy and medicines risk register has been developed and continues to be reviewed as a standing agenda item at the Medicines Safety Group.

The graphs below provide a breakdown of incidents reported over time of medication and prescribing incidents. No incident resulted in severe or catastrophic harm to patients. The majority of the incidents resulted in low or no harm to the patient.







Significant efforts are already being undertaken to address a number of the incident types, for example, diversion in offender health, clozapine issues at Wathwood, and missing signatures on drug cards in the recording of medicines administration. Recommendations identified by the Trust are:

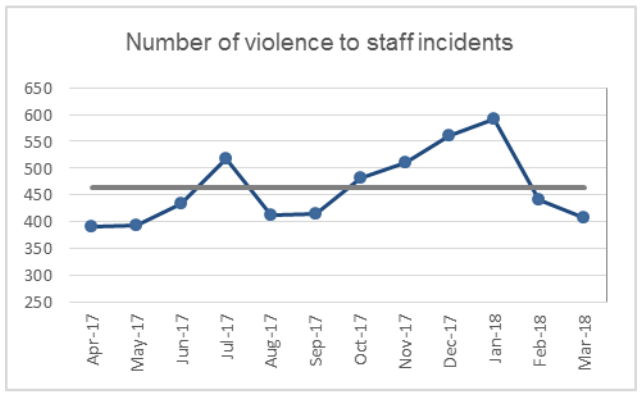
1. Analysis of wrong medicine incidents for themes and shared learning
2. Analysis of all insulin incidents in administration incidents category to identify any work required which may be appropriate for 'Insulin Task and Finish Group' to complete
3. Focus of Medicines Safety team to review and re-categorise any medicines administration incident reports that have an error type of 'Other', as 16% reported as 'Other' is higher than the average across all medicines incidents.

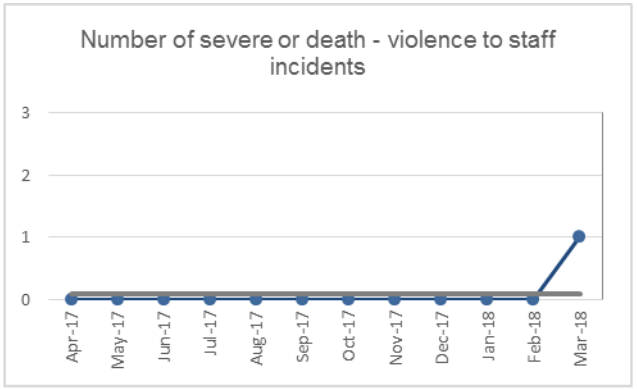
2017/18 Priorities	Our Ambition	How we will Measure the Priority

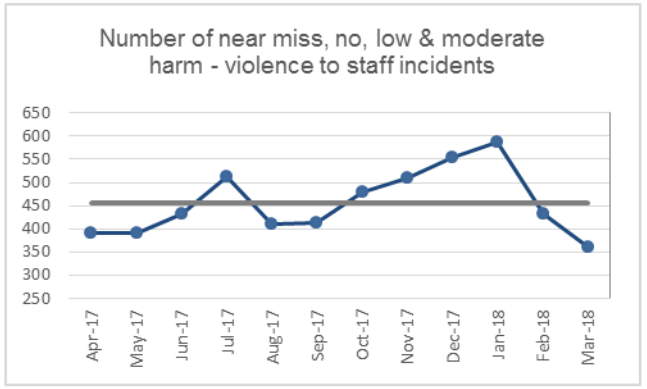
Assaults –

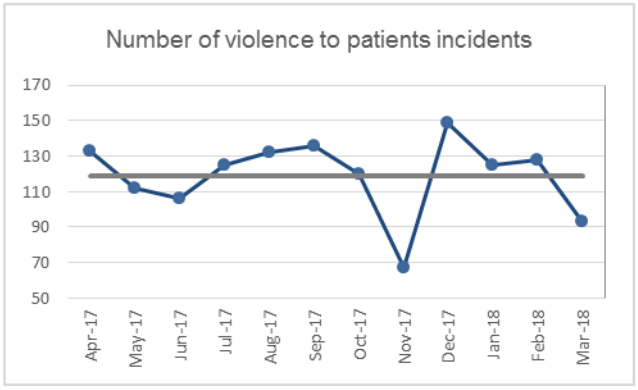
The Trust continues to review of all existing clinical risk assessment protocols across our organisation in terms of their effectiveness, evidence- base and fitness for purpose has taken place. There has been a consensus agreed on merging the Violence Reduction Strategy Group and Restrictive Practice Group to improve reporting and managing incidents. The revised Violence Reduction Strategy will include least restrictive practice and work has commenced on reviewing the strategy.

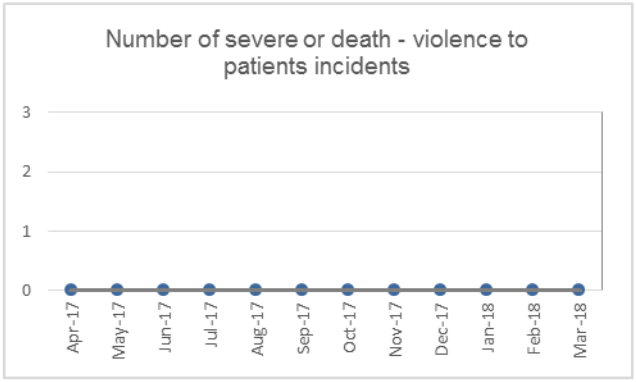
A focused piece of work to look at post incident interviews of staff who have been involved in being assaulted by patients. This involves reviewing information transcripts of interviews to establish what improvements can be made. The outcome of this work will help improve training and policies to support staff. The graphs below provides a high level account of 'assault' incident reported over time and the level of harm of these incidents.

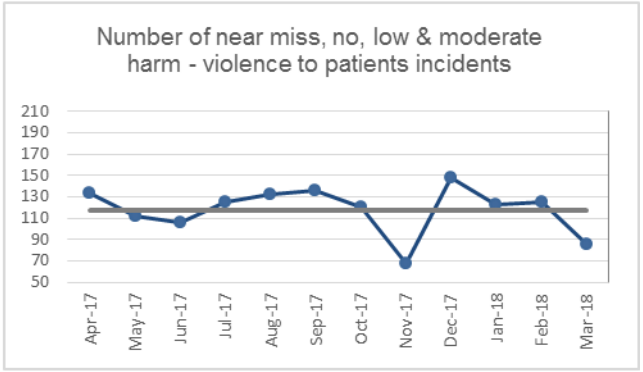












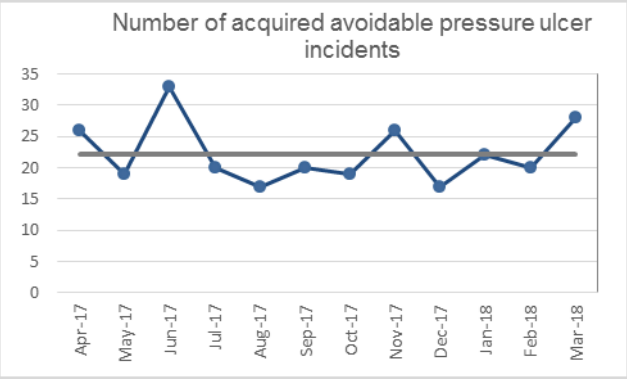
2017/18 Priorities	Our Ambition	How we will Measure the Priority

Pressure Ulcers –

The Tissue Viability team won a bid from the East Midlands Patient Safety Collaborative to develop a training resource on the prevention and management of moisture lesions which has now been launched.

The healing rates for simple leg ulcers have significantly improved and electronic reporting templates are now embedded within practice.

The CQUIN around wound assessment audit in Q2 has highlighted that only 58% of wounds that have failed to heal after 4 weeks have had a full wound assessment completed.



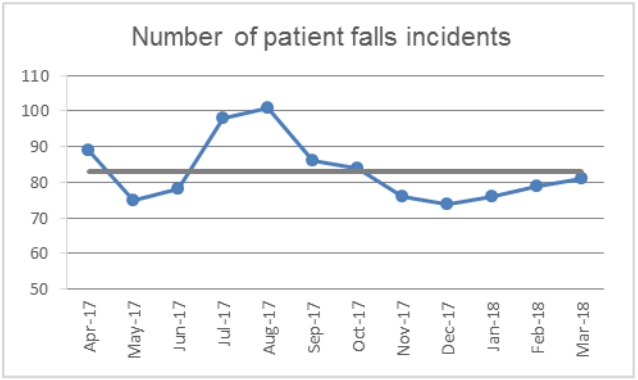
2017/18 Priorities	Our Ambition	How we will Measure the Priority

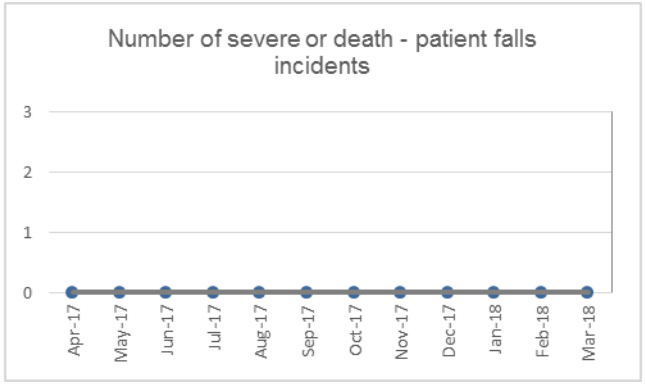
Patient Falls –

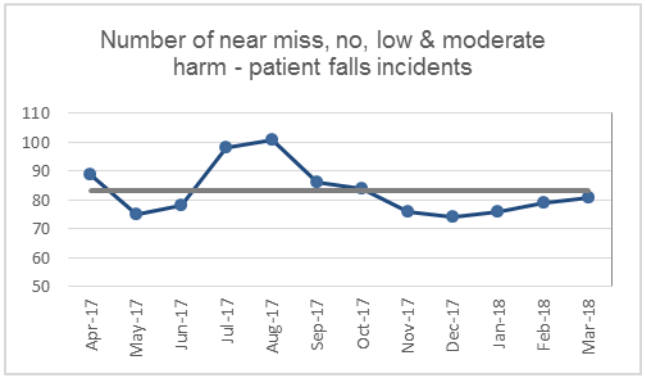
The focus on patient falls was part of the three year Sign Up to Safety Campaign. During 2017/18 the Trust strengthened its infrastructure for falls reporting, data analysis, compliance with NICE guidance and updating assessment and intervention tools to support clinicians. The Trust Falls Group examines falls reports and data from across the Trust and analyses incidents to identify lessons learned or areas where developments are required to improve safety of patients in the care of the Trust. The aim going forward is to embed falls prevention into everyday practice by:

- Identifying repeat fallers and explore these cases further by accessing clinical records and having anonymised case studies for shared learning. This will involve using identification of repeat fallers and those with high harm ratings for case discussion and lessons learned.
- Focusing on the 'high harm level' cases and having a table top discussion on the cases to identify lessons for learning.
- Having a focus on 3rd party falls to promote 3rd party falls reporting across the Trust, as there appears to be some in-equity of this practice.
- Possibly looking at some internal benchmarking on falls and link in contributory factors of the patient fall.
- The timings of falls is initially quite alarming, however work will be carried out to establish if the timings was in regards to when the IR1 was entered into Ulysses rather than the actual fall event – in which case it is significantly less of a concern.

The graphs below provide the rate of patient falls over time. It also provides a breakdown on the severity of harm caused to patient following a fall. The Trust has not reported any patient falls which had led to a severe or catastrophic harm to the patient. The majority of patient falls have had resulted low or no harm to patients.







2017/18 Priorities	Our Ambition	How we will Measure the Priority

Suicide Prevention and Self-Harm –

While its causes are complex and no strategy can be expected to completely remove the tragedy of suicide, there is much that can be done to ensure that we reduce the likelihood of suicide and to ensure support is available for those at their most vulnerable. The Trust will aim to ensure that by working in partnership with other agencies (such as The Nottinghamshire Suicide Prevention Strategy Group which is a multiagency group chaired by Public Health), vulnerable people in the care of mental health and social care at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or n crisis. Nottingham Healthcare Trust is signed up to the key principles of the zero suicide alliance which are to:

- **Lead**: Create a leadership-driven, safety-oriented culture in order to reduce suicide amongst the people under the Trusts care by establishing a group of key clinical individuals chaired by the Medical Director who will form the implementation team and be responsible for driving forward this initiative.
- **Train**: Evaluate and benchmark against national best evidence our current depression/self-harm and suicide screening, assessments, risk formulation, treatment and care transitions. Examining the use of health care records in supporting these processes. To ensure our workforce training is contemporary and can support a skilled competent, confident and caring workforce.
- **Identify**: Systematically identify and assess suicide risk among people receiving our care to support safety planning for people at risk of suicide, involving families and carers throughout the process
- **Gather appropriate information:** to ensure that we can evaluate progress and measure results

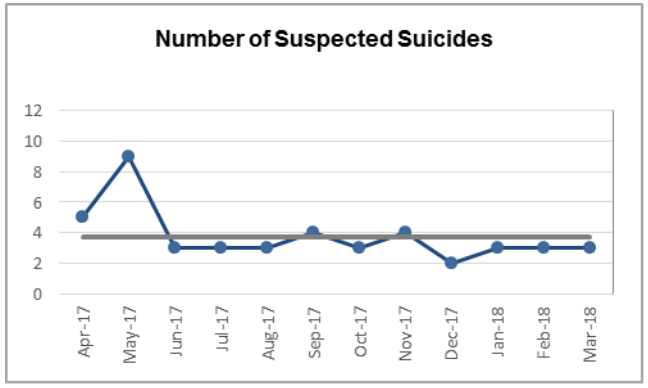
In order to deliver the zero suicide strategy across the Trust, investment is required in an implementation team inclusive of administrative and clinical expertise. This would be a 1 year project do to the following:-

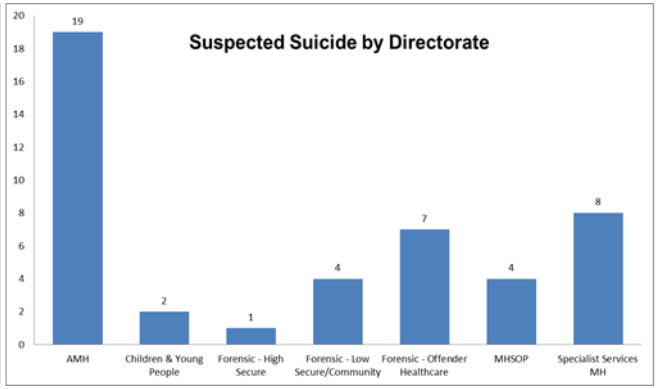
- Communication and Awareness: Dissemination of key messages / information – education and awareness raising on the promotion of mental health and suicide prevention – suicide prevention is everyone's business
- Review of Suicide and self harm prevention training with the plan to move to a formal practice development model by the end of year 1 the Trust will identify and implement a new model of training. Sign Up to Safety identified Suicide and Self harm training offered by the Trust was significantly lacking and needed to be a priority for review.
- Review of current depression care offered and outcomes completing a fully worked up gap analysis developing a detailed plan against "perfect depression care" – linking to the Rushcliffe Right Link work

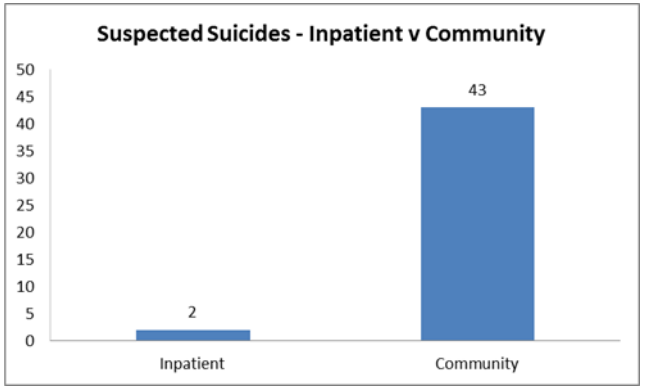
The following graphs on page 18 provide information of and data of activity of 'suspected suicides' and self-harm incidents.

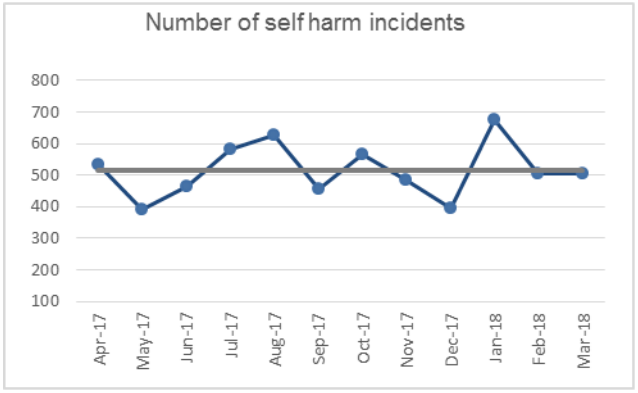
The definition of 'suspected suicide' is *a death incident where the Trust has made an assumption that the person has taken their own life based on the information they have at the time of the incident being reported*. However, it is the coroner who will determine whether the person has taken their own life.

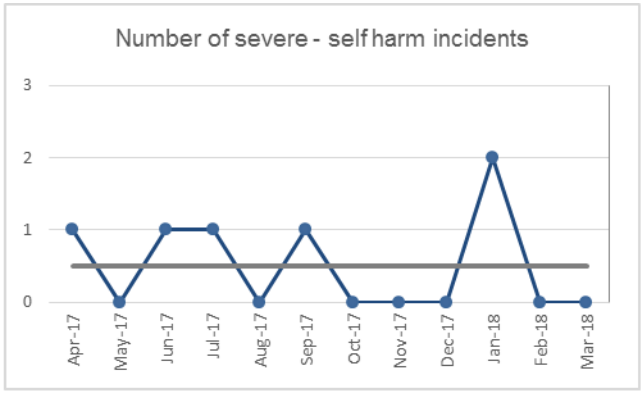
2017/18 Priorities	Our Ambition	How we will Measure the Priority

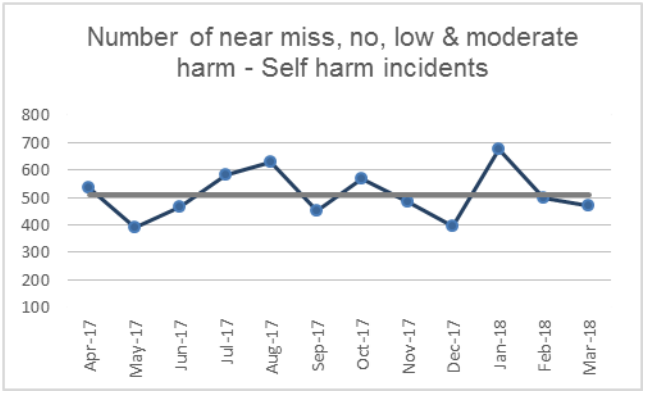












2017/18 Priorities	Our Ambition	How we will Measure the Priority

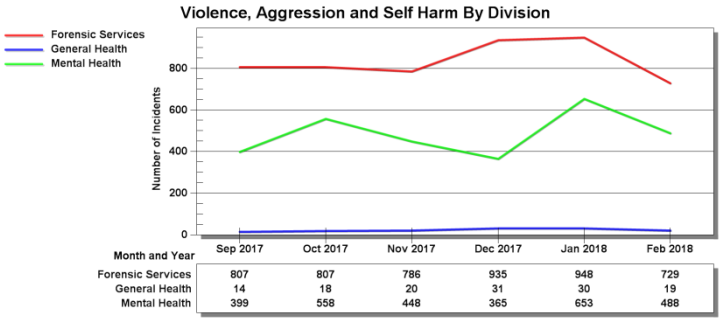
Restrictive Practice –

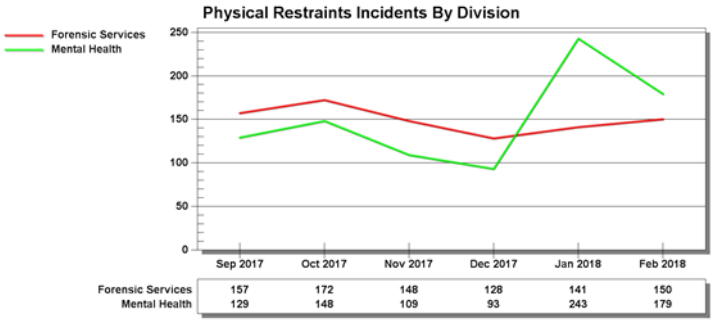
Practices throughout the Trust were varied but training is now compliant with the Positive and Safe Violence Reduction Manual and it is expected that all staff will apply their training in practice.

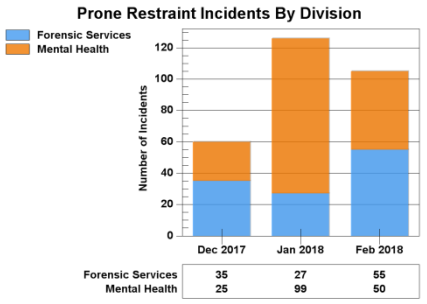
The 'Manual' and our Training Strategy promotes 'Primary' (hands off) interventions, where staff are not laying hands on the patient but use distraction, diffusion and de-escalation to avoid escalation of the incident.

De-escalation skills are routinely taught at the beginning of the training and importantly, before the focus turns to the potential use of secondary (passive restraint) and tertiary (full restraint).

The graphs below show the latest data available for the use of restraint within the clinical divisions. The first shows the level of self-harm and violent incident reported. It then correlates to the use of physical restraints used to keep the patients and staff safe. The third graph shows prone restraints used by divisions.







2017/18 Priorities	Our Ambition	How we will Measure the Priority
4. Improve experience through better management of complaints *This priority was chosen because efficient and effective handling of complaints ensures that NHS organisations continuously review and improve the quality and safety of care they deliver*	Our ambition is to have a complaints process that meets national best practice: • Complainant at the centre • Easily understood and accessible • Addresses concerns raised • Responsive • Focused on improvement • Integral part of feedback	Review of effectiveness of actions completed in the Complaints Management Improvement Plan Analysis of complaints information by service area, in particular: • Reasons for complaint • Complainant satisfaction with process • Response times • % Upheld or upheld in part • Number referred to the Parliamentary Health Service Ombudsman Thematic review utilising human factors and triangulation with other forms of feedback (including compliments) *Monitored by the Patient Experience and Service Improvement Sub-Committee*

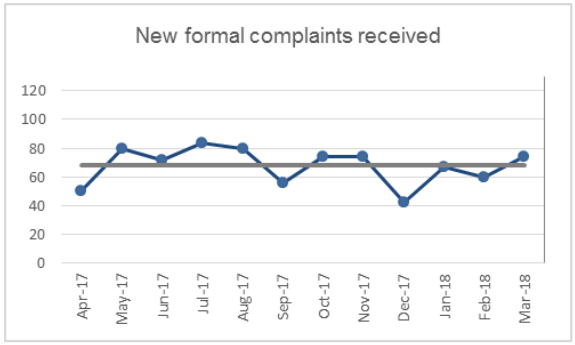
Overall during 2016/17 the Trust received a total of **1020** complaints compared to **937** in 2015/16 and increase of approximately **9%**. The table below shows the number of complaints for 2016/17 split by those that were considered to be formal complaints and those that were locally resolved.

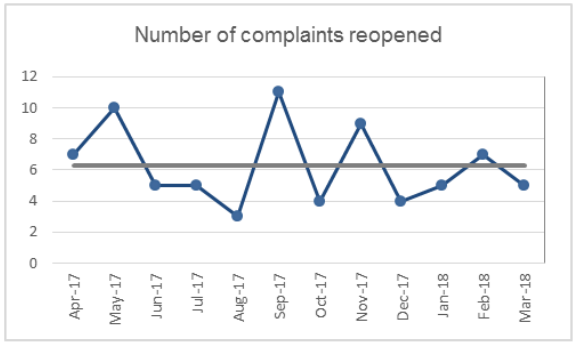
	Formal complaints	Local resolution complaints
Local Partnerships General health	54	145
Local partnerships Mental Health	223	76
Forensic Services	258	264

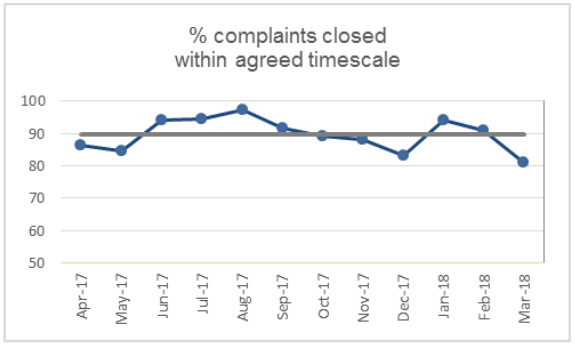
A formal complaint is where the complainant has made an informed decision to pursue the formal complaints route in accordance with the NHS Complaints Policy. A full investigation is undertaken following trust procedure and adhering to Trust timescales (25 working days). Local resolution is a way of handling complaints by resolving, explaining or clearing up a matter directly with the complainant. This can be a proportionate, flexible and timelier way to resolve many complaints that would not require a full investigation adhering to Trust timescales (25 working days) or where a complainant prefers this method.

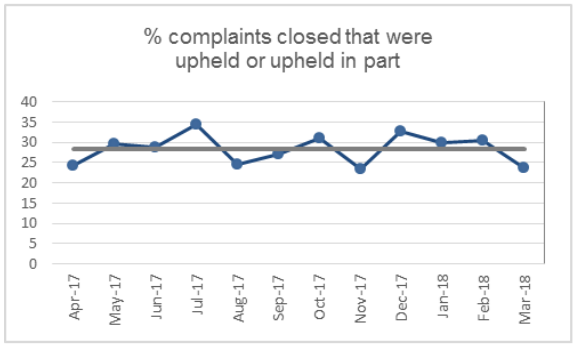
Since April 2017 to March 2018 the Trust received a total of **813** formal complaints with **75** were re-opened. Page 21 provides progress on the complaints metric reviewed by the Trust. The Patient Experience and Service Improvement Sub-Committee chaired by the Executive Director of Nursing strategically provide oversight of complaints and the experience of the complainant. Work continues to ensure that there is a standardised trust wide approach to managing complaints.

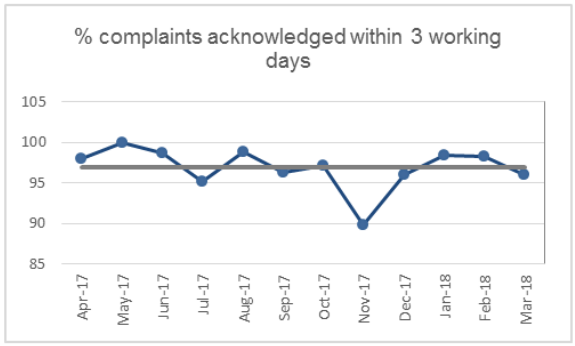
2017/18 Priorities	Our Ambition	How we will Measure the Priority

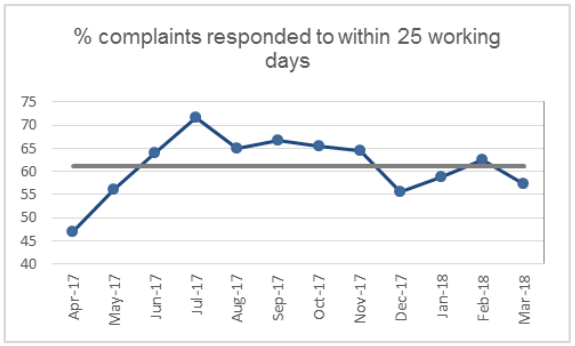


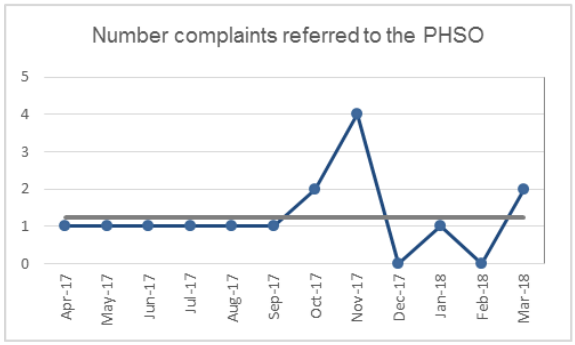


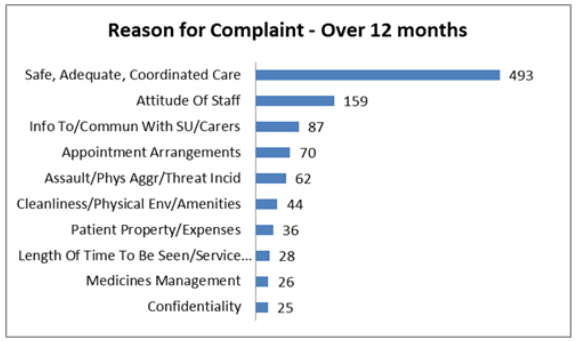


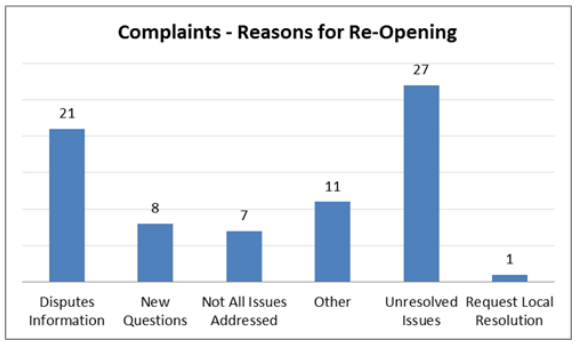












2017/18 Priorities	Our Ambition	How we will Measure the Priority
5. Improve the health and quality of life of our patients and service users through implementation of a Clinical Outcomes Framework *This priority was chosen because we use a variety of clinical outcome measures across our services and we want to continue to ensure there is a consistent approach*	To have a Trust clinical outcomes framework which demonstrates clinically effective care and treatment is being delivered resulting in positive outcomes for patients.	Progress with implementation of the Clinical Outcomes Framework Specific outcome measures to be monitored at Trust level in 2017/1 to be agreed. *Monitored by the Clinical Effectiveness Sub-Committee*

The tools that will be used in mental health services to collect the Clinical Reported Outcome Measure (CROM), Patient Reported Outcome Measure (PROM) have now been agreed. Tools identified are Outcome Rating Scale (ORS) that will be used a part of the care planning process and the Health of the Nation Outcome Scales (HoNOS) tool will be used for the CROM. Plans to roll out the PROM are now being developed and training requirements are being scoped.

The clinical development unit and Applied Information are working together to develop more robust analysis functions linked to both contractual requirements and capturing a baseline of performance/expected outcomes to base future monitoring on. Options for analysing HoNOS have been presented to commissioners to review and consider reporting requirements.

The patient reported outcome measure the ORS has been built into RiO (patient information system – mental health services) and launched in Mid Notts in March 2018. Caseload dashboards for teams and service level reporting will be launched in May 2018 the dashboard will feature the HoNOS score and ORS score where available. Training packages to support collection of outcome data and use in caseload dashboards will be delivered to teams during April and May 2018.

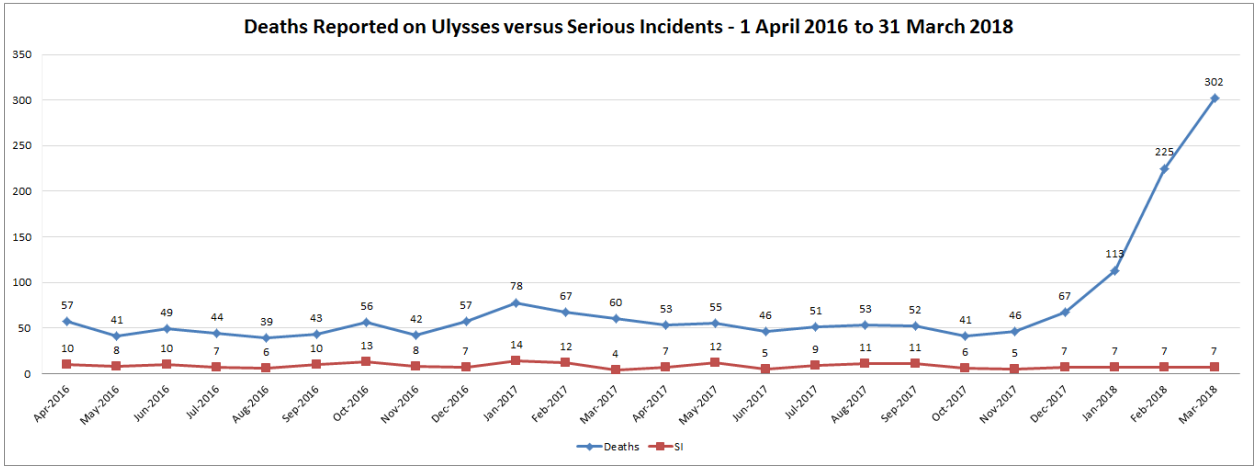
Physical healthcare services are developing outcome reporting measures linked to the self-care agenda through the requirements of the NHS England CQUIN 11: Personalised Care & Support Planning has provided an opportunity to develop measurement of outcomes relating to personalised care. This year, measurement tools have been developed and integrated in SystmOne (patient information system – general health) to give baseline data about the way that patients on an identified number of caseloads feel about the support they receive and their confidence to manage their health. Over the next year, further processes and measurement tools will be created in order to measure changes in people's responses, and therefore how we are supporting outcomes related to personalised care.

Contractual requirements for the outcomes development are currently being met, key milestones for the development processes will be incentivised rather than the actual outcomes for the next 12 months, this will allow for some shadow reporting and testing of the measures. For continued monitoring external Progress reports will be presented in contract review meetings and internal progress reports are presented to the clinical effectiveness sub-committee. Representatives from the Trust attend the UK Routine Clinical Outcomes Measurement Network on a regular basis and hosted the meeting in September 2017

2017/18 Priorities	Our Ambition	How we will Measure the Priority
6. Improve outcomes for users of Trust services through effective monitoring and learning from deaths of patients who die whilst in receipt of services, or within six months of discharge. *This priority was chosen because the Trust, whilst having robust systems in place for reporting and investigating serious incidents, a wider piece of work is required to understand mortality rates and causes of death and avoidability.*	To reduce deaths that are considered to be preventable through implementation of best practice, clinically effective care.	Review of effectiveness of actions completed in the Mortality Reporting Quality Improvement Plan Development and monitoring of Mortality Dashboards – (metrics to be agreed) Thematic review utilising human factors and triangulation with other sources of information *Monitored by Trust CIRCLE*

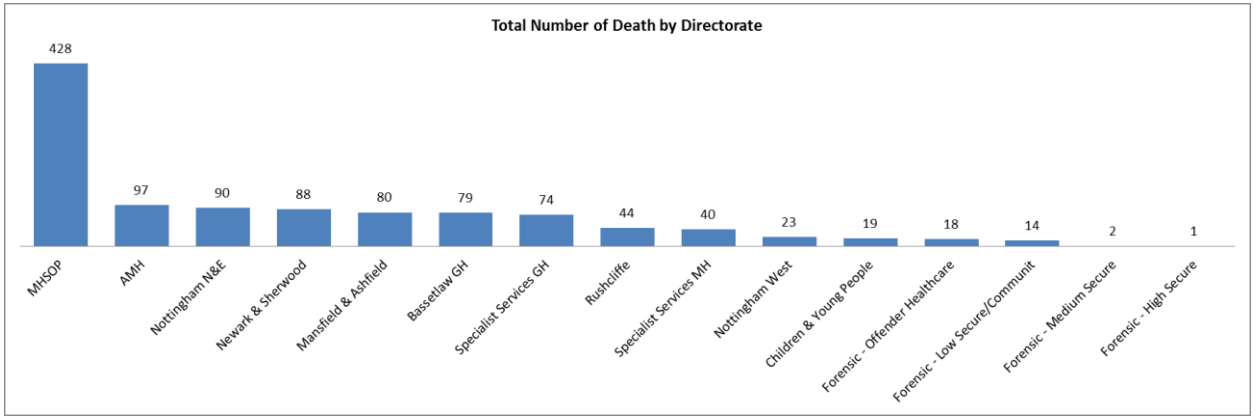
The data below details the number of deaths of patients receiving services from the Trust from 1 April 2017 to 31 March 2018. The data is extracted from Ulysses, the Trusts risk management system. Graph 1 provides the number of deaths reported on Ulysses each month; this is all deaths reported from all services included deaths from natural causes and patients who were on an end of life care pathway. There were **1098** deaths reported from 1 April 2017 to 31 March 2018. It should be noted that due to the implementation of the revised policy where all known deaths are reported, the increase from January is expected. Graph 1 also provides a comparison against deaths reported as a Serious Incident.

Graph 1 – All Deaths Reported on Ulysses

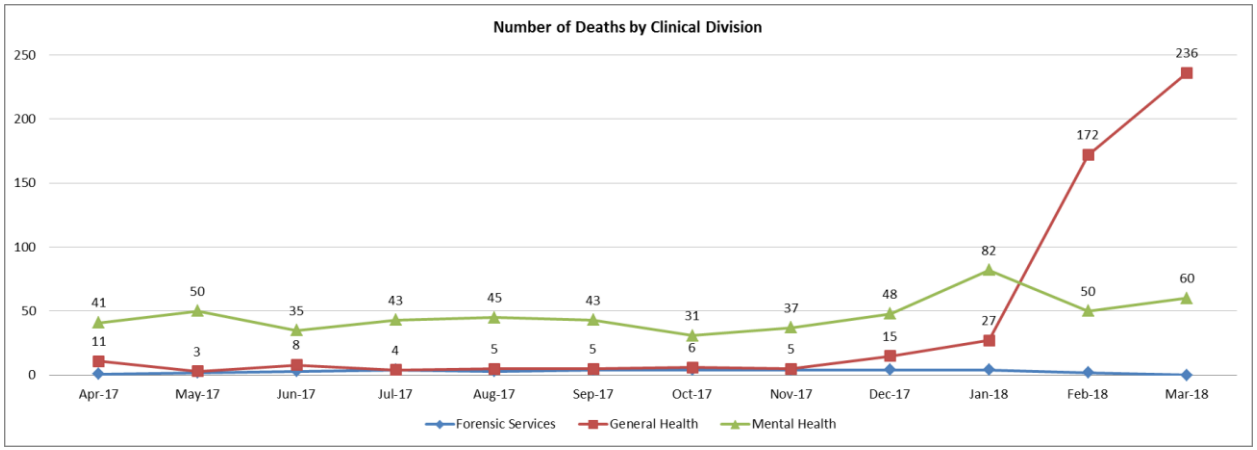


Graph 2 represents the number of deaths reported by each directorate with Mental Health Services for Older People (MHSOP) reporting the highest number followed by Adult Mental Health (AMH).

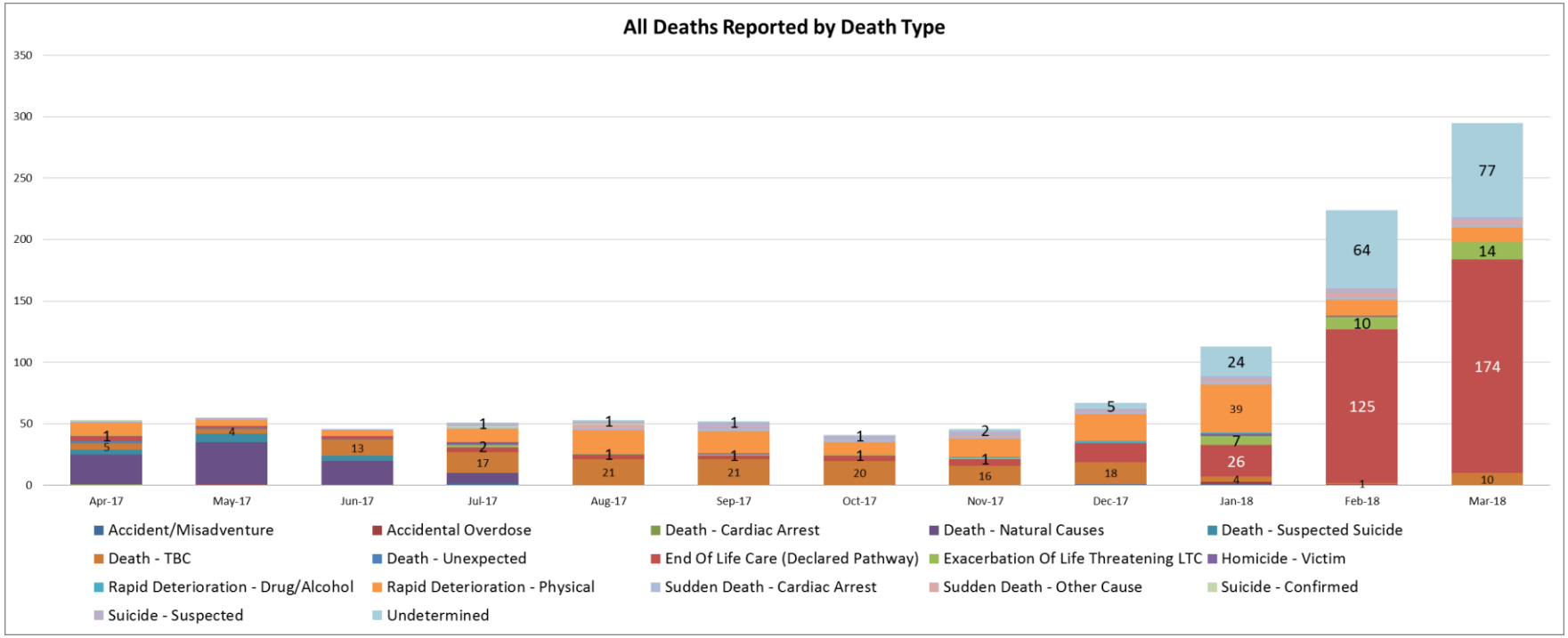
Graph 2 – All Deaths Reported by Directorate



Graph 3 – Deaths Reported by Clinical Division



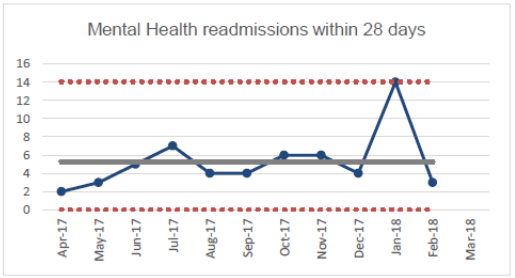
Graph 4 – All Deaths Reported by Death Type

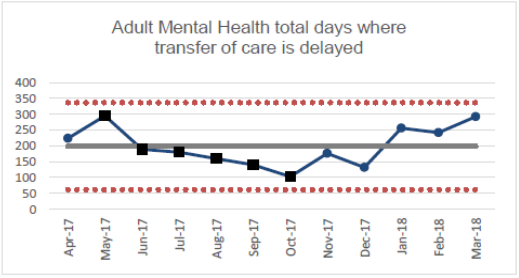


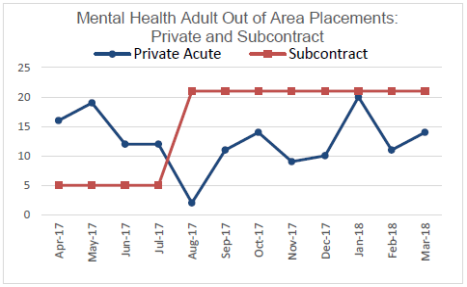
2017/18 Priorities	Our Ambition	How we will Measure the Priority
7. Ensure timely access to services which are provided from locations which meet service users clinical need *This priority was chosen as feedback from service users and carers, as well as monitoring of waiting times and other access metrics, points to this being an area requiring quality improvement.*	Our ambition is to ensure all waiting time targets are met and negative feedback reduces. Patients are cared for in the most appropriate service to meet their clinical need.	Responsive Metrics for 2017/18: • Monitor access targets – IAPT & First Episode Psychosis • Delayed Transfers of Care • 28 day re-admission • Length of stay • Occupancy rate • Out of area placements • A&E breaches • Waiting times Analysing relevant feedback – complaints & patient surveys *Monitored by the Finance and Performance Committee*

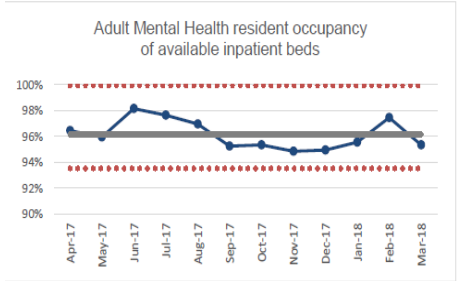
IAPT & First Episode Psychosis - The Service remains under target - at the end of March reporting 70.8% and 69.9% for quarter 4 2017/18 against the 75% target. Whilst there has been a small improvement in March, significant improvement is expected by June 2018. In summary, the comprehensive action plans in place should continue to improve the waiting times for the Leicestershire & Rutland service, which would enable the Trust's IAPT service as a whole to return to compliance with target requirements. Performance will continue to be monitored on a weekly basis in service and on a monthly basis by the Trust. Currently the Service is on target with the performance improvement trajectory plan and, following a meeting with NHSE and NHS Improvement on 9th April 2018 regarding the Capacity and Demand modelling, the commissioners are assured that the Service will continue over the coming months to improve on waiting times and access to services for patients. The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care at the end of quarter 4 was 84% (50% target).

The following graphs provide the positions for the other metrics.









2017/18 Priorities	Our Ambition	How we will Measure the Priority
8. Ensure the Trust has a culture that encourages staff to have the 'freedom to speak up' *This priority was chosen as we want our staff to speak up about any concerns they have, feel they are listened to and their concerns acted upon*	For all concerns to be raised to help us to keep improving our services for all patients and the working environment for our staff. We want to investigate what staff say and provide access to the support they need.	Specific measures are being developed Top 20% Trusts with relevant national staff survey questions. *Monitored by Trust CIRCLE and the Workforce, Equality and Diversity Committee*

In the financial year of 2017/2018, 120 concerns were raised through the Trust's FTSU Guardian. The FTSU Guardian continues to encourage staff to raise concerns where necessary and to sign post and support in doing so. In addition, alongside the National FTSU Guardian, she works to help instil an open and honest culture within the Organisation where raising concerns becomes "the norm".

All concerns are treated confidentiality and held on a central tracker to disseminate trends and theme to the WED Committee bi-monthly and the Board of Directors bi-annually. In addition, the FTSU Guardian meets regularly with members of the executive team to discuss activity and resolutions in the respective areas and any cases that may be open longer than anticipated.

The FTSU Guardian works alongside staff side, HR and equality and diversity colleagues on the DOPAT strategy and to share intelligence within the Organisation. She has worked alongside NHSI in developing the "Whistle-blowers Support Scheme" and continues to support the National Guardians Office through presenting workshops and representing the East Midlands Network as Chair.

In addition, the anonymous two way dialogue system "SpeakInConfidence" has been renewed for another 12 months in order to offer staff a voice in total anonymity as another route to raise concerns. The FTSU agenda continues to be disseminated to all staff through Trust induction, seminars and away days and in the latter part of the financial year has focussed on supporting leaders to assist those raising concerns in an open and transparent manner"

Priorities for Quality Improvement 2018/19

Our ambition is that every person who uses our services receives the best health care possible every time they have contact with us. Listening to patients, their carer's and families enables us to understand their experience to help us to achieve this ambition. Our staff are recognised for delivering outstanding care and compassion for patients. We continue to build upon this achievement and strive to deliver integrated care that is safe and effective every time. Our Quality Priorities for 2018/19 will continue to help us to achieve this ambition.

To develop and agree our priorities for improvement for 2018/19 we considered; the outcome of recent CQC well-led and core service inspections and Mental Health Act reviews, the number and type of incidents and the outcome of subsequent investigations, the outcome of patient and staff surveys complaints and analysis of other forms of service user and carer experience (SUCE) feedback, including complaints. This enabled us to develop a shortlist of priority areas which were refined following further discussions at the Trusts Leadership Council in February 2018. The Quality Committee considered these further in March 2018 and agreed the nine outlined in the table below.

Further consultation was held with external stakeholders through the Quality Improvement Committee at Nottingham City Clinical Commissioning Group, the Health Scrutiny Committee's and Healthwatch. The Trusts Council of Governors was also consulted.

Quality Priorities 2018/19

The table below sets out our priorities and how, in addition to monitoring progress at the Quality Committee, they will be monitored and measured. Specific ambitions and trajectories for improvement will continue to be developed and each priority area will have a Quality Improvement Plan defining what action will be taken to work towards achieving our ambitions, underpinned by quality improvement methodologies. The Trusts Quality Strategy will be updated to reflect the new priorities.

2018/19 Priorities	Our Ambition and Desired Outcome	How we will Measure Progress
SAFE		
1. Improve medicines optimisation with a focus on: **1.1. Missed doses of critical medication** **1.2. Accurate recording of medicines administered** **1.3. Management of controlled drugs** **1.4. Safe storage**	Our ambition is to reduce medicines related harm Increase the reporting of these incidents and reduce the overall level of harm To have no medication related incidents causing moderate or severe harm or death	• Effective implementation of the Quality Improvement Plan • Number of occasions critical* medication missed • Number of occasions medication administration records not completed • Outcome of quarterly checks of controlled drugs • Number of and analysis of incidents relating to controlled drugs • % medication related incidents by harm category • Number of and analysis of incidents of incorrect storage of medications (including fridge temperatures) **as specified on the Trusts Critical Medication List* *Monitored by* ***Trust CIRCLE***
2. Improve the physical healthcare of patients with a focus on the use of NEWS* to recognise and act on physical health deterioration (*National Early Warning Score)	Our ambition is to: • Reduce harm caused by failure to recognise and act on physical health deterioration	• Effective implementation of the Quality Improvement Plan to use NEWS2 • % in-patients who have had a NEWS recorded on admission as a baseline assessment • % in-patients who have had a repeat NEWS recorded • % in-patient NEWS with evidence action has been taken when the score meets the threshold for further action • Analysis of outcomes of incident investigation or case note reviews relating to physical deterioration to determine appropriate use of and acting on NEWS (including following resuscitation and use of oxygen) • % compliance with Infection Prevention and Control (including sepsis) training • Compliance with Patient Safety Alert NHS/PSA/RE/2018/003 *Monitored by the* ***Clinical Effectiveness Sub-Committee***
3. Reduce the number of our patients who die from apparent suicide and reduce self-harm	Our ambition is to: • Have zero suicides • Have no incidents of self-harm causing severe harm • Reduce avoidable self-harm by 50% • Increase the reporting of these incidents	• Effective implementation of the Quality Improvement Plan • % self-harm incidents causing moderate harm or above • Number of suicides regarded as potentially preventable following investigation • Number of repeated issues identified following investigations • Board quarterly Learning from Deaths Report • Monitoring of Do Not Attends – measure to be confirmed *Monitored by* ***Trust CIRCLE***

2018/19 Priorities	Our Ambition and Desired Outcome	How we will Measure Progress
4. Reduce restrictive practice to ensure the 'least restrictive' principle is applied for all patients	Our ambition is to: • Reduce the number of restrictive interventions by 25% over 2 years • Ensure seclusion and restraint is proportionate to risk • Reduce blanket restrictions	• Effective implementation of the Quality Improvement Plan in priority areas (includes actions to reduce assaults which are often a precursor to seclusion and restraint) • Measures currently being developed but will include - episodes and length of seclusion, use of prone and mechanical restraint, use of medication, long-term segregation and use of blanket restrictions • % appropriate nursing and medical staff who have received rapid tranquilisation training • Number of incidents of violence to patients and staff *Monitored by* ***Mental Health Legislation Oversight Group***
EFFECTIVE		
5. Improve the quality of and access to clinical records	Our ambition is to: • Ensure high quality, contemporaneous clinical records are available to our clinicians at the right time • Reduce the risks relating to multiple records	• Effective implementation of the Quality Improvement Plan • Measures currently in development *Monitored by the* ***Clinical Effectiveness Sub-Committee***
6. Improve compliance with the Mental Health Act, Mental Capacity Act and Deprivation of Liberties	Our ambition is to: • Ensure legislation is only used when appropriate • Ensure when used there is evidence we are fully compliant with the legislation	• Effective implementation of the Quality Improvement Plan • Measures currently in development • Analysis of the outcome of CQC Mental Health Act monitoring visits *Monitored by the* ***Mental Health Legislation Oversight Group***
CARING		
7. **Improve involvement in care planning and treatment decisions and ensure they are recovery focussed**	Our ambition is to ensure all care plans support recovery and there is evidence that patients and families where appropriate have been involved in developing and evaluating them	• Effective implementation of the Quality Improvement Plan • % of care plans on clinical information systems that demonstrate involvement • Outcome of clinical record audits of care plans to demonstrate recovery focussed • Outcome of patient surveys • Outcome of monthly in-patient surveys on involvement in decision making and provision of information relating to the use of medication in their care *Monitored by the* ***Patient Experience and Service Improvement Sub-Committee***

2018/19 Priorities	Our Ambition and Desired Outcome	How we will Measure Progress
RESPONSIVE		
8. To reducing waiting times in services where delays in access could potentially cause harm and improve the experience whilst waiting	Our ambition is to: • Improve access to services where feedback has told us there may be problems • Ensure appropriate support is available whilst waiting Ensure no patient is harmed whilst waiting to access services	• Effective implementation of the Quality Improvement Plan • Waiting times in: ➢ Child and Adolescent Mental Health ➢ Adult Mental Health ➢ Mental health Services for Older People ➢ Psychological Therapy (IAPT) ➢ Offender Health • Analysis of relevant feedback – complaints & patient surveys • Analysis of incidents relating to people waiting to access services *Monitored by the **Patient Experience and Service Improvement Sub-Committee and Clinical Effectiveness Committee***
WELL-LED		
9. Making the Trust a great place to work by improving the well-being our staff	Our ambition is to improve the well-being of our staff and keep them at work by: • Reducing physical and psychological harm caused by work • Ensuring appropriate support is provided to staff • Ensure staff have access to education and awareness raising to support them in being as well as they can	• Effective implementation of the Quality Improvement Plan • Outcome of: ➢ ONS Stress Questionnaire ➢ National staff survey well-being questions ➢ Evaluation of impact of education programmes and provision of support • Sickness relating to stress, muscular-skeletal injuries and assaults • Staff engagement with Occupational Health *Monitored by the **Workforce, Equality and Diversity Committee***

The quality priorities have been relatively consistent over the past few years. Where a quality priority for 2017/18 has not been carried forward to 2018/19 this should be viewed as positive. This is because sufficient progress is being made towards achieving the ambition and there is confidence that the governance arrangements in place are strong and the improvements will continue without the enhanced scrutiny. These are outlined in the table below.

Domain	2017/18 Quality Priority Not Continuing in 2018/19	Comment
Safe	Reduce avoidable harm, with clear focus on: • Physical assaults • Pressure ulcers • Medication errors • Patient falls	Reduction of physical assaults will be included in the ongoing reducing restrictive practice priority Significant progress has been made and pressure ulcers and patient falls will continue to be monitored by the Physical Healthcare Steering Group Some aspects of this priority are included in the revised medicines management priority however medication errors in general will continue to be monitored by the Medicines Optimisation Group
Caring	Improve experience through better management, understanding and response to issues raised through complaints	The complaints process has been reviewed and a new policy issued in July 2017. The CQC well-led inspection in November 2017 acknowledged that effective complaints system was in place Complaints are monitored through the Patient Experience and Service Improvement Sub-Committee
Effective	Improve the health and quality of life of our patients and service users through implementation of a Clinical Outcomes Framework	The Clinical Outcomes Framework continues to develop and improve and is an integral part of the work of the Clinical Effectiveness Sub-Committee
Effective	Improve outcomes for users of Trust services through effective monitoring and learning from deaths of patients who die whilst in receipt of services, or within six months of discharge.	A revised policy was issued in August 2017 and progress with implementing the national Learning from Deaths framework was included in the CQC well-led inspection in November 2017 which acknowledged that the Trust had set up good processes to investigate and learn from deaths. A robust continuing development plan is in place which is monitored by the Mortality Surveillance Group and Trust CIRCLE
Well-Led	Ensure the Trust has a culture that encourages staff to have the 'freedom to speak up'	The role of the Freedom to Speak Up Guardian is embedded within the Trust, there is evidence staff are using this process and accessing the guardian. This continues to be monitored by the Workforce, Equality and Diversity Committee

Statements of Assurance from the Board

This section has a pre-determined content to allow comparison between Quality Reports from different organisations. The content and wording within the light blue boxes are requirements taken from The NHS Improvement's Detailed Requirements for Quality Reports 2017/18. This incorporates the requirements for all trusts to produce a Quality Account as set out in The National Health Service (Quality Account) Regulations 2010 and additional requirements set by NHS Improvements for Foundation Trusts.

Review of Services

During 2017/18 Nottinghamshire Healthcare NHS Foundation Trust provided and/or subcontracted **139** relevant health services.

Nottinghamshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in **139** of these relevant health services.

The income generated by the relevant services reviewed in 2017/18 represents **88%** of the total income generated from the provision of relevant health services by Nottinghamshire Healthcare NHS Foundation Trust for 2017/18.

Participation in Clinical Audit

During 2017/18 **15** national clinical audits and **1** national confidential enquiry covered the relevant health services that Nottinghamshire Healthcare NHS Foundation Trust provides.

During that period Nottinghamshire Healthcare NHS Foundation Trust participated in **100%** national clinical audits and **100%** national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Nottinghamshire Healthcare NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

- The National Prescribing Observatory for Mental Health (POMH) – 5 audits
- Sentinel Stroke National Audit Programme (SSNAP)
- PLACE (Patient Led Assessments of the Care Environment)
- National COPD Pulmonary Rehab Audit
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Young People's Mental Health (YPMH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Chronic Neuro disability
- Learning Disability Mortality Review Programme (LeDer)
- CQUIN - Collaboration with Primary Care Clinicians
- CQUIN - Cardio metabolic risk assessment in patients with psychosis
- CQUIN 10 - Improving the assessment of wounds
- Mental Health Clinical Outcome Review programme - National Confidential Inquiry into Suicide and Homicide
- National Audit of Intermediate Care
- National Audit of Psychosis
- UK Parkinson's Audit
- Physiotherapy Hip Fracture Sprint Audit (PHFSA)

The national clinical audits and national confidential enquiries that Nottinghamshire Healthcare NHS Foundation Trust participated in during 2017/18 are as follows:

- The National Prescribing Observatory for Mental Health (POMH) – 5 audits
- Sentinel Stroke National Audit Programme (SSNAP)

- PLACE (Patient Led Assessments of the Care Environment)
- National COPD Pulmonary Rehab Audit
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Young People's Mental Health (YPMH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Chronic Neuro disability
- Learning Disability Mortality Review Programme (LeDer)
- CQUIN - Collaboration with Primary Care Clinicians
- CQUIN - Cardio metabolic risk assessment in patients with psychosis
- CQUIN 10 - Improving the assessment of wounds
- Mental Health Clinical Outcome Review programme - National Confidential Inquiry into Suicide and Homicide
- National Audit of Intermediate Care
- National Audit of Psychosis
- UK Parkinson's Audit
- Physiotherapy Hip Fracture Sprint Audit (PHFSA)

The national clinical audits and national confidential enquiries that Nottinghamshire Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
Prescribing Observatory for Mental Health (POMH-UK) - Topic 1G and 3D - Prescribing high dose and combined anti-psychotics	**430**	**100%**
Prescribing Observatory for Mental Health (POMH-UK) - Topic 17a use of Depot/LA antipsychotic, injections for relapse prevention	**119**	**100%**
Prescribing Observatory for Mental Health (POMH-UK) - Topic 16a Rapid Tranquilisation	**10**	**100%**
Prescribing Observatory for Mental Health (POMH-UK) - Topic 15b Prescribing Valproate for Bi-polar disorder	**28**	**100%**
Audit Title	**Cases Submitted**	**% of the number of registered cases required**
Prescribing Observatory for Mental Health (POMH-UK) - Topic 6d Assessment of side effects of depot antipsychotics	**94**	**100%**
Sentinel Stroke National Audit Programme (SSNAP)	**Not known***	**100%**
PLACE (Patient Led Assessments of the Care Environment)	**12**	**100%**

Audit Title	Cases Submitted	% of the number of registered cases required
National COPD pulmonary rehab audit	**20**	**100%**
Child Health Clinical Outcome Review Programme NCEPOD - Chronic Neuro disability	**1**	**100%**
Child Health Clinical Outcome Review Programme NCEPOD - Young Peoples Mental Health	**7**	**100%**
Learning Disability Mortality Review Programme (LeDer)	**78**	**100%**
CQUIN - Collaboration with Primary Care Clinicians	**109**	**100%**
CQUIN - Cardio metabolic risk assessment in patients with psychosis	**27**	**100%**
CQUIN 10 - Improving the assessment of wounds	**150**	**100%**
Mental Health Clinical Outcome Review programme - National Confidential Inquiry into Suicide and Homicide	**24**	**87.5%**
National Audit of Intermediate Care	**N/A**	**100%**
National Audit of Psychosis	**55**	**100%**
UK Parkinson's Audit	**N/A**	**100%**
Physiotherapy Hip Fracture Sprint Audit (PHFSA)	**N/A**	**100%**

The reports of 15 national clinical audits were reviewed by the provider in 2017/18 and Nottinghamshire Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- **Prescribing Observatory for Mental Health (POMH) Audit**

  As a result of participating in Prescribing Observatory for Mental Health (POMH) Audit programmes (and other programmes of work) the following actions have been taken:
  These were discussed at Trust Medicines Optimisation Group in November 2017 and the following actions were agreed:

- It was agreed that Adult Mental Health (AMH) Services should look at the findings as a priority and discuss with senior staff/AMH consultants forum and AMH Clinical Governance meeting and ensure increased awareness regarding using the term ‘high dose’ and ‘combination’.
- Pharmacy staff are developing an overarching document that covers the use of high dose and combination antipsychotic treatment, as there isn’t one at present.

The Trust is still waiting for the specific POMH-UK audit results/reports.

- ***Sentinel Stroke National Audit Programme (SSNAP)**

Nottinghamshire Healthcare NHS Foundation Trust participates in this audit on behalf of the acute Trusts (Nottingham University Hospitals / Sherwood Forest Hospital). The national report does not allow the Trust to extract local data so it is unclear how many cases were submitted in 2017/18. The Trust is awaiting the results.

- **PLACE – Patient Led Assessments of the Care Environments (Local Partnerships – General Health Services)**

Key messages of service improvements

The annual PLACE assessments were undertaken at Bassetlaw Hospice, Children’s Development Centre, John Eastwood Hospice and Lings Bar Hospitals and all areas scored above the national average for Cleanliness, Food, Dementia (excluding CDC which is not assessed in this category) and Disability. There were also improvements on the previous year’s scores at Bassetlaw Hospice and Children’s Development Centre for Privacy and Dignity and at Children’s Development Centre and Lings Bar Hospital for Condition, Appearance and Maintenance.

Any areas for development/concern

Quality improvement plans were developed to address the following issues identified:

- Children’s Development Centre – The carpets and vinyl floor coverings have been replaced in the lounge and central areas and a programme of additional garden maintenance has been put in place to ensure the ground are kept tidy.
- John Eastwood Hospice – Cleaning rotas have been reviewed.
- Lings Bar Hospital – Along with some minor issues that required addressing in regards to cleanliness signage on the unit has been improved to assist patients with dementia and a lower call bell has been installed in the dining room for wheelchair users.
- Bassetlaw Hospice – An outdoor slab has been repaired and a parking space has been allocated for use for disabled parking with appropriate signage installed.

- **National Confidential Inquiry into Suicides & Homicides (NCISH)**

The NCISH published an annual report but this does not provide a local breakdown. The Trust only submitted 21 out of 24 questionnaires (87.5%) sent to the Trust. Questionnaires are sent directly to clinicians for completion and in some cases clinicians rotate their post or move to other Trusts and this may cause delays in the questionnaires being completed. The Trust has now established a process to ensure that questionnaires can be completed by the service.

The Trust tracks mortality and produces a quarterly report to the Board of Directors on mortality surveillance and learning from incidents. Trust Clinical Incident Review Creating a Learning Environment (CIRCLE) Group who monitors mortality, has agreed revised categories for reporting deaths which will be applied after the death has been reviewed or investigated by a smaller group of staff to improve consistency. The Managing Serious Incidents and Reporting and Learning from Deaths policy has been developed and implemented and incorporates the Trusts approach to reporting and investigating deaths.

All homicides, suicides, unexpected deaths and near misses involving patients of the Trust are regarded as serious incidents and managed in accordance with national guidance and with agreed policies within the Trust and NHS England. In addition, in line with NHS England Learning from Deaths guidance, the Trust has established it Mortality Surveillance Group to provide corporate oversight of Trust systems to report, review, analyse and learn from deaths of service users. It also provides a framework for determining what level of review/investigation should be conducted following deaths of service users that meets national reporting requirements. As a result the Trust is improving its learning from deaths of service users by introducing the Initial Management Review (IMR) process which determines the level of investigation required. The Trust therefore participates in this research and reports its investigations to the National Confidential Inquiry.

The distinctive feature of each inquiry's contribution is the critical examination by senior and appropriately chosen specialists, into each incident. There are established arrangements for communicating lessons learned (both within the Trust and externally where appropriate), carrying out of gap analysis for any areas of concern, developing any additional action plans where applicable to meet the recommendations of the study and to ensure that there is a robust and expedient system for the dissemination of information.

The Trust is awaiting the results of the other national audits and will ensure that key recommendations are shared with services for areas of improvements. Individual audits will be monitored by the Trust Clinical Effectiveness Sub Committee.

The reports of **124** local clinical audits were reviewed by the provider in 2017/18 and Nottinghamshire Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Within our Forensic Services Division

The reports of 56 local clinical audits were reviewed within Forensic Services during 2017/18. The following are examples of actions taken to improve the quality of healthcare provided:

- Following an audit of the NEWS physical observation charts within the Forensic Services, A3 folders were distributed to all wards within Rampton to ensure consistent filing of NEWS charts throughout the hospital. Guidance in the completion and scoring of charts was issued and a greater focus on NEWS is given in Hospital Life Support training. A standard format for NEWS charts and storage was also agreed at Arnold Lodge.
- Gaps identified in an audit on tribunal reports at Wathwood led to the instigation of a standardised template which is being used by all clinical teams.
- Offender Health undertook an audit of Lithium Therapy which highlighted that, due to the fact that the number of patients prescribed lithium across the directorate is very small, staff may be unfamiliar with some of the requirements. A learning the lessons flyer was circulated to raise awareness of what is expected when lithium therapy is initiated and reminding staff not to issue ibuprofen via the discretionary medicines protocol to patients prescribed lithium.
- Following several audits around seclusion and restrictive practice a group was set up to review paperwork at Rampton Hospital. As a result new files were issued for restrictive practice and observations along with revised indices and navigation guides for seclusion, segregation and mechanical restraint to alleviate more general issues with documentation and filing.

Within our Local Partnerships Division

There were a total of 68 different audit topics registered on the audit programme during 2107/18. The following are examples of actions taken to improve the quality of healthcare provided:

- **Medicines Management – Out of Hours Service Audit (Local Partnerships – General Health Services)**

  Key messages of service improvements

  A process has been established which ensures delivery notes are stored for the relevant time and disposed of appropriately.

  Any areas for development/concern

  To have a Trust Medicines Management Policy in place which clearly reflects and supports Medicines Management and the Safety and Security of Medicines for Out of Hours services.

- **Podiatry – Implementation and Effectiveness of the Diabetic High Risk Foot Register within Podiatry (Local Partnerships – General Health Services)**

Key messages of service improvements

The audit found the use of registers in effective as 85% of patients followed up re-attended the service. Registers have been implemented in new areas City and Bassetlaw.

Any areas for development/concern

All clinics have registers, however the audit highlighted discrepancies in documenting and recording on the registers and that some registers are not being checked regularly enough. Training sessions have been held to address these issues.

- **NICE Guidelines – QS10 – Chronic Obstructive Pulmonary Disease in Adults**

  Key messages of service improvements (Local Partnerships – General Health Services)

  This audit led to the development of links with secondary care through the establishment of weekly ward rounds at Bassetlaw Hospital and Cedar House Hospice. The team are also now providing “Managing Breathlessness” education at the Day Hospice.

- **NICE Guidelines – CG161 Falls and CG146 Osteoporosis assessment and intervention in NNE Adult Community Teams (Local Partnerships – General Health Services)**

  Key messages of service improvements

  The identification of person’s at risk of falls is the biggest factor to then ensuring appropriate assessment and intervention. The first step of this is routinely asking about falls history. Across all localities, records audited from “Community Therapy” achieved above the standard set, this practice is embedded in professional culture, and fits with the interconnection between “Falls” and “Therapy”. This audit data will be used to direct the Falls Lead to target education and training to Community Nursing in Nottingham North and East.

  Any areas for development/concern

  There is a need to build on the good work to expand to other areas within the Adult Community Services along with the message that “falls are everybody’s business”.

  The recording of Falls History also needs to be standardised, clinical reporting systems are currently in place to capture this data, but if people are not correctly recording this information the data will be inaccurate and not representative of practice. Standard 5 asks that verbal guidance on falls risks is provided to patients and their carers and while it may be the case that verbal guidance is provided this is not always documented. Further education to staff members on the importance of this is crucial. For the provision of written guidance around falls risks, the poor result in the audit demonstrates

an unawareness of this quality standard amongst teams. Further work to improve performance in this standard could include, self-management plans for fallers, and promotion of falls advice leaflets currently available to the community teams. Regarding Fracture risk assessment, all localities and services are well below the standard set in the audit. This demonstrates a clear training need, which the Falls Lead is working to address. The Falls Lead is also working towards clinical reporting via FRAX (Fracture Risk Assessment Tool) read coding and template.

- **Nasogastric Tube Audits (Local Partnerships – General Health Services)**

  Key messages of service improvements

  A number of nasogastric tube audits have been completed during Quarter 1 and 2 2017/18 at the Children's Development Centre. The audits found the team are complying with new guidance ensuring evidence of competencies signed by parents are in the child's record. This audit also led to improvements on the nasogastric tube templates on SystmOne and for refresher training for all staff who are currently caring for patients with nasogastric tube's in situ to ensure they are up to date with current practice.

  Any areas for development/concern

  Whilst the above positives have been found it is clear more work needs to be done about care plans in the records and this is being addressed via SystmOne training. Also the cleaning equipment document is not always scanned into the system and so the team needs to be made aware of this.

  To improve on this documentation a presentation was given to the community nurses to discuss the audit findings in detail and identify where the information should be documented within the patient record. This generated a lot of discussion and identified areas which require some development/confirmation. Work is currently progressing to address these issues and update the audit tool accordingly to measure performance accurately.

- **Documentation Audit across Local Partnerships**

  A number of changes have been made to the electronic patient records in both RiO and SystemOne as a result of the Documentation Audit:

  - The Safeguarding Childrens' assessment has been identified to be at risk of falsely identifying children to be at risk and changes to the risk assessment document are planned as a result.
  - The ability for staff to record 'Not Applicable' on various templates has helped provide clarity and better communication for teams and service users. A review of the audit process across the Division was undertaken and plans have been agreed to align the process across MHS and GHS in order to better benchmark services across the Division. Changes to the frequency and compliance threshold will come into place on the 1st April 2018 with MHS adopting the Head of Service audit process that offers increased assurance to the Division. A

consultation process will begin in April to agree the standards to be included in the audit tools.

- **Audit of Physical Monitoring of Adult Patients Currently Prescribed Medication for ADHD**

  This audit set out to ensure adequate monitoring of adult patients currently prescribed medication for ADHD. As a result of the findings:

  - A template has been designed to be kept with each patient's prescription that will indicate when measurements are required with a reminder the month before that this is required. This will enable patients to be given a months' notice to get these measurements taken and communicate the results to us. The template will also be used to record the results as well as recording them on RIO.
  - A letter was sent to all patients reminding them of the importance of physical monitoring and that we aim to improve our compliance with this which may include considering discontinuing prescriptions if we are unable to obtain regular measurements.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Nottinghamshire Healthcare NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee **6054.**

The number of patients recruited to participate in research approved by a research ethics committee within the National Research Ethics Service is **6054** (as reported 26/02/18) so this is not the full year. For 16/17 recruitment was **1373**

Nottinghamshire Healthcare NHS Foundation Trust records the number of studies for each medical condition. This enables the Trust to monitor over-researched medical conditions and to ensure that there is an equal distribution of research being conducted over a variety of disease areas.

During 2017/18 there has been high numbers of studies approved relating to a broad range of topics; there are a high number of studies within offender health, suicide and self-harm, dementia, and generic health relevance. For those studies ongoing (opened before 2017/18), services with high research activity include adverse drug reactions, personality disorder, mood disorders, ASD, Autism and Tourette's syndrome. The Trust also undertakes a significant amount of research in health service delivery, which mainly includes staff as participants and our research in general health conditions, is also on the increase, for example cancer, musculoskeletal disorders, stroke, and renal and urogenital disorders.

Please note the recruitment number does not include staff studies, as the information requested is for *patients* recruited and also studies that have been approved by a research ethics committee. Research involving staff as participants are exempt from research ethics committee approval.

Research Activity 2016/17 & 2017/18

	2016/17	2017/18
Total Non-Portfolio Open Studies	39	40
Total Portfolio Participant Identification Centre Studies	2	2
Total Portfolio Open Studies (including ongoing)	63	40
Total Open Studies	**104**	**82**

Commissioning for Quality and Innovation (CQUIN)

A proportion of Nottinghamshire Healthcare NHS Foundation Trust income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Nottinghamshire Healthcare NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available online at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/

https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19 guidance.pdf

Achievement of CQUIN and Outcome measures became significantly more challenging in 2016/17 with the addition of far more local outcome measures on top of the national CQUIN targets in a number of the general health contracts. The target also increased to 4% of total contract in 2017/18 with the addition of more local outcome measures in general health. The national targets within all CCG contracts also include a flu (staff uptake) target that the Trust has not achieved in previous years. The Trust's flu uptake was 61.09% which, by exceeding 60% of staff having the flu jab triggers a 50% payment of the target.

Guidance has been issued stating that the 0.5% CQUIN linked to financial target delivery is to be paid to Trusts who achieved their 2016/17 target and have included the payment of the 0.5% as part of their plan to deliver their current year financial target. Forecast outturn assumes full payment of this reserve to the Trust.

Based on the actual achievement in 2016/17 (confirmed after plan submission) the forecast shows a more prudent outturn position for CQUIN and Outcome measures for CCG contracts.

The monetary total for income in 2017/18 conditional upon achieving quality improvement and innovation goals was £8.4m (actual £7.8m). The monetary total for the associated payment in 2016/17 was £8.3m (actual £7,1m).

Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The CQC monitor, inspect and regulate services to make sure that health and social care providers meet fundamental standards of quality and safety, with the power to take action if care services are failing to meet those standards. The CQC also has a role in protecting the rights of vulnerable people whose rights are restricted under the Mental Health Act 1983, monitoring the use of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Nottinghamshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is **GOOD**. Nottinghamshire Healthcare NHS Foundation Trust has the **NO** conditions on registration.

The Care Quality Commission **HAS** taken enforcement action against Nottinghamshire Healthcare NHS Foundation Trust during 2017/2018.

The CQC assess all health and social care services against the following five key questions:

- **Are they SAFE?** By safe, they mean that people are protected from abuse and avoidable harm.
- **Are they EFFECTIVE?** By effective, they mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
- **Are they CARING?** By caring, they mean that staff involve and treat people with compassion, kindness, dignity and respect.
- **Are they RESPONSIVE?** By responsive, they mean that services are organised so that they meet people's needs.
- **Are they WELL-LED?** By well-led, they mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Nottinghamshire Healthcare NHS Foundation Trust was first registered with the CQC on 1 April 2010. The Trust is currently registered to provide regulated activities from 33 separate locations. During registration the CQC implement routine conditions which define the regulated activities to be provided at agreed locations. The CQC has not applied any non-routine conditions to the Trusts registration.

The Trust has not been required to participate in any special reviews or investigations by the CQC in 2017/18 but has been inspected under the CQC's routine inspection programme.

On 15 June 2017, the CQC published a report of the inspection they undertook of Rampton Hospital in March 2017. They made six requirement notices to improve practice against the Fundamental Standards. A further planned inspection took place

in March 2018 and the outcome, when known, will confirm if the progress the Trust has made in bringing about compliance.

During 2017/18, the CQC has undertaken a series of other inspections of services provided by the Trust. In England, all inspections of prisons are conducted jointly between HM Inspectorate of Prisons and the CQC. This collaborative approach ensures expert knowledge is deployed in inspections and avoids multiple inspection visits by different regulators. The CQC reviewed four of the Trusts prison healthcare services during 2017 and found them to be compliant.

The CQC's annual core inspection of the Trust took place from 9th to 16th November 2017. The CQC inspected five complete core services and assessed the Trust against the Well-led key line of enquiry. The outcome was that Effective, Caring, Responsive, and Well-led was rated as 'Good' and 'Safe' was rated as 'Requires Improvement'. The CQC's aggregated rating for the Trust overall was 'Good'.

Following the November 2017 inspection, the CQC issued eight requirement notices which related to 25 breaches of legal requirement in four of the five core services they inspected. In addition, the CQC advised the Trust is to make a further 48 improvements to comply with minor breaches which did not justify regulatory action or to improve services. The CQC also issued one warning notice to the Trust during 2017/18 in respect of medicine management in Local Mental Health Teams. The Trust took prompt action to bring about the improvements required. The CQC has not yet undertaken follow up inspections for assurance that the concerns which led to the warning notice and requirement notices being issued have been addressed.

Between 20 and 22 March 2018, the CQC undertook a full inspection of Rampton High Secure Hospital during which they also followed up on the requirement notices they issued in March 2017. The draft report will be issued in April 2018.

In addition to compliance inspections, the CQC's Mental Health Act Reviewers also undertake visits to services where patients are detained to ensure their rights under the Mental Health Act 1983 are protected. Reviewers visited 12 services and made 76 recommendations to improve practice overall. The Mental Health Legislation Operation Group (LOG) oversees the Trusts response to the improvements which are required and will report on progress to the Mental Health Legislation Committee which in turn reports directly to the Board of Directors.

In summary, the CQC issued requirement actions in four of the nine inspections they made to services of the Trust during 2017/18 and one inspection report is yet to be received in draft. The Trust expects further inspections during 2018/19 to test the improvements which have been made.

Figure 1:

Location	Review Date	Outcome	Requirement Notices
Rampton Hospital	06/03/17 to 10/03/17	6 Requirement Notices and 15 Recommendations	1. Staff were not calculating the National Early Warning Scores and recording them correctly. The trust audit did not address this issue. 2. Staff were not adhering to the infection prevention control and dress code policy as we observed staff wearing, rings, nail varnish and full sleeves. 3. The emergency major incident trolley had not been checked. 4. Fire doors were left open overnight on the women's wards to facilitate observations. 5. The trust did not have effective systems in place to ensure the staff were engaged and were able to give feedback without fear of victimisation. 6. The trust was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients. There was regular lone working at night.
HMP North Sea Camp	03/07/17 to 13/07/17	0 Requirement Notices 7 Recommendations	None
*HMP & YOI Doncaster	10/07/17 to 21/07/17	0 Requirement Notices 5 Recommendations	None *This service is no longer operated by Nottinghamshire Healthcare NHS Foundation Trust.
HMP Ranby	24/10/17	0 requirement notices 1 Recommendation	None
HMP & YOI Nottingham	08/01/18 to 11/01/18	0 requirement notices 6 Recommendations	None
Rampton Hospital	20/03/18 to 22/03/18		To be confirmed

Nottinghamshire Healthcare NHS Foundation Trust Inspection Report

Review Dates 09/10/17 to 14/11/17

Outcome: 1 Section 29A Warning Notice, 25 Requirement Notices, 48 Recommendations

Warning Notice:

Core Service	Warning Notice
Community Based Mental Health Services for Adults of Working Age	Controlled drugs medicines management is not operating effectively. This places the safety of patients at risk.

Requirement Notices:

Core Service	Requirement Notices
Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	Seclusion facilities at the Willows and Lucy Wade Unit must meet Mental Health Act Code of Practice requirements
	Staff must record clinic room and medicines fridge temperature checks
	Assurance that medicines remain safe to use when fridge temperatures exceed maximum temperature ranges.
	Staff must check resuscitation equipment regularly
	Staff must sign for medicines administered to patients
	Staff must make checks of controlled drugs in accordance with trust policy and guidance
	The privacy and confidentiality of patients must be protected at all times.
	Staff must share copies of care plans with patients and that this is demonstrated in patients' records
	Patients admitted to wards must have access to psychological therapies
	Section 17 leave forms must be complete and staff make copies available to patients, family members and carers
	Staff must provide patients with information in accordance with Section 132 of the Mental Health Act
	Staff must make capacity assessments that are decision specific and evidence thorough discussions and outcomes in patient records

Core Service	Requirement Notices
Specialist Community Mental health services for Children and Young People	Clinic rooms must be clean, secure and contain equipment that is in date and suitable for the purpose for which they are being used
	Provide cleaning records for all of the rooms within the community CAMHS locations
Community Based Mental Health Services for Adults of Working Age	Staff must follow their controlled drugs protocol
	Patients' files and medication records must be easily accessible to staff when needed
	Patients must have care plans in place that contain patients' views, strengths and goals, be recovery orientated and holistic
	Care plans and risk assessments must be updated in line with patient needs
	Staff must access training in the Mental Health Act and Mental Capacity Act
	Local mental health teams must demonstrate and apply good practice in using the Mental Capacity Act
Community Health In-Patient Services	Appropriate arrangements must be in place for using bank and agency staff
	Medicines must always be stored securely
	Staff must understand and work within the requirements of the Mental Capacity Act 2005.
	Deprivation of Liberty Safeguards (DoLS) must always be appropriately applied
	Patients identified with sepsis must be treated promptly in line with trust policy

Public reports which detail the full findings of inspections can be accessed via the CQC website. http://www.cqc.org.uk

Joint CQC and HMIP inspection reports can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/

Nottinghamshire Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data Quality

Nottinghamshire Healthcare NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.6% for admitted patient care;

- 99.9% for out-patient care; and
- Not applicable for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

- 99.8% for admitted patient care;
- 99.9% for out-patient care; and
- Not applicable for accident and emergency care

Information Governance Toolkit Attainment Levels

Nottinghamshire Healthcare NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 84% and was graded **GREEN** (Satisfactory).

A validation exercise was conducted on the Review of Information Governance Toolkit by Internal Audit 360 Assurance with their final report received in March 2018. The Trust maintains a well-kept Toolkit. At the time of review, the Trust was demonstrating attainment of at least the baseline level two for all ten of the ten sampled requirements reviewed and for four of the five Prison Health requirements reviewed. 360 Assurance confirmed the accuracy with which the Trust has self-assessed its current level of compliance. They confirmed that an appropriate Information Governance Management Framework is in place. 360 Assurance provided **Significant Assurance** that there is a generally sound system of control designed to meet the Toolkit's objectives.

Clinical Coding Error Rate

Nottinghamshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Nottinghamshire Healthcare NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust Information Assurance Framework provides the strategy and range of controls for monitoring of data quality across the Trust.
- The data quality of our national submissions is monitored every month and a report summarising the results and raising awareness of other significant data quality issues is regularly reviewed within the Trust's governance structures. Our latest published Data Quality Maturity Index score is 97.3% (2017-18 Q2, http://content.digital.nhs.uk/dq)
- The Performance Indicator Assurance Process is embedded in the Trust Information Assurance Framework and continues to be used to review the data quality of NHS Improvement's Operational Performance Standards and main Trust KPIs in the Integrated Performance Report provided to the Trust Board.
- Data quality reports are widely available to users of our clinical systems, and services apply resources to deal with and resolve data quality issues as they arise across our many information systems.

Learning From Deaths

During 2017/18, **1098** of Nottinghamshire Healthcare NHS Foundation Trust patients died.

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- **154** in the first quarter;
- **156** in the second quarter;
- **154** in the third quarter;
- **634** in the fourth quarter.

The mortality data used for this report has been extracted from Ulysses, the Trust's Risk Systems. The increase in the fourth quarter was due to a change in policy. The Trust's Managing Serious Incidents and Reporting and Learning from Deaths policy was introduced in September 2017 which requires all deaths to be reported on the Trust's Ulysses system. This included deaths classed as end of life or due to long term condition which were previously only recorded on the patient information system.

By **31 March 2018, ZERO** case record reviews and **80** investigations have been carried out in relation to **1098** of the deaths reported.

In **ZERO** cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- **24** in the first quarter;
- **25** in the second quarter;
- **13** in the third quarter;
- **18** in the fourth quarter.

The Trust has developed a Case Note Review process which commenced during February 2018 using a Structured Judgement Review approach which is developmental for providers of mental health and community services. The Trust has adapted the tool developed by Humber NHS Foundation Trust in conjunction with the Academic Health Science Centre in Sheffield. The first phase of reviewers has been identified and 9 cases have been identified for review, of which 4 have commenced. The Trust allows 60 days for completion and therefore these have not yet concluded.

ZERO representing **0%** of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- **0** representing **0%** for the first quarter;
- **0** representing **0%** for the second quarter;
- **0** representing **0%** for the third quarter;
- **0** representing **0%** for the fourth quarter.

These numbers has been estimated using the information form the serious incident investigation reporting process and the outcome of the reports.

The number of deaths in 2017/18 which were regarded as a Serious Incident (SI) was 80 which represent 7.5% of the total amount of deaths reported on Ulysses.

The methodology for Case Note Reviews requires making a structured judgement on the quality of the care received and a further judgement on whether: 'the death is thought to be more likely or not due to a problem in care'

Therefore, when Case Note Reviews are completed, this judgement will be made. In 2017/18 all deaths that have been reviewed were deaths that have been investigated in accordance with the National Serious Incident Reporting Framework. The Trusts current methodology did not include making this judgement. The investigations may have identified improvements in care required, however this does not necessarily mean that these contributed to the persons death.

In 2018/19, changes will be made to the serious incident investigation process to ask this question. Therefore, the Trust will be able to report on this going forward.

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths reported

As part of the implementation of the Learning from Deaths Framework, the Trust is committed to identifying areas for improvement which may help prevent future deaths. The processes to do this are currently being reviewed and reporting from Division to Trust CIRCLEs have been strengthened further with the implementation of a new format for reporting. This will enable themes and improvements identified at Division level to be captured more easily and facilitate more of a whole system approach.

Divisions have reviewed lessons learnt and actions from Divisional serious incident improvement plans, Regulation 28 Summaries (Coroners report to prevent future deaths), Division communications on lessons learnt and Prison and Probation Ombudsman (PPO) recommendations. A number of recurring themes have been identified and are summarised below, a detailed analysis will be presented to the quality committee.

In Forensic Services the themes are:

- Offender Health reception screening
- Offender Health management of complex cases
- Provision of information to family/carers in the event of a serious incident
- Care Plans
- Failure to learn from serious incident investigation reports
- Emergency Bags (governance mechanisms)

In Local Partnerships the themes are:

- Implementation of the Did Not Attend Policy
- Communication with patients and care planning
- Documenting clinical records, including NEWS scores
- Risk assessments

- Physical healthcare of patients with a mental illness

A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period

The investigation panel in conjunction with the service are required to develop a Quality Improvement Plan. During the early part of the CIRCLE process the development of the QIP's was not always adhered to in a timely fashion. As part of the review of internal assurance and the Investigation report sign of by the Associate Director of Nursing – with effect from 1st June 2017, no Investigation was approved or submitted to CIRCLE unless a QIP was included.

Across all of the Quality Improvement Plans that CIRCLE has reviewed there is a broad range of headings identified which are as follows:

- Safeguarding
- Communication
- Documentation
- Risk Assessments
- Physical Health (Mental Health Patients)
- Adherence to Policy and Procedure
- Involvement (Patient, Family and Carers)

Throughout all of the reports that CIRCLE has considered there are five key areas where as a division there should be consideration given to concentrate on the improvement of quality of care and reduce the impact of incidents on patients. The 5 key themes are:

<u>Children on adult wards</u>

As part of the review of the serious incidents there has been a theme with regards the admission of children/adolescents onto adult beds/136 facilities

Whilst consideration has more recently being given to the review of the Divisional 136 procedure with the inclusion of relevant advice from safeguarding and the revised procedure will be approved shortly through divisional governance groups

<u>Attendance DNA</u>

A Divisional review of the DNA policy has been implemented by the Divisional Deputy Director. This will involve a review and of the Trust Policy and then ensure that where service specific procedures are in place these comply with minimum standards.

The purpose of the review is to both ensure we have a consistent and risk based approach to DNA's and also to ensure the staff of some of our most vulnerable patients. This work should be completed by April 2018

<u>CPA uptake</u>

A report on the uptake and barriers to the division's performance on CPA is currently being prepared for discussion as the Clinical Effectiveness group. With that paper

there will be recommendations outlined to improve performance and any resulting actions will become the responsibility of the Mental Health LOG group

Communication GP's and Internal and External teams

Within this particular area of action there are some very specific issues with regards both the continued use of both paper and electronic records and also the use of primarily two main clinical systems (RIO & Systm1).

This area of work at present sits within the domain of the Trust Clinical Systems group (Chaired by Dr Chris Packham). This is part of the review of the Quality Priorities for 2018-19 a priority with regards Record Keeping and/or EPR may well be considered

Consideration of Physical Healthcare Needs/ Deteriorating Patient

The audit of areas relating to Physical Healthcare and NEWS scores is now contained with the documentation audits. The divisional physical healthcare team is also active in monitoring and providing advice. In addition within the MHSOP wards at Highbury a Community General Health nurse has been employed to support patients with physical healthcare needs.

The Forensic Division holds a weekly Serious Incident Review Group where all new and existing serious incidents are discussed and reviewed. The details of new serious incidents include discussion of good practice and any initial lessons learned as required.

It has been agreed that two Governance/Risk Information Boards will be created at Rampton Hospital. The boards will hold current information for staff including the top risks at Rampton, lessons learnt, the programme of forthcoming audit activity highlighting where immediate improvements are required and CQC updates. There will also be a section on the board relating to the options that staff have for raising concerns. A post-box will be affixed and comment cards will be available for staff to post; either named if they want an individual response or they can be submitted anonymously. Themes will be identified and it is felt that related discussions can then potentially take place at the Staff Council and feedback can be displayed on the board as to what actions will be taken/changes to practice as a result of staff feedback.

An assessment of the impact of the actions described above which were taken by the provider during the reporting period.

The Division reports to Trust CIRCLE which included a summary of improvement actions. Division CIRCLEs are considering how they are assured that the appropriate controls or actions are in place, and any gaps in assurance are addressed. In addition, the Division CIRCLE reports are being analysed, along with the outcomes of the human factors analysis of Serious Case Reviews to identify the overarching issues to inform the quality priorities for 2018/19 and other potential quality improvement projects. The outcome of this will be included in a paper for Trust CIRCLE and the Quality Committee to consider.

Within the Forensic Services, the Performance Department provides an 'Action Plan/QIP Summary & Updated Action Plan/QIP Monitoring Sheet' monthly report that

the group monitors and reviews. The Performance Team work closely with Action Plan Leads to ensure regular updates are obtained, timescales are adhered to and explanations sought for overdue actions.

The Team ensures that the action plans are closed in a timely manner and that dates of sign off both at local governance Groups and CIRCLE are recorded onto the action plans prior to archiving. The Forensic CIRCLE culture is one whereby constructive challenge, scrutiny and questioning is welcomed. All QIPs are reviewed and progress against each recommendation is highlighted and examined, prior to sign off.

ZERO case record reviews and **5** investigations completed after **31 March 2017** which related to deaths which took place before the start of the reporting period.

ZERO representing **0%** of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the information form the serious incident investigation reporting process and the outcome of the reports.

ZERO representing **0%** of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

National Quality Indicators

The Department of Health identified 16 indicators which should be included in Trust Quality Reports/Accounts, where they are applicable to services. Five of these indicators are relevant to Nottinghamshire Healthcare NHS Foundation Trust; in addition we have chosen to include the optional 'Friends and Family Test' indicator. Those indicators subject to limited assurance audit are marked with the symbol Ⓐ

CPA 7 Day Follow-up – The data is made available to Nottinghamshire Healthcare NHS Foundation Trust by NHS England with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.

The term 'Care Programme Approach' (CPA) describes the framework to support and coordinate effective mental health care for people with mental health problems in secondary mental health services. Although the policy has been revised over time, CPA remains the central approach for coordinating the care for people in contact with these services who have more complex mental health needs and who need the support of a multidisciplinary team.

Following up someone on care programme approach (CPA) within seven days of discharge from inpatient care reduces risk of harm and social exclusion and can maintain and improve access to care. Trusts must ensure that a minimum of 95% of inpatients on CPA are followed up within seven days of discharge from hospital.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is collected and analysed by the Trust Applied Information team before being released on the Trust reporting site.

- CPA 7 day follow up rates are scrutinised on a monthly basis at Directorate meetings and Divisional Business meetings.
- Directorate and ward level managers are required to monitor the CPA 7 day rate as one of part of their duties.
- Divisional performance heads are required to sign off CPA 7 data performance reports before inclusion into the Trust's monthly Board of Directors Performance Report.

Nottinghamshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Continuing to work closely with service users and their families in developing discharge care plans which support patients in a safe transition from inpatient care to life in the community.
- Nottinghamshire Healthcare NHS Foundation Trust has continued to achieve this target throughout the last four years, remaining consistently above the national average for levels of follow up care in the community.

7 Day Follow Up	Nottinghamshire Healthcare NHS Foundation Trust (NHS England data)	Nottinghamshire Healthcare NHS Foundation Trust (local data taken from the Rio Clinical information System*)	National Average (NHS England data)	Highest Performing Trust in any given Quarter (NHS England data)	Lowest Performing Trust in any given Quarter (NHS England data)
2017/2018	98.7%	98.5%	96.3%	100%	69.2%
2016/2017	98.9%	98.8%	96.6%	100%	73.3%
2015/2016	98.6%	98.6%	97.0%	100%	50%

Crisis Team Gatekeeping Admissions: The data made available to Nottinghamshire Healthcare NHS Foundation Trust by the Information Centre, with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period.

In a crisis resolution context within psychiatric care, a 'crisis' is defined as the breakdown of an individual's normal coping mechanisms. Crisis Resolution and Home Treatment is an alternative to in-patient hospital care for service users with serious mental illness, offering flexible, home-based care, 24 hours a day, seven days a week. These teams act as gatekeepers to acute in-patient services, and are measured against the 95% minimum gatekeeping target set out in the Single Oversight Framework 2017.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Crisis Resolution gatekeeping is an embedded and key process within the Trust before in-patient admission, evidenced through localised record keeping;
- Crisis Resolution gatekeeping levels are presented on a monthly basis at Board of Directors' Meetings;
- Divisional Performance Heads are required to sign off Crisis Resolution data reports before inclusion in the Trust's monthly Board Report.

Nottinghamshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Improving the centralised management and recording of Crisis Resolution gatekeeping performance data through the development of bespoke reporting systems available on the Trust's Rio clinical information system;
- Focusing on the data quality of Crisis Resolution gatekeeping at clinical team level where admission information is recorded onto Rio.
- The Trust has fully considered the Crisis Care Concordat making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.

Crisis Resolution	Nottinghamshire Healthcare NHS Foundation Trust (Rio Clinical information system)	National Average (NHS England data)	Highest Performing Trust in any given Quarter (NHS England data)	Lowest Performing Trust in any given Quarter (NHS England data)
2017/2018	95.7%	98.6%	100%	84.3%
2016/2017	97.1%	98.5%	100%	76.0%
2015/2016	97.0%	97.2%	100%	18.3%

Re-admission Rates: Nottinghamshire Healthcare NHS Foundation Trust internal data for mental health re-admission rates, with regard to the percentage of re-admissions to mental health wards within 28 days during the reporting period*.

The criteria as laid out by the Department of Health in regards to readmission rate reporting in Quality Accounts is based on data collected by the Health and Social Care Information Centre.

This data collection is not directly applicable to mental health trusts due to the age related criteria not being relevant to mental health services. Nonetheless readmission rates are of concern to all health service providers including mental health services, and therefore the figures provided are those based on our own internal mental health records.

Readmissions of patients to inpatient areas can be extremely distressing, leading to potentially harmful consequences for patients' mental and physical wellbeing. NHS organisations endeavour to keep readmission rates as low as possible; however there can be a wide variation in readmission rates between similar NHS organisations. These variations can act as a trigger to look at practice within an organisation or geographical area. This could in turn help to prevent avoidable readmissions and lead to improved levels of care.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is collected in line with Trust reporting requirements.
- Instances of readmission within 28 days are investigated to ensure that each case is clinically appropriate.

Nottinghamshire Healthcare NHS Foundation Trust has taken the following actions to improve the percentage and so the quality of its services, by:

- Maintaining a focus on effective and therapeutic relationships between patient and its services to ensure wellness and reducing readmission;
- Enabling patients making the transition from a structured hospital based environment to the community to have as positive and enabling experience as possible, providing support to reassure patients around the challenging aspects of greater personal involvement in the community.

0-15 years is not applicable.

16 years and over, see the table below:

Psychiatric Re-admission Rates (Adult mental health)	Nottinghamshire Healthcare NHS Foundation Trust (local data Rio Clinical information system)	Nottinghamshire Healthcare NHS Foundation Trust	National Average	Highest Performing Trust in any given Quarter	Lowest Performing Trust in any given Quarter
2017/2018	3.4%	Not Available	Not Available	Not Available	Not Available
2016/2017	2.3%	Not Available	Not Available	Not Available	Not Available
2015/2016	3.7%	Not Available	Not Available	Not Available	Not Available

Community Mental Health Survey - The data made available to Nottinghamshire Healthcare NHS Foundation Trust by the Care Quality Commission for the Trust's 'Patient Experience of Community Mental Health Services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

The summary of the results of the annual Community Mental Health Survey details how patients graded different aspects of their care. These results also enable each of the Trusts involved in the survey to assess their own findings and develop services accordingly.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The sample for the Trust-commissioned survey was collected and checked in line with the process approved by the Confidentiality Advisory Group (CAG), which provides independent expert advice to the Health Research Authority (HRA) and the Secretary of State for Health;
- Patients selected in the sample are informed of how their confidentiality will be protected. Details of how we do this are included in the letters patients receive alongside the questionnaires and published FAQs that support each survey. These documents tell patients how we apply data protection and ensure that personal data is kept confidential.

Nottinghamshire Healthcare NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, as follows:

- The Trust will continue to recognise the importance of working to individual strengths and aspirations, using recovery focused ways of working;
- All comments received via the community mental health survey will be entered and coded on the 'Your Feedback Matters' website, alongside comments received via the Feedback Survey and Patient Opinion. This will ensure that services are aware of this feedback and use it to inform service development/delivery, and they will be expected to report on any changes made as a result via their quarterly Involvement and reports, which in turn inform the assurance reports submitted to the Board of Directors;
- The Trust will continue to work in partnership with those using services, their families and carers (where appropriate), staff and membership, listening to individual lived experience and seeking to plan care in partnership. The Trust strives to provide as many diverse ways as possible to enable feedback from those using services and their carers.
- The Trust is committed to ensuring people's experiences of care are positive. All services are expected to submit an Involvement and Experience report every quarter, detailing how they have used feedback to reflect on people's experiences and improve services accordingly;

Patient Experience of Community Mental Health Services - rating	Nottinghamshire Healthcare NHS Foundation Trust (Overall rating) (CQC data)	Highest Performing Trust (CQC data)	Lowest Performing Trust (CQC data)	National average: patients with a positive experience of Community Mental Health services (CQC data)
2017/2018	7.2 (out of a possible 10)	7.5 (out of a possible 10)	5.9 (out of a possible 10)	6.4 (out of a possible 10)
2016/2017	7.3 (out of a possible 10)	7.5 (out of a possible 10)	6.1 (out of a possible 10)	6.5 (Out of a possible 10)
2015/2016*	34% (the lower the better)	N/A	N/A	36% (the lower the better)

**15/16 Notts HC Foundation Trust results - this was a new sample survey taken from a different time period to that of the national Community Mental Health Services survey.*

Patient Safety Incidents - The data made available to Nottinghamshire Healthcare NHS Foundation Trust through NHS Improvement's management of the National Reporting and Learning System (NRLS) with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

A patient safety incident is any healthcare related event that was unintended, unexpected and undesired, and which could have or did cause harm to patients. It is recommended as a preferred term when considering adverse events, near misses and significant events to minimise confusion and help the formal reporting of relevant incidents.

All incidents graded as moderate harm to severe harm or death on the Trust's incident reporting system (Ulysses) are validated to ensure they are graded correctly, as part of the Trust's obligation under the Duty of Candour.

The Trust reported 14,439 Patient Safety Incidents (PSI) for 2017/18, of which 40 resulted in severe harm or death.

Never Events – The Trust reported 2 incident for 2017/18.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The Ulysses electronic reporting system employed by the Trust enables a rapid and proactive reporting ethos with increased accountability at all levels;
- The Trust reports a range of incident data to the monthly Board of Directors ensuring openness and accountability, reflecting a reporting culture that is founded on continual learning and improvement through analysis and openness;
- The Trust reports regularly to the *National Reporting and Learning System* (NRLS) regarding any incident of patient safety whether actual or potential;
- The Trust reports all incidents of crime, including all violent incidents, to *NHS Protect*;
- Incidents involving staff absences of 7 days or more or other specified criteria are reported to the *Health and Safety Executive* (HSE) under the 'Reporting of Injuries, Diseases and Dangerous Occurrences' regulations (RIDDOR);
- Serious incidents are reported to commissioners via the Strategic Executive Information System STEIS system and are investigated fully. Where the investigation highlights recommendations for change, these are converted to action plans and are monitored to completion.

Nottinghamshire Healthcare NHS Foundation Trust has taken the following actions to improve the following incident rates, and so the quality of its services, by:

- Ensuring there is organisational learning from all incidents including serious incidents;
- Continuing to promote the national 'Sign Up to Safety' initiative, with a particular focus on front line learning;
- Improving its performance in the monitoring and treatment of pressure ulcers;
- Created new incident reporting portals within the Trust to improve visibility and access to incident reporting for staff.

Data released by NHS Improvement

Incident Data Reporting Periods	Notts HC Trust - incidents total	Notts HC Trust - Severe Harm/ Death incidents total	Notts HC Trust - Severe Harm/ Death incidents total	National - Severe Harm/ Death incidents as a % of total incidents	National – highest level of Severe Harm/ Death incidents as a % of total incidents	National – lowest level of Severe Harm/ Death incidents as a % of total incidents
Apr – Sept 2017	6905	12	0.17%	1.04%	3.72%	0.04%
Oct16– Mar 2017	6447	16	0.25%	1.13%	4.73%	0.05%
Apr – Sept 2016	6220	32	0.51%	1.11%	6.06%	0.26%
Oct15– Mar 2016	5,555	24	0.43%	1.14%	6.01%	0.10%
Apr – Sept 2015	5572	27	0.48%	1.02%	3.70%	0.09%

The data released by NHS Improvement is part of a dataset that provides information on all trusts nationally; this takes a number of months of collation and preparation and the period April 2017 to September 2017 is the most recent set of data publicly available. Nonetheless, Nottinghamshire Healthcare NHS Foundation Trust submits data on a weekly basis to the NHS Improvement National Reporting and Learning System and has, therefore, provided an accurate assessment of its performance at a local level in regard to Patient Safety Incident reporting.

Data reported by the Trust to the NHS Improvement National Reporting and Learning System

Patient Safety Incidents Reporting Periods	Nottinghamshire Healthcare NHS Foundation Trust – Rate of Patient Safety Incidents (number of incidents divided by total bed days of care) x 1000 bed days (Ulysses incident recording system and Rio Clinical information system data)	Nottinghamshire Healthcare NHS Foundation Trust – Number of Patient Safety Incidents Resulting in Severe Harm or Death (Ulysses incident recording system)	Nottinghamshire Healthcare NHS Foundation Trust – Total number of Patient Safety Incidents in the Year (Ulysses incident recording system)	Nottinghamshire Healthcare NHS Foundation Trust **–** Percentage of Patient Safety Incidents Resulting in Severe Harm or Death (incidents rated at least severe divided by total number of patient safety incidents in the year) (Ulysses incident recording system)
2017/2018	43.38	40	14,439	0.28%
2016/2017	37.92	54	12,897	0.42%
2015/2016	32.33	50	11,123	0.45%

Further Quality Indicators

In addition to the requirement for the Trust's external auditors to undertake a review of the content of the Quality Report, there is a requirement for two mandated indicators to be audited. An additional locally agreed indicator is also selected for audit by the Council of Governors.

The two mandated indicators are:

- The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care
- Inappropriate out-of-area placements for adult mental health services

The locally agreed indicator is:

- Number of bullying and harassment cases

<u>The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care</u>

The introduction of the access and waiting time standard for early intervention in psychosis (EIP) services and improving access to psychological therapy (IAPT) services heralded the start of a new approach to deliver this improved access and embed standards akin to those for physical health. It is expected that this standard will make a major difference to the quality of care received by those with first episode psychosis, and greatly improve their ability to recover.

Inappropriate out-of-area placements (OAPs) for adult mental health services

The Government has set a national ambition to eliminate inappropriate OAPs in mental health services for adults in acute inpatient care by 2020-21. It is essential to introduce a collection of OAPs in order to understand whether progress is being made on the ambition and to understand where and why OAPs are happening, to ultimately to improve patient care and ultimately eliminate the practice of inappropriately sending patients out of area to receive acute inpatient care.

Number of bullying and harassment cases

Bullying is completely unacceptable and ongoing work is needed across the NHS to tackle it. To improve the working lives of our staff and deliver the best possible care to patients, we need to create supportive, positive, and open and cultures in our organisations across the health system.

Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual.

Harassment is unwanted conduct affecting the dignity of men and women in the workplace. It may be related to age, sex, race, disability, religion, sexual orientation, nationality or any personal characteristic of the individual, and may be persistent or an isolated incident. The key is that the actions or comments are viewed as demeaning and unacceptable to the recipient.

PART THREE: REVIEW OF QUALITY PERFORMANCE 2017/18

Overview of Performance in 2017/18

This section provides information on performance against our quality and performance indicators agreed internally by the Trust, and also performance against relevant indicators and performance thresholds set out in Appendix 3 of NHS Improvement's Single Oversight Framework.

The Trust continued to develop its Performance Management Framework which includes a monthly Board Integrated Performance Report (IPR). The content of the IPR is reviewed and approved each year by the Finance and Performance Committee on behalf of the Board of Directors. This includes all relevant Single Oversight Framework (SOF) operational metrics, as defined within their Single Oversight Framework, and locally agreed indicators. This report provides performance information at Trust level, structured around the SOF themes:

- Quality of care (safe, effective, caring, responsive)
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Data Quality

Accurate information is fundamental to support the delivery of high quality care; we therefore strive to ensure all data is as accurate as possible. The Trust's Performance Indicator Assessment Framework (PIAF) enables the Trust to ensure that indicators are assessed against five dimensions of data quality.

Data Quality Dimension	Definition
Completeness	Valid data – measures how much of the collected data can be used
Timeliness	Data entry – is all the data readily available at the time of calculation for the period being measured
Accuracy	Accurate recording of data, consistent interpretation of business rules when selecting values from lists and accurate calculation method for indicator construction
Audit	Has an audit, either local, internal or external, been carried out in the last 2 years and on either the system used to collect the data or on the specific indicator itself, and if so, what was the result
Validation	Divisions or other departments are monitoring the indicators locally and flagging up if there is an issue

Indicator Data Quality RAG Rating	Definition
Blue	Highly Significant Assurance (very robust)
Green	Significant Assurance (good enough)
Amber	Limited Assurance (significant issues)
Red	Very Limited Assurance (systemic issues, minimal confidence)

The Trust has various information systems in which data is collected and from which performance against local and national indicators is calculated. These include nationally available systems:

- **RiO** – Clinical information system used by our mental health services from which data is used for CPA, readmissions, delayed transfers of care, crisis gatekeeping, early intervention in psychosis, and data completeness and outcome indicators
- **SystmOne** – Clinical information used in community services, used for community data completeness indicators
- **ESR** – Electronic staff record for sickness and appraisal rates
- **Integra** – Finance system for turnover and vacancy rates
- **PC-MIS** – for IAPT indicators
- **Ulysses** – for incident and complaint indicators

Some of the data from these systems is extracted into national datasets such as the National Reporting and Learning System (NRLS) which is managed and operated by NHS Improvement and the Mental Health Services Data Set (MHSDS).

In addition, the Trust utilises local reporting systems for patient experience, training and clinical supervision.

An overview of performance against indicator sets for patient safety, clinical effectiveness and patient experience

The three indicators chosen for patient safety:

- **Safety Thermometer All Harms - % Harm Free Care**

  Explanation: A measurement of the prevalence of four different types of harm experienced by patients. The data is taken from a monthly survey carried out by Trust staff in a range of clinical environments, and reported nationally). The Safety Thermometer is not only about data; the act of data collection at the point of care raises awareness and brings the opportunity for immediate improvements to patient care, empowering frontline teams with data and calling them to action.

- **Total Staff Sickness %**

  Explanation: Absences due to sickness can have a detrimental impact not only on the employee but also on quality and safety of services that the Trust provides through covering work, costs to business, and reduction of frontline staff delivering frontline care.

- **Minimising mental health delayed transfers of care %**

Explanation: Keeping patients in hospital longer than required impacts upon patient safety directly; it can have a number of detrimental effects, affecting patient morale, mobility, and increasing the risk of hospital-acquired infections.

The three indicators for clinical effectiveness:

- **Care Programme Approach - % patients having a follow up within 7 days**

Explanation: There is strong national evidence that the period immediately following discharge from hospital has been shown to be a high risk period for service users in terms of risk of harm, particularly in relation to self-harm and suicide. To ensure we can be as effective and safe as possible in our clinical care the Trust is committed to ensuring every service user subject to CPA who has been discharged from inpatient care will be seen or receives a telephone call within seven days of discharge.

- **Mandatory Staff Training**

Explanation: the Trust support its employees to ensure they can be as effective in their roles as possible, maintaining and developing their knowledge and skills they require to meet the needs of their job and the service.

- **Annual Reviews carried out % (Staff Appraisals)**

Explanation: There is significant evidence that effective performance review and staff development has a positive contribution to effectiveness – through to improving patient outcomes. This is supported by the standards set out by the Care Quality Commission and the NHS Constitution. Quality appraisals ensure that staff have a clear understanding of their role and the part they play in their team and organisation, an agreed set of work objectives and a plan for acquiring and applying the knowledge and skills they need to do their job well and achieve their organisation's linked objectives.

The three indicators chosen for patient experience:

- **Friends and Family Test scores**

Explanation: The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

- **Number of new complaints received**

Explanation: The Trust tries to ensure that it takes a proactive and listening approach to complaints received, as we expect to learn from our patients' and carers' experiences and make improvements to services we provide. The total number of complaints enables us to understand whether there are trends in service provision for patients that indicate an underlying issue that needs to be addressed.

- **Service Quality Rating %**

Explanation: Whilst the Friends and Family Test (FFT) is an important feedback tool, the Trust Service Quality Rating provides a localised patient and carer feedback tool developed specifically around Trust needs and services.

Quality and Performance Indicators *numbers given at year's end are the full year's figures where appropriate, or the Trust's latest performance levels for monthly targets*

Indicator Set	Indicator Description	Local Data Source	2016/17	2017/18	Benchmarked performance where external data is available and appropriate
Patient Safety	Safety Thermometer All Harms - % Harm Free Care	NHS Safety Thermometer website	92.2%	91.8%	
	Total Staff Sickness %	Electronic Staff Records (ESR)	5.4%	5.4%	NHS DIGITAL November 2017 - National mental health trust rate – 5.8% / National rate 4.4%
	Minimising mental health delayed transfers of care %	Rio clinical information system	3.3%	2.2%	
Clinical Effectiveness	Care Programme Approach - % patients having a follow up within 7 days	Rio clinical information system	98.9%	98.5%	
	Mandatory Staff training %	HR Training Database	88.2%	89.3%	
	Annual Reviews carried out % (Staff Appraisals)	Rio clinical information system	86.7%	82.9%	Staff Survey 2017 - Trust 89% vs national average of 92%
Patient Experience	Friends and Family Test scores	Trust on-line Feedback site	95%	95%	
	Number of new complaints received	Ulysses incident information system	876	815	
	Service Quality Rating %	Trust on-line Feedback site	94.0%	94%	

Compliance with the NHS Improvement Single Oversight Framework (SOF)

The NHS Improvement Single Oversight Framework (SOF) has been revised in 2017/18, with a new set of operational metrics released in November 2017. The Trust will provide an overview of the performance against those metrics which were relevant for the greater part of the year under review, and provide a commentary on the new indicators now in place, and issues that are still to be resolved in terms of clarifying definitions, methods and targets.

The Trust is monitoring compliance with new standards and a range of local indicators to provide an overview of performance, quality and assurance within the Trust and escalate actual or potential underperformance.

There are five themes in the Single Oversight Framework:

- Quality of care (safe, effective, caring, responsive)
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

There is currently one indicator which is under target at Quarter 4 end 17/18:

Single Oversight Framework (SOF) operational metrics: Improving Access to Psychological Therapies (IAPT) - Waiting time to begin treatment within 6 weeks

The Trust is at 69.9% for Quarter 4 end position against a target of 75%. The Trust's IAPT service provision covers a number of geographically based teams, all of which are achieving target, with the exception of the IAPT service in Leicestershire. This service has experienced an increase in waiting times, due to a significantly greater than expected increase in referrals compared to last year and a lack of psychological wellbeing practitioners (PWP). Whilst the service expects increased staffing levels to bring the performance to the required level over the forthcoming months, there will be a lag due to the nature of the reporting indicator; only when patients are discharged can this feed through into the national requirement, i.e. for patients on discharge to have waited less than 6 weeks.

To achieve a sustainable, well performing service the Trust is working towards a single IAPT service with a consistent model throughout the Trust, with one operational manager. In view of the current reporting position, a robust recovery plan has been developed to address the issues identified and give assurance that the required target can be met in due course. This includes a clear time line for improvement to ensure that necessary actions are completed within timescales agreed.

Single Oversight Framework (SOF) operational metrics: indicators not reported against

There were two indicators in the earlier Single Oversight Framework (SOF) for 2017/18 that the Trust was unable to report against on due to the lack of definition and methodology supplied by NHS Improvement. These were:

Cardio-metabolic assessment and treatments
This indicator is in the new SOF released in November 2017; there is a lack of clarity in regard to the definition and methodology to be used. The Trust is considering how best to provide an accurate and meaningful representation of Trust performance regarding this indicator.

Complete and valid submissions of metrics in the monthly Mental Health Services Data Set: Priority metrics (Ethnicity, accommodation and employment status)

This indicator has been superseded by the Data Quality Maturity Index (DQMI) which is present in the new SOF released in November 2017.

NHS Improvement Single Oversight Framework operational metrics: (SOF): New operational indicators November 2017

The new indicators relevant to the Trust are:

Inappropriate out-of-area placements (OAPs) for adult mental health services

Inappropriate OAPs are where patients are sent out of area because no bed is available for them locally which can delay their recovery. It is essential to collect OAPs data in order to monitor progress towards achieving the ambition and to understand where and why OAPs are happening. Having this information is critical to improving patient care and ultimately eliminating the practice of inappropriately sending patients out of area to receive acute inpatient care.

The details and trajectory for this target are currently being finalised, to meet the national goal of eliminating acute out of area placements no later than 2021.

Data Quality Maturity Index (DQMI) MHSDS dataset score

The Data Quality Maturity Index (DQMI) provides healthcare data submitters with timely and transparent information about their data quality.

The Health and Social Care Act 20121 (section 266) states that our statutory data quality role is to assess the extent to which the data it collects meets defined national standards and to publish the results of the assessments. The Data Quality Maturity Index (DQMI) is a quarterly publication intended to raise the profile and significance of data quality in the NHS

Single Oversight Framework operational metrics: *(quarter positions given as national indicator measurements are quarterly)*							
Indicator Description	**Data Source**	**Target**	**Quarter 4 position 2016/17**	**Quarter 4 position 2017/18**	**Average Monthly Performance 2016/17**	**Average Monthly Performance 2017/18**	**Data Quality Rating**
Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	Rio clinical system	95%	92.7%	95.2%	96.4%	95.7%	
The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care Ⓐ	Rio clinical system	50%	75.8%	83.3%	73.3%	74.6%	
Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	Rio clinical system	75%	86.0%	69.9%	82.5%	75.6%	
Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	Rio clinical system	95%	98.5%	97.9%	99.1%	98.3%	
Improving access to psychological therapies (IAPT): Proportion of people completing treatment who move to recovery	NHS Digital	50%	51.0%	54.8%	51.0%	52.7%	
Mental health data completeness: identifiers	Rio clinical system	97%	98.5%	98.5%	98.8%	98.5%	
Single Oversight Framework Appendix 1: Quality of Care: *(covering relevant indicators not covered in other sections)*							
Admissions to adult facilities of patients under 16 years old (mental health)	Rio clinical system	n/a	0 admissions	0 admissions	0 admissions	0.25 admissions	

New Single Oversight Framework operational metrics: *(from November 2017)*					
Indicator Description	**Data Source**	**Target**	**2017 total**	**Latest Performance 2017/18**	**Bench-marked performance**
Data Quality Maturity Index (DQMI) MHSDS dataset score	NHS Digital	95%	97.2% (YTD position)	97.3% (latest quarterly performance)	90.7% national average (latest quarterly performance)
Inappropriate out-of-area placements (OAPs) for adult mental health services Ⓐ	Trust Bed Management data	Zero by 2020/21	n/a	790 inappropriate out-of-area bed days monthly average Qtr 4 2017/18	

The new Single Oversight Framework operational metric relating to Inappropriate out-of-area placements for adult mental health services has been subject to indicator testing by external auditors as part of the Quality Report assurance process for 2017/18. The data tested related to quarter 4 17/18 only, to align with the new reporting requirements set in the Single Oversight Framework November 2017.

Further information around Trust data for Out of Area Placements in Mental Health Services for 2017/18 is available from NHS Digital, http://digital.nhs.uk/pubs/oapsrepdec17. It should be stressed that NHS Digital is running this interim OAPs data collection in the Clinical Audit Platform (CAP) until the data becomes aligned and available from the Mental Health Services Data Set (MHSDS). The MHSDS is the chosen mechanism for the long term collection of this data. NHS Digital stress that these reports should be treated with caution due to the limitations of the data collection process.

ANNEXES TO THE QUALITY REPORT

Annex 1 – Statements of Assurance from Other Bodies

Nottingham City Clinical Commissioning Group

Nottinghamshire Healthcare Trust Quality Account Corroborative Statement 2017/18

'NHS Nottingham City Clinical Commissioning Group (CCG) is the Co-ordinating Commissioner for Nottinghamshire Healthcare NHS Foundation Trust on behalf of a number of associate Commissioners and as such is responsible for gaining assurance on the quality and performance of services provided by the Trust.

The 2017/18 contract and service specifications with the Trust identified the level and standards of care expected and how they were to be measured, monitored and reviewed. The main process for this is via monthly Quality and Contract Review meetings which have been held with the Trust to explore assurance, supplemented by quality visits and responsive discussions when additional assurance has been required. The CCG can validate that the information received during the year is consistent with the information in this Quality Account.

Commissioners acknowledge the hard work and commitment of Nottinghamshire Healthcare NHS Foundation Trust staff to ensure patients remain at the centre of care delivery. As healthcare Commissioners we are dedicated to commissioning high quality services from our providers and are encouraged that the Trust focuses on patient safety, patient experience and clinical effectiveness. Nottinghamshire Healthcare NHS Foundation Trust has worked constructively with Commissioners and other partners to respond to commissioning intentions and develop integrated care pathways to support the reduction of health inequalities and improve the health of the local community.

Commissioners have noted that a CQC annual comprehensive inspection was undertaken in November 2017 and the Trust was rated overall as 'Good'. CQC issued eight requirement notices and the Trust implemented an improvement plan to address the areas of non-compliance which is overseen by the Trust's Quality Committee. The Trust took prompt action to implement improvements required in respect to the one warning notice issued by CQC.

The Commissioners are pleased to acknowledge the Trusts performance against priorities for quality improvement during 2017/18, which included alignment to the three year Sign Up to Safety Campaign. As the Campaign draws to a close, Commissioners support the Trust's approach to review their safety priorities and embed the work in practice, with the focus on a wider quality improvement programme, including safety being led by the Trust Quality Committee.

Significant progress has been made around reducing the number of pressure ulcers and falls in patients receiving care from the Trust and Commissioners expect this improvement and monitoring via the Trust Physical Healthcare Steering Group to continue during 2018/19.

The Trust complaints process has been reviewed and strengthened to ensure that monitoring arrangements are robust and a new policy was issued in July 2017 to reflect this. Commissioners are pleased to note that the CQC, at their visit in November 2017, also acknowledged that the Trust had good processes and an effective complaints system in place to investigate and learn specifically from deaths.

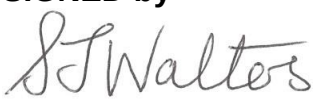
Commissioners acknowledge The Trust has worked to embed the role of the Freedom to Speak Up (FTSU) Guardian and have seen evidence to support staff are using and accessing the guardian, with 120 concerns being raised in 2017/18.

The Quality Account reflects the ongoing commitment from the Trust to improve patient and staff experiences whilst recognising that there are still some areas for improvement which are ongoing, for example, medicines safety across the Trust. This has had focused review and as a consequence remains a Trust quality priority for 2018/19.

Commissioners have been assured of the clinical effectiveness within the Trust and the ongoing work by the Trust Clinical Effectiveness Committee through receiving reports and data presented at monthly Quality Review Meetings.

Commissioners will monitor progress against the quality priorities set by the Trust for 2018/19, which build on the 2017/18 quality priorities. We will continue to work with Nottinghamshire Healthcare NHS Foundation Trust in 2018/19 to assure ourselves of the continual quality of the services provided and to monitor achievement of targets, indicators and priorities in line with quality and contractual requirements.

SIGNED by



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Signature

Accountable Officer for the Greater Nottingham CCGs
……
Title

16 May 2018
……
Date

Healthwatch Nottingham and Nottinghamshire

Statement in response to the Nottinghamshire Healthcare NHS Foundation Trust 2017-2018

As the independent watchdog for health and care in the Nottinghamshire County, we work hard to ensure patient and carer voices are heard by both commissioners and providers. We are grateful for the opportunity to view and comment on the Nottinghamshire Healthcare NHS Foundation Trust Quality Account 2017-18.

The report provides a good overview of the progress made against the 2017/18 quality priorities, including how each priority was measured and progress to date. The number of complaints received, number closed within an agreed timescale, number reopened and reason for complaint is given. The top three were safe, adequate coordinated care, attitude of staff and information to/communication with service users/carers. The report states the intention to improve experience through better management, understanding and response to issues raised through complaints. This will be supported by the new July 2017 policy which was acknowledged by the CQC as effective.

The Learning from Deaths section effectively describes the themes that emerged included provision of information to family/carers, communication with patients and care planning and physical health care of patients with a mental illness. It is helpful to read these themes and understand what improvements the Trust is making as a result.

The report also describes how patient experiences are entered into the, 'Your Feedback Matters' website in order to inform service development/delivery. This leads to quarterly Involvement and Experience reports that include how services will be improved. However the detail of these improvements and learning is not given in this report.

Patient experiences are also collected through the Family and Friends Test and Service Quality Rating with results of 95% and 94%. While it is positive to read these high scores it would be useful to include qualitative feedback, learning and any improvements made as a result.

The 2017/18 priority to, 'Ensure timely access to services which are provided from locations which meet service users clinical need' is described as being closely monitored on a weekly basis. However findings from the patients surveys and feedback is not detailed.

While this report states, 'there is organisational learning from all incidents including serious incidents' what this learning is and what improvements have been made is not stated.

The 2018/19 Quality Improvement Priorities are challenging enough to drive improvement and include improving waiting times. However there are no specific priorities related to collecting and improving the quality of patient experience which Healthwatch would value seeing.

We recommend the Trust shares qualitative data in the report in order to illustrate the quality improvements that have/have not been attained. Including patient stories,

numbers of responses to surveys, recommendations and improvements provides tangible evidence to the public of the positive work the Trust is doing.

Nottingham and Nottinghamshire Health Scrutiny Committee

Nottinghamshire Health Scrutiny Committee

The Health Scrutiny Committee for Nottinghamshire welcomes the opportunity to comment on Nottinghamshire Healthcare NHS Foundation Trust's Quality Report.

The committee commends the Trust's willingness to learn from deaths, even in circumstances where they do not represent a serious incident.

The committee hopes that the Trust will continue to augment its partnership working – making partnerships both integral and explicit, as well developing a focus on opportunities which may arise as a result of the STP.

The committee urges the Trust to always ensure that the physical health needs of mental health patients are fully, met and that robust use is made of care plans.

The committee congratulates the Trust on its successful work in previous years on the prevention of falls and pressure ulcers; and while, going forward, these will not be priorities we hope that the extent to which good practice has been embedded will continue to be monitored.

The committee appreciates that the management of governance in a clinical environment is both complex and problematic, and hopes that the Trust will continue to strive to deliver good quality while ensuring the safety of staff, particularly in lone working settings.

Nottingham City Health Scrutiny Committee

The Nottingham City Health Scrutiny Committee welcomes the opportunity to comment on the Nottinghamshire Healthcare Foundation Trust Quality Account 2017/18. Our comment focuses on the areas in which we have engaged with the Trust during 2017/18.

As in previous years, the Committee has found the Trust open and willing to engage with scrutiny when it has been requested to do so during the year.

Over the past few years the Committee has welcomed the Trust's deliberate approach of largely retaining the same quality improvement priorities for several years so as to maintain a focus on the same issues and allow sufficient time to deliver sustained improvement. The Committee accepts that many of these areas, for example patient safety, have become embedded within the organisation and supports a shift in quality improvement priorities to focus on other areas. However, it is important that the Trust continues robust monitoring in relation to these issues to ensure that the progress made is maintained and built upon. Given that the October 2017 Care Quality Commission inspection of the Trust found that a number of 'basics' were not being done correctly, the Committee considers that it is vital that the importance of 'business as usual' activities is not forgotten.

The Committee particularly supports a continued focus in 2018/19 on addressing waiting times and access to services. Reducing waiting times has been a priority in previous years and it is disappointing that last year's target to meet all waiting time targets was not met. Based on the feedback received by the Committee this is one of the main areas of concern for local people and the Committee has heard about

concerns in relation to access to a number of services. For example, during the year the Committee has spoken to the Trust and commissioners about child and adolescent mental health services and had some concerns about timely access to those services. The Committee would encourage this service to be an area of focus for the Trust within this priority. As it is an area of particular interest to the Committee, actions being taken in relation to this priority and progress on delivering those actions will be scrutinised by the Committee during the course of the year.

Nottinghamshire Healthcare NHS Foundation Trust Council of Governors

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Report for 2017/18

Governors have a prime role in holding Non-Executive Directors to account for the performance of the Board of Directors, with a particular focus on quality. As part of the Council's governance structure it meets regularly at its monthly assurance meetings to discuss, learn and challenge different areas of services. These meeting are attended by governors, Non-Executive Directors and relevant Senior/General Managers of services. To date the governors have sought to assure and challenge on quality within the following service areas:

- Wathwood Medium Secure Hospital
- Mental Health Services for Older People
- Rampton Hospital
- Offender Healthcare
- Adult Mental Health Services

Governors received a dedicated learning session solely focussed on the Care Quality Commission and, more specifically, their fundamental standards. This had enabled governors to appreciate and understand the regulatory body and how it carries out inspection to establish the level of quality, safety, effectiveness, responsiveness and leadership of the Trusts services.

Within the last 12 months governors have done the following:

- Discussed and challenged the Trust Quality Priorities
- Participated in a governor focus group with the CQC around the Well-led Review
- Identified a local quality performance indicator for the Trust to audit
- Directly challenged Non-Executive Director's around quality issues
- Received a regular Integrated Performance Report and provided open challenge and scrutiny at its Council of Governors meetings
- Regularly observe the Quality Committee and the Board of Directors meeting where assurance was sought

Overall the Council of Governors is assured by the performance of the Trust and will continue to challenge and scrutinise, on behalf of its members, over the next 12 months.

Annex 2 – Statement from Directors

Statement of Directors' Responsibilities in Respect of the Quality Account

"The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to the date of signing the limited assurance report (the period);
    - Papers relating to Quality reported to the board over the period April 2017 to 31 March 2018
    - Feedback from the commissioners: Nottingham City Clinical Commissioning Group dated 16/05/2018
    - Feedback from the Council of Governors dated 19/04/2018
    - Feedback from local Healthwatch organisations: Healthwatch Nottingham and Nottinghamshire dated 22/05/2018
    - Feedback from Overview and Scrutiny Committees: Nottinghamshire Health Scrutiny Committee received on 26/04/2018 and Nottingham City Health Scrutiny Committee received on 30/04/2018;
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/08/2017;
    - The 2017 national and local patient survey; Mental Health Community Service User 2017 Nottinghamshire Healthcare NHS Foundation Trust Full Survey Results Manual – Basic and Additional samples combined – 18 July 2017 and survey of people who use community mental health services 2017 dated 30/11/2017
    - The 2017 national and local staff survey: 2017 National NHS staff survey Results from Nottinghamshire Healthcare NHS Foundation Trust dated staff survey 29/03/2018
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 15/05/2018
    - Care Quality Commission Inspections: CQC – Forensic inpatient/secure for Rampton Hospital wards Quality Report – Date of inspection visit: 6-10 March 2017 received on 14/16/2017; CQC Report on an unannounced inspection of HMP North Sea Camp by HM Chief Inspector of Prisons dated 13/07/2017; CQC HMP Ranby Quality Report Date of inspection visit: 24 October 2017 received on 1/12/2017; CQC Core Services and Well-Led Inspection Report dated February 2018 received on 02/02/2018 and Nottinghamshire Healthcare NHS Foundation Trust Inspection report dated 08/02/2018.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date 24 May 2018 .....Chair

Date 24 May 2018 .....Chief Executive

Annex 3 – Glossary and Definitions for Audited Indicators

Early intervention in psychosis (EIP): The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care
Indicator Description: The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care
Numerator/Value: The number of referrals to and within the trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral
Denominator: The number of referrals to and within the trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period
Target: Red: <50% Green: ≥50%
Additional Information: The data is obtained from the Trust's RiO Patient data system. EIP data submissions are to continue via both MHSDS and UNIFY2 until March 2018. An updated data collection timetable will be provided on UNIFY2.The EIP data collection has been extended from December until March 2018 to: · include activity undertaken during this period · allow commissioners and providers to undertake further data quality work to reduce disparity between the Mental Health Services Data Set (MHSDS) and UNIFY2 collections
Criteria: The data analysed includes patients who were considered not to have been experiencing a first episode psychosis after meeting with clinicians, but would have been necessarily included in the waiting times for calculation.

Inappropriate out-of-area placements for adult mental health services
Indicator Description: Total number of bed days mental health patients admitted to acute wards have spent inappropriately out of area in last quarter
Numerator/Value: Total number of bed days mental health patients admitted to acute wards have spent inappropriately out of area in last quarter
Denominator: n/a
Target: Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021
Additional Information: The data is obtained from the Trust's Bed Management team Patient records data. The disclosure in the quality report is the number of bed days spent inappropriately out of area, presented as an average per month (this excludes those patients who were admitted out of area but who meet the criteria for an appropriate out of area placement are excluded (reasons such as - staff member, for safeguarding reasons, etc). Those who were admitted out of area because a bed was unavailable at the provider are included. This is a new indicator, first present in the Single Oversight Framework released in November 2017
Criteria: The process for agreeing trajectories toward eliminating acute mental health out-of-area placements (OAPs) will be jointly led by the NHS England and NHS Improvement regional teams during October to December 2017. Sustainability and transformation partnership (STP) mental health leads, supported by regional teams, will work with their clinical commissioning groups and mental health providers during this period to develop both STP and provider level baselines and trajectories. Provider boards must be assured by 31 December 2017 that data is being properly and completely submitted every month to the NHS Digital administered Clinical Audit Platform (CAP) collection. The January 2018 submission will be taken as an agreed baseline position.

Bullying and Harassment

Indicator Description:

The total number of cases of bullying and/or harassment formally raised (prior to investigation), by employees and bank workers, against other employees/bank workers from April 2017 to March 2018 inc, which have been recorded by the Human Resources Business Operations Team.

Definitions

ACAS defines bullying as, “offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient” (ACAS 2009) (additions from Equality Act 2010 to include e.g. by association and perception)

Harassment is often linked to bullying, however bullying may or may not amount to harassment under the Equality Act 2010 which defines harassment as “unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual’s dignity or creating an intimidating, hostile, degrading, humiliating, or offensive environment for that individual”.

Numerator/Value:

There have been 13 reported cases by Trust Employees – see the additional information for a breakdown of these.

No cases have been recorded concerning bank workers.

Additional Information:

During the period between April 17 and March 18, there were 13 cases raised, and following investigation the outcomes were as follows:

There was 1 case where the allegations of bullying and/or harassment was upheld

There were 5 cases where allegations of bullying and/or harassment were not upheld.

There are still 7 cases which are ongoing and are yet to reach a conclusion.

Target:

The Trust has a zero tolerance approach towards all forms of inequality, including harassment, discrimination and bullying. As outlined in the Nottinghamshire Healthcare NHS Foundation Trust People and Culture Strategy 2017 – 2022.

Denominator:

The total number of Trust employees and bank workers average 11,376 headcount.

Criteria:

The Trust is committed to promoting a positive workplace culture in which all employees are treated with dignity and respect by colleagues, service users, patients, clients, relatives, carers and other members of the public.

The Trust aims to create and manage a positive culture in the organization, where bullying or harassment in any form is not tolerated and inappropriate behaviours are challenged confidently and respectfully. The behaviour of Directors and senior employees in setting the tone of respect and dignity in the workplace is important in establishing a culture free from bullying and harassment, our leaders will act as role models for the behaviour we expect.

Annex 4 – Independent Auditors Limited Assurance Report to the Council of Governors of Nottinghamshire Healthcare NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Nottinghamshire Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Nottinghamshire Healthcare NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol (A) in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHSI):

Specified Indicators	**Specified indicators criteria** (exact page number where criteria can be found in the Annual Report)
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Healthcare and Care Excellence (NICE) – approved care package within two weeks of referral.	The performance indicator is on page 207 and the criteria are set out on page 218
Inappropriate out-of-area placements for adult mental health services	The performance indicator is on page 208 and the criteria are set out on page 219

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2017/18" issued by NHSI.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2017 to the date of signing the limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2017 to the date of signing the limited assurance report;
- Feedback from the Commissioners: Nottingham City Clinical Commissioning Group dated 16/05/2018;
- Feedback from the Council of Governors received on 19/04/2018;
- Feedback from Local Healthwatch organisations: Healthwatch Nottingham and Nottinghamshire dated 22/05/2018;
- Feedback from Overview and Scrutiny Committees: Nottinghamshire Health Scrutiny Committee received on 26/04/2018 and Nottingham City Health Scrutiny Committee received on 30/04/2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/08/2017;
- The 2017 national and local patient survey: Mental Health Community Service User Survey 2017 Nottinghamshire Healthcare NHS Foundation Trust Full Survey Results Manual - Basic and Additional samples combined - 18 July 2017 and Survey of people who use community mental health services 2017 dated 30/11/2017;
- The 2017 national and local staff survey: 2017 National NHS staff survey Results from Nottinghamshire Healthcare NHS Foundation Trust dated 30/03/2018;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 15/05/2018; and
- Care Quality Commission inspections: CQC - Forensic inpatient/secure for the Rampton Hospital wards Quality Report - Date of inspection visit: 6 - 10 March 2017 received on 14/06/2017; CQC Report on an unannounced inspection of HMP North Sea Camp by HM Chief Inspector of Prisons dated 13/07/2017; CQC HMP Ranby Quality Report Date of inspection visit: 24 October 2017 received on 1/12/2017; CQC Core Services and Well-Led Inspection Report dated February 2018 received on 02/02/2018 and Nottinghamshire Healthcare NHS Foundation Trust Inspection report dated 08/02/2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.
We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Nottinghamshire Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting Nottinghamshire Healthcare NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Nottinghamshire Healthcare NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS foundation trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Nottinghamshire Healthcare NHS Foundation Trust.

Basis for Adverse Conclusion – Inappropriate out-of-area placements for adult mental health services

We found an unacceptable level of errors in our testing of the inappropriate out-of-area placements for adult mental health services indicator, based on the total number of bed days spent inappropriately out-of-area each month, reported as an average over the three month period from January – March 2018. These related to an incorrect calculation of the number of bed days, based on the incorrect date of admittance in 13% of cases tested. Nottinghamshire Healthcare NHS Foundation Trust is unable to isolate the error to a particular set of circumstances, therefore there is a risk that the issue is pervasive.

Conclusions (including adverse conclusion on inappropriate out-of-area placements for adult mental health services)

In our opinion, because of the significance of the matters described in the Basis for Adverse Conclusion paragraph, the inappropriate out-of-area placements for adult mental health services indicator has not been prepared in all material respects in accordance with the Criteria.

Based on the results of our procedures nothing has come to our attention that causes us to believe that for the year ended 31 March 2018:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral indicator, has not been prepared in all material respects in accordance with the Criteria.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Donington Court
Pegasus Business Park
Castle Donington
East Midlands
DE74 2UZ

Date: 25 May 2018.

The maintenance and integrity of the Nottinghamshire Healthcare NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Independent Auditors' Report to the Council of Governors of Nottinghamshire Healthcare NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Nottinghamshire Healthcare NHS Foundation Trust's financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Our audit approach

Context

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and key audit matters was largely unchanged.

Overview

1. Overall materiality: £9,119,577, which represents 2% of total revenue.
2. All work was performed by a single audit team who assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement and determined the extent of testing we needed to do over each balance in the financial statement.
3. Our key audit matters were:
    - Risk of fraud in the revenue and expenditure recognition; and
    - Valuation of Property, Plant and Equipment.

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified by our audit.

Key audit matter	***How our audit addressed the Key audit matter***
Risk of fraud in revenue and expenditure recognition *Refer to note 1 to the financial statements for the directors' disclosures of the accounting policies, judgements and estimates relating to the recognition of revenue and expenditure and to notes 3 to 5 for further information.* We focused on this area because the Trust is facing increased pressure to achieve its forecast 2017/18 control total as set out in its plan submitted to NHS Improvement. Achievement of the control total provides the Trust with access to Sustainability and Transformation funding; and therefore the incentive to recognise revenue for services which have not been delivered during the financial year, and to omit to recognise expenditure in 2017/18, to improve the reported financial position. We consider the risk for revenue recognition to be heightened for: • revenue streams with commissioners that are based on contracts that depend on patient volumes. The Trust invoices each month based on actual activity. The volume of activity is recorded by the Trust and is subject to review by commissioners. • Commissioning for Quality and Innovation (CQUIN) revenue, which can be earnt as a percentage of the contract value for demonstrating improvements in quality and innovation in specified areas of patient care. We also considered expenditure recognition to be a fraud risk. Given these incentives, we focused on work on the elements of revenue and expenditure that are most susceptible to manipulation, being: • healthcare income agreements with the Trust's commissioners; • items of expenditure where the value is dependent upon estimates, in particular accruals; • non-standard journal transactions; and	*Journals* We tested a sample of journal transactions that had been recognised in both revenue and expenditure, focusing in particular on those that arose from unexpected account combinations. We agreed the journal entries to supporting documentation, for example invoices. Our testing found that they were supported by appropriate documentation and that the revenue and expenditure was recognised in the appropriate accounting period for the correct value. *Revenue* For a sample of transactions recognised during the year and around the year-end (both before and after), we confirmed that revenue and expenditure had been recognised in line with the Trust's accounting policies and in the correct accounting period by agreeing transactions to the supporting evidence when appropriate. We tested a sample of revenue by agreeing revenue recognised from commissioners to underlying signed contracts. We found no material issues from these procedures or unusual revenue recognition practices occurring. For a sample of the revenue from commissioners which is recognised based on volume of activity, we agreed the revenue recognised to the related invoices and cash received. We also compared activity values across the year to identify unusual trends in activity volumes. No material issues were identified with this work or the CQUIN values that had been recognised by the Trust. *Expenditure* We performed testing to identify whether there were any unrecorded liabilities. We tested a sample of payments made after 31 March 2018 and unpaid invoices after year end to supporting documentation, to check that, where they related to the 2017/18 financial year, an accrual was recognised appropriately. We tested all accruals posted to operating expenditure above £250,000 and sample tested the remaining balance of accruals. Accruals were supported by valid evidence and met the recognition criteria. The value of accruals was materially correct.

- unrecorded liabilities.

We also inspected the information from the year-end intra-NHS balance agreement process to identify any significant differences between the expenditure and creditors reported with NHS organisations. No material issues were identified from the work performed.

Valuation of property, plant and equipment

We focused on this area because Property, Plant and Equipment ("PPE") represents the largest balance in Nottinghamshire Healthcare NHS Foundation Trust's Statement of Financial Position and the valuation of land and buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions. Therefore our work has focused on whether the methodology, assumptions and underlying data used to determine the value of Property, Plant and Equipment were appropriate and correctly applied.

The PPE balance at 31 March 2017 is £397 million of which £375.3m relates to land and buildings.

All PPE assets are measured initially at cost, with land and buildings being subsequently measured at fair value based on periodic valuations. The valuations are carried out by a professionally qualified valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date.

A desktop valuation of Nottinghamshire Healthcare NHS Foundation Trust's portfolio of land and buildings was undertaken as at 31 March 2018 by Nottinghamshire Healthcare NHS Foundation Trust's valuation expert.

We considered the key areas of focus to be:

- the key inputs to the valuation, in particular the floor areas on which the valuation is based; and
- the methodology, assumptions and underlying data used by the valuation expert.

We obtained the valuation reports directly from Nottinghamshire Healthcare NHS Foundation Trust's valuation expert and read the relevant sections of the reports. We confirmed that the valuer had relevant experience and was a member of a relevant professional body.

We used our valuation expertise to evaluate the assumptions and methodology applied in the valuation exercise. Our work included a sample test to confirm whether buildings had been correctly identified as specialist or non specialist. We also reviewed the movements in floor areas of assets valued in 2017/18 compared to the prior year. We found no issues from these procedure.

When valuing buildings, Nottinghamshire Healthcare NHS Foundation Trust has applied the alternative site Modern Equivalent Asset (MEA) concept. The impact of Nottinghamshire Healthcare NHS Foundation Trust applying the alternative site concept, and situating the buildings in a different location to which they are currently in, is a £14.9m reduction in the value of buildings, which has a net book value of £337.9m. The alternative site approach adopted by the Trust is consistent with the prior year. We accept the basis on which this assumption has been made and management have set out this critical judgement in note 1.2.1.

In 2017/18, the Trust departed from its normal methodology for using location factors in the calculation of building values. In 2017/18, the Trust used a ten year average of location factors as opposed to a location factor at a point in time. This treatment was followed due to variability in year on year published location factors. The change in approach resulted in a £26m reduction in the value of buildings, which had a net book value of £337.9m. Our valuation experts completed an exercise to assess the estimated gross replacement cost (GRC) for the four highest value blocks/buildings and compared these estimated GRCs to Building Cost Information Service (BCIS) benchmarks and considered them to fall within a reasonable range.

We tested whether the change in valuation was correctly accounted for and appropriately disclosed in the financial statements and found that it was.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the accounting processes and controls, and the environment in which the Trust operates.

The audit was conducted at Nottinghamshire Healthcare NHS Foundation Trust's site in Mansfield where the main finance team is based. We also visited other finance staff based at Nottinghamshire Healthcare NHS Foundation Trust's headquarters in Nottingham.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£9,119,577 (2017: £9,012,780)
How we determined it	2% of revenue (2017: 2% of forecast revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £250,000 (2017: £250,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which ISAs (UK) require us to report to you when:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 25, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors 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.

In preparing the financial statements, the directors are responsible for 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 the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

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 an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism.

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has 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. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Nottinghamshire Healthcare NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018. We have nothing to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- The statement given by the directors on page 25, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for members to assess the Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- The section of the Annual report on page 36, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- The Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- We have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- We have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- We have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Alison Breadon (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Donington Court, Pegasus Business Park, Castle Donington

Date: 25 May 2018

ANNUAL ACCOUNTS 2017/18

Foreword to the accounts

Nottinghamshire Healthcare NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Nottinghamshire Healthcare NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Name **Ruth Hawkins**
Job title **Chief Executive**
Date **24 May 2018**

Statement of Comprehensive Income for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	402,185	408,516
Other operating income	4	53,794	50,892
Operating expenses	5, 7	(432,998)	(444,708)
Operating surplus from continuing operations		**22,981**	**14,700**
Finance income	10	121	123
Finance expenses	11	(2,079)	(2,101)
PDC dividends payable		(11,542)	(11,035)
Net finance costs		**(13,500)**	**(13,013)**
Other gains / (losses)	12	303	(69)
Surplus for the year from continuing operations		**9,784**	**1,618**
Surplus for the year		**9,784**	**1,618**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	26,622	(3,003)
Total comprehensive income / (expense) for the period		**36,406**	**(1,385)**

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	2,005	2,102
Property, plant and equipment	14	396,963	366,262
Total non-current assets		**398,968**	**368,364**
Current assets			
Inventories	16	449	477
Trade and other receivables	17	22,482	22,625
Non-current assets held for sale / assets in disposal groups	18	1,245	-
Cash and cash equivalents	19	38,624	37,414
Total current assets		**62,800**	**60,516**
Current liabilities			
Trade and other payables	20	(30,995)	(33,650)
Borrowings	22	(794)	(792)
Provisions	24	(577)	(603)
Other liabilities	21	(244)	(167)
Total current liabilities		**(32,610)**	**(35,212)**
Total assets less current liabilities		**429,158**	**393,668**
Non-current liabilities			
Trade and other payables	20	(176)	(190)
Borrowings	22	(19,315)	(20,109)
Provisions	24	(5,324)	(5,432)
Total non-current liabilities		**(24,815)**	**(25,731)**
Total assets employed		**404,343**	**367,937**
Financed by			
Public dividend capital		240,562	240,562
Revaluation reserve		174,805	148,714
Income and expenditure reserve		(11,024)	(21,339)
Total taxpayers' equity		**404,343**	**367,937**

The notes on pages 238 to 280 form part of these accounts.

Name R Hawkins
Position Chief Executive
Date 24/5/18

Ruth Hawkins
Chief Executive
24 May 2018

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**240,562**	**148,714**	**(21,339)**	**367,937**
Surplus for the year	-	-	9,784	**9,784**
Other transfers between reserves	-	-	-	**-**
Impairments	-	26,622	-	**26,622**
Transfer to retained earnings on disposal of assets	-	(531)	531	**-**
Public dividend capital received	-	-	-	**-**
Taxpayers' equity at 31 March 2018	**240,562**	**174,805**	**(11,024)**	**404,343**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**240,537**	**152,079**	**(23,319)**	**369,297**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**240,537**	**152,079**	**(23,319)**	**369,297**
Surplus for the year	-	-	1,618	**1,618**
Other transfers between reserves	-	(362)	362	**-**
Impairments	-	(3,003)	-	**(3,003)**
Transfer to retained earnings on disposal of assets	-	-	-	**-**
Public dividend capital received	25	-	-	**25**
Taxpayers' equity at 31 March 2017	**240,562**	**148,714**	**(21,339)**	**367,937**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus		22,981	14,700
Non-cash income and expense:			
Depreciation and amortisation	5.1	10,134	10,384
Net impairments	6	2,564	8,547
Increase in receivables and other assets		(257)	(4,386)
Decrease / (Increase) in inventories		28	(11)
Decrease in payables and other liabilities		(4,140)	(529)
(Decrease) / Increase in provisions		(148)	239
Net cash generated from operating activities		**31,162**	**28,944**
Cash flows from investing activities			
Interest received		121	123
Purchase of intangible assets		(248)	(496)
Purchase of property, plant, equipment and investment property		(17,967)	(15,493)
Sales of property, plant, equipment and investment property		1,748	505
Net cash used in investing activities		**(16,346)**	**(15,361)**
Cash flows from financing activities			
Public dividend capital received		-	25
Capital element of finance lease rental payments		(6)	(6)
Capital element of PFI, LIFT and other service concession payments		(786)	(725)
Interest paid on finance lease liabilities		(24)	(27)
Interest paid on PFI, LIFT and other service concession obligations		(2,040)	(2,000)
Other interest paid		-	(1)
PDC dividend paid		(10,750)	(11,441)
Net cash used in financing activities		**(13,606)**	**(14,175)**
Increase / (decrease) in cash and cash equivalents		**1,210**	**(592)**
Cash and cash equivalents at 1 April - brought forward		**37,414**	**38,006**
Cash and cash equivalents at 31 March	19.1	**38,624**	**37,414**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, 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 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to **the** accounts.

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

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Note 1.2 Critical judgements in applying accounting policies

There are no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies.

Note 1.2.1 Sources of estimation uncertainty

● Provisions for permanent injury awards and early retirements have been calculated using the Government Actuary's Department interim life tables to estimate expected lives.

● The Trust has three PFI schemes which have been accounted for in line with the Department of Health guidance.

● The Trust has made an assessment of the amount payable in relation to employee holiday pay based on information contained within the Employee Service Record (ESR) Human Resources and payroll system.

●As stated in note 1.7 to the accounts, the Trusts specialised buildings are valued on a modern equivalent asset basis. In view of the specialty, super-regional and national nature of the services provided from a range of premises, the Trust has considered it appropriate to conduct its valuation based on an 'alternative site' basis. For 2017/18 the impact of this approach resulted in a valuation of circa £14,892,000 lower than it would have been if the valuation was based on an alternative site in the same locality as where the properties are currently situated. The impact on the SoCI (PDC dividends) during 2017/18 of this valuation approach is £261,000.

Location factors published by BCIS combined with BCIS tender price indices are a significant element in the annual re-estimation of property values. Location factors have exhibited variability in the last few years, undermining Trust confidence in annual figures. The Trust has therefore sought to normalize by applying location factors based on a ten year average. For 2017/18 the impact of this approach resulted in a valuation of circa £25,992,000 lower than it would have been if the valuation was based on single point in time location factors as customarily used for valuations in previous years.

If both of these approaches had not been used by the Trust then the value of the Trusts buildings would have been circa £35,499,000 higher than the value in the accounts.

Note 1.3 Interests in other entities

The Trust is the corporate trustee to the Nottinghamshire Healthcare NHS Charitable Trust Fund (registration number 1111895), it effectively has the power to exercise control so as to obtain economic benefits.

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common controls with NHS Bodies are consolidated within the entities' returns, where those funds are determined to be material.

The Trust has reviewed its NHS charitable funds and concluded that they are not material and so are not consolidated within these accounts. Details of the transactions with the charity are included in the related parties' note 30.

The Charities draft accounts for 2017/18 show a net movement in funds for the year of £44,000 and total funds at 31 March 2018 of £1,113,000.

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 is 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 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. There, the schemes are accounted for as though they are 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. PC's and laptops attached to networks are considered interdependent, and where the remaining criteria for grouped assets apply, are capitalised. Also, assets which are capital in nature acquired as part of the initial setting-up of new buildings but which are valued individually at less than £5,000 but more than £250 may be capitalised as collective or grouped assets.

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. All assets are measured subsequently at fair value.

Land and buildings used for the 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 subsequent accumulated depreciation and impairment losses.

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 are determined as follows:

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

In accordance with the latest RICS guidance, depreciated replacement cost valuations are based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Land, specialised and non-specialised buildings are valued on an annual basis as at 31 March by an independent professional valuer. In 2017/18 this was undertaken by the District Valuer (Valuation Office Agency).

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.

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 are taken to expenditure. A transfer from the Revaluation Reserve to Retained Earnings is made for the lower of the impairment charged and the balance in the Revaluation Reserve for the asset. Gains and losses recognised in the Revaluation Reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

An item of property, plant and equipment 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.

Subsequent expenditure

Expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and day to day maintenance, is normally charged to the Statement of Comprehensive Income in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits or service potential expected to be obtained from the use of an item of property, plant and equipment, and where the cost of the item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement. The impact of such capitalised expenditure on the Fair Value of assets is captured in the annual Revaluation exercise.

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 **surplus / deficit.**

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

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be 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.
The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income on disposal, the balance for the asset on the Revaluation Reserve is transferred to Retained Earnings. 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. Fair value is open market value including alternative uses.

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

Lifecycle replacement

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

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

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

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

There are no assets contributed by the Trust to the operator for use other than in the scheme.

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 Years	Max life Years
Land	-	-
Buildings, excluding dwellings	3	65
Dwellings	18	30
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	5
Furniture & fittings	4	5

Buildings, installations and fittings are depreciated over the estimated remaining life of the asset as advised by the Valuer.

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

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 lives of intangible assets

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

	Min life Years	**Max life Years**
Software licences	5	10

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.10 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 entity]'s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Carbon Reduction Commitment scheme (CRC)

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

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

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

Note 1.12 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 elsewhere in this note.

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

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: 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.

Financial liabilities
All 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.

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.

Note 1.13 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 1.13.1 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 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 24.2 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 1.15 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 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, 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 1.16 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 1.17 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 1.18 Corporation tax

The Trust has determined that it has no corporation tax liability as it does not operate any commercial activities that are not part of core health care delivery.

Note 1.19 Foreign exchange
The functional and presentational currency of the trust is sterling.

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

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.]

Note 1.20 Third party assets

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

Note 1.21 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 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted
The Treasury FReM does not require the following Standards and Interpretations to be applied in 2017/18.
IFRS 9 Financial Instruments
IFRS 15 Revenue from Contracts with Customers
IFRS 16 Leases
IFRIC 22 Foreign Currency Transactions and Advance Consideration

Note 2 Operating Segments

Nottinghamshire Healthcare NHS Foundation Trust has determined that in the context of IFRS 8, the Chief Operating Decision Maker (CODM) for the Trust is the Trust Board as the Board receives and reviews the Finance Board Report on a regular basis. The Finance Board Report contains information regarding expenditure divided across different service areas. However, it also contains the main accounting statements, none of which are divided nor reported at a lower level as these are considered on a Trust wide basis. The Trust considers it has one segment of healthcare for reporting purposes. Further detail is provided below:

	2017/18	2016/17
	£000	£000
Income	455,979	459,408
Retained Surplus	9,784	1,618
Net Current Assets	30,190	25,304

The services provided by Nottinghamshire Healthcare NHS Foundation Trust are delivered by the Local Partnerships and Forensic Divisions and are supported by Trust Corporate Services.

The Local Partnerships Division is responsible for services provided in the community and acute settings and includes:

Adult Mental Health Services

Child and Adolescent Mental Health Services

Mental Health Services for Older People

Intellectual and Developmental Disabilities Service

Substance Misuse Service

Psychological Therapies Service

Children's services - including health visiting, school nursing, specialist services, children's centres (Surestart).

Adult services - including community nursing, intermediate care, therapy services, inpatient and outpatient services, specialist palliative care.

Dental services

The Trust's Forensic Services break down into the following areas:

High secure services (Rampton Hospital)

Medium secure services (Wathwood Hospital and Arnold Lodge)

Low secure in patient service

Community forensic service

Prison healthcare

Note 3 Operating income from patient care activities

Note 3.1 Operating Income from patient care activities (by nature)	2017/18	2016/17
	£000	£000
Mental health services		
Block contract income	272,106	270,511
Clinical partnerships providing mandatory services (including S75 agreements)	20,449	28,525
Clinical income for the secondary commissioning of mandatory services	5,518	5,073
Other clinical income from mandatory services	4,731	4,565
Community services		
Community services income from CCGs and NHS England	85,684	83,342
Income from other sources (e.g. local authorities)	13,697	16,500
Total income from activities	**402,185**	**408,516**

Note 3.2 Operating Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	Restated 2016/17
	£000	£000
NHS England	167,482	175,875
Clinical commissioning groups	216,220	211,328
Department of Health and Social Care	53	-
Other NHS providers	149	146
Local authorities	16,920	19,886
Non NHS: other	1,361	1,281
Total income from activities	**402,185**	**408,516**
Of which:		
Related to continuing operations	402,185	408,516
Related to discontinued operations	-	-

Prior year breakdown of Operating Income from patient care activities (by source) has been restated to reflect changes in categorisation of income mandated by the Department of Health and Social Care Group Accounting Manual (GAM).

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	7,669	6,305
Education and training	11,661	11,656
Charitable and other contributions to expenditure	-	3
Non-patient care services to other bodies	21,585	20,601
Sustainability and transformation fund income	5,326	4,720
Income in respect of staff costs where accounted on gross basis	3,085	2,344
Other income	4,468	5,263
Total other operating income	**53,794**	**50,892**
Of which:		
Related to continuing operations	53,794	50,892
Related to discontinued operations	-	-

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	140,687	141,396
Income from services not designated as commissioner requested services	261,498	267,120
Total	**402,185**	**408,516**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The Trust sold a number or properties during the course of the financial year.

	NBV £ 000's	Proceeds (net of costs of sale) £ 000's
1-4 Enright Close	746	886
35 Dovecote Lane	558	787
Land at Balderton	140	50
Various equipment	1	25
	1,445	**1,748**

None of the properties sold was being used for the provision of commissioner-requested services in the financial year.

Note 5.1 Operating expenses

	2017/18	Restated 2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	566	448
Purchase of healthcare from non-NHS and non-DHSC bodies	17,979	15,684
Staff and executive directors costs	328,242	331,615
Remuneration of non-executive directors	142	154
Supplies and services - clinical (excluding drugs costs)	6,049	6,433
Supplies and services - general	5,543	5,860
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	6,602	6,459
Consultancy costs	642	495
Establishment	8,252	9,269
Premises	19,903	21,516
Transport (including patient travel)	893	947
Depreciation on property, plant and equipment	9,789	10,100
Amortisation on intangible assets	345	284
Net impairments	2,564	8,547
(Decrease) / Increase in provision for impairment of receivables	(154)	139
Change in provisions discount rate(s)	251	614
Audit fees payable to the external auditor		
audit services- statutory audit	75	66
other auditor remuneration (external auditor only)	12	18
Internal audit costs	135	191
Clinical negligence	474	339
Legal fees	1,061	1,241
Insurance	436	486
Research and development	2,793	1,661
Education and training	3,761	3,553
Rentals under operating leases	9,881	11,135
Early retirements	5	5
Redundancy	619	92
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	3,521	4,474
Hospitality	55	58
Other	2,562	2,825
Total	**432,998**	**444,708**
Of which:		
Related to continuing operations	432,998	444,708
Related to discontinued operations	-	-

Prior year breakdown of Operating expenses has been restated to reflect changes in categorisation mandated by the Department of Health and Social Care Group Accounting Manual (GAM).

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus resulting from:		
Changes in market price	2,564	4,837
Other	-	3,710
Total net impairments charged to operating surplus	**2,564**	**8,547**
Impairments charged to the revaluation reserve	(26,622)	3,003
Total net impairments	**(24,058)**	**11,550**

The revaluation exercise has resulted in a reversal of impairments charged to the Statement of Comprehensive Income (SOCI) in previous years for buildings of £6,198,000. There has been an increase in SOCI impairments arising from the revaluation exercise relating to buildings of £1,199,000 and a further £7,563,000 relating to a new development still under construction to be handed over shortly following the SoFP date. The net impairment arising from market changes in relation to premises and chargeable to SOCI is £2,564,000.

There have been no other transactions giving rise to impairments and reversals charged to the SOCI during the course of the year.

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	262,688	262,436
Social security costs	24,742	24,640
Apprenticeship levy	1,263	-
Employer's contributions to NHS pensions	31,947	32,231
Pension cost - other	25	23
Termination benefits	853	381
Temporary staff (including agency)	7,702	12,354
Total staff costs	**329,220**	**332,065**
Of which		
Costs capitalised as part of assets	354	353

Note 7.1 Retirements due to ill-health

During 2017/18 there were 11 early retirements from the trust agreed on the grounds of ill-health (16 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £670k (£931k in 2016/17).

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

Note 8 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. 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.

Note 9 Operating leases

Note 9.1 Nottinghamshire Healthcare NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Nottinghamshire Healthcare NHS Foundation Trust is the lessee.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	9,881	11,135
Total	**9,881**	**11,135**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	9,833	9,618
- later than one year and not later than five years;	13,040	11,046
- later than five years.	318	481
Total	**23,191**	**21,145**

Note 10 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	121	123
Total	**121**	**123**

Note 11.1 Finance expenses

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Finance leases	24	27
Interest on late payment of commercial debt	-	1
Main finance costs on PFI and LIFT schemes obligations	1,295	1,330
Contingent finance costs on PFI and LIFT scheme obligations	746	670
Total interest expense	**2,065**	**2,028**
Unwinding of discount on provisions	14	73
Total finance costs	**2,079**	**2,101**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	1

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of non-current assets	303	-
Losses on disposal of non-current assets	-	(69)
Total gains / (losses) on disposal of assets	**303**	**(69)**

Note 13.1 Intangible assets - 2017/18

	Software licences
	£000
Valuation / gross cost at 1 April 2017 - brought forward	**4,051**
Additions	248
Reclassifications	-
Disposals / derecognition	-
Gross cost at 31 March 2018	**4,299**
Amortisation at 1 April 2017 - brought forward	**1,949**
Provided during the year	345
Amortisation at 31 March 2018	**2,294**
Net book value at 31 March 2018	**2,005**
Net book value at 1 April 2017	**2,102**

Note 13.2 Intangible assets - 2016/17

	Software licences
	£000
Valuation / gross cost at 1 April 2016	**3,438**
Additions	496
Reclassifications	121
Disposals / derecognition	(4)
Valuation / gross cost at 31 March 2017	**4,051**
Amortisation at 1 April 2016	**1,665**
Provided during the year	284
Amortisation at 31 March 2017	**1,949**
Net book value at 31 March 2017	**2,102**
Net book value at 1 April 2016	**1,773**

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**35,403**	**339,899**	**2,549**	**10,834**	**2,366**	**1,749**	**7,577**	**350**	**400,727**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	-	-	15,617	548	158	2,800	-	**19,123**
Impairments	(63)	(471)	-	-	-	-	-	-	**(534)**
Reversals of impairments	605	26,454	97	-	-	-	-	-	**27,156**
Reclassifications	76	2,486	-	(2,562)	-	-	-	-	**-**
Transfers to/ from assets held for sale	(525)	(720)	-	-	-	-	-	-	**(1,245)**
Disposals / derecognition	(505)	(970)	-	-	(11)	(228)	-	-	**(1,714)**
Valuation/gross cost at 31 March 2018	**34,991**	**366,678**	**2,646**	**23,889**	**2,903**	**1,679**	**10,377**	**350**	**443,513**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**25,113**	**234**	**-**	**1,585**	**1,337**	**5,863**	**333**	**34,465**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	8,646	97	-	156	103	782	5	**9,789**
Impairments	-	1,199	-	7,563	-	-	-	-	**8,762**
Reversals of impairments	-	(6,198)	-	-	-	-	-	-	**(6,198)**
Disposals / derecognition	-	(31)	-	-	(11)	(226)	-	-	**(268)**
Accumulated depreciation at 31 March 2018	**-**	**28,729**	**331**	**7,563**	**1,730**	**1,214**	**6,645**	**338**	**46,550**
Net book value at 31 March 2018	**34,991**	**337,949**	**2,315**	**16,326**	**1,173**	**465**	**3,732**	**12**	**396,963**
Net book value at 1 April 2017	**35,403**	**314,786**	**2,315**	**10,834**	**781**	**412**	**1,714**	**17**	**366,262**

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016	**35,563**	**330,202**	**2,453**	**8,431**	**2,047**	**1,697**	**7,233**	**350**	**387,976**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	-	-	15,725	319	57	344	-	**16,445**
Impairments	20	(7,827)	96	-	-	-	-	-	**(7,711)**
Reversals of impairments	-	4,708	-	-	-	-	-	-	**4,708**
Reclassifications	-	13,201	-	(13,322)	-	-	-	-	**(121)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	(180)	(385)	-	-	-	(5)	-	-	**(570)**
Valuation/gross cost at 31 March 2017	**35,403**	**339,899**	**2,549**	**10,834**	**2,366**	**1,749**	**7,577**	**350**	**400,727**
Accumulated depreciation at 1 April 2016	**-**	**7,584**	**138**	**-**	**1,469**	**1,212**	**5,087**	**328**	**15,818**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	8,982	96	-	116	125	776	5	**10,100**
Impairments	-	8,953	-	-	-	-	-	-	**8,953**
Reversals of impairments	-	(406)	-	-	-	-	-	-	**(406)**
Disposals/ derecognition	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2017	**-**	**25,113**	**234**	**-**	**1,585**	**1,337**	**5,863**	**333**	**34,465**
Net book value at 31 March 2017	**35,403**	**314,786**	**2,315**	**10,834**	**781**	**412**	**1,714**	**17**	**366,262**
Net book value at 1 April 2016	**35,563**	**322,618**	**2,315**	**8,431**	**578**	**485**	**2,146**	**22**	**372,158**

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	34,991	310,617	2,315	16,326	1,173	465	3,732	12	**369,631**
Finance leased	-	130	-	-	-	-	-	-	**130**
On-SoFP PFI contracts and other service concession arrangements	-	27,202	-	-	-	-	-	-	**27,202**
Owned - donated	-	-	-	-	-	-	-	-	**-**
NBV total at 31 March 2018	**34,991**	**337,949**	**2,315**	**16,326**	**1,173**	**465**	**3,732**	**12**	**396,963**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	35,263	290,382	2,315	10,834	781	412	1,714	17	**341,718**
Finance leased	-	125	-	-	-	-	-	-	**125**
On-SoFP PFI contracts and other service concession arrangements	-	24,279	-	-	-	-	-	-	**24,279**
Owned - donated	140	-	-	-	-	-	-	-	**140**
NBV total at 31 March 2017	**35,403**	**314,786**	**2,315**	**10,834**	**781**	**412**	**1,714**	**17**	**366,262**

Note 15 Revaluations of property, plant and equipment

The Trusts land and building property including dwellings (but excluding Assets under Construction) is held at revalued amounts for the 31st March 2018, as assessed by the District Valuer, who is independent to the trust.

Land and non-specialised buildings are assessed at market value for existing use at an overall value of £45,300,000.

Specialised buildings are valued at depreciated replacement cost on a modern equivalent asset basis, alternative sites being used where appropriate. The overall assessed value of specialised properties is £329,955,000.

Note 16 Inventories

	31 March 2018	31 March 2017
	£000	£000
Drugs	284	338
Energy	165	139
Total inventories	**449**	**477**

Inventories recognised in expenses for the year were £3,542k (2016/17: £2,694k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 17.1 Trade and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	6,594	8,047
Accrued income	8,284	7,234
Provision for impaired receivables	(218)	(433)
Prepayments (non-PFI)	4,198	3,843
PDC dividend receivable	-	400
VAT receivable	580	1,048
Other receivables	3,044	2,486
Total current trade and other receivables	**22,482**	**22,625**
Of which receivables from NHS and DHSC group bodies:		
Current	14,178	13,366

Note 17.2 Provision for impairment of receivables

	2017/18
	£000
At 1 April	**433**
Increase in provision	(154)
Amounts utilised	(61)
At 31 March	**218**

An impairment provision is made for invoices which are overdue and where recovery is deemed unlikely.

Note 17.3 Credit quality of financial assets

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	-	-
30-60 Days	-	-
60-90 days	-	21
90- 180 days	109	96
Over 180 days	110	316
Total	**219**	**433**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	552	1,151
30-60 Days	490	357
60-90 days	376	236
90- 180 days	567	250
Over 180 days	2,138	869
Total	**4,123**	**2,863**

The majority of the trust's trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As Clinical Commissioning Groups and NHS England are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Note 18 Non-current assets held for sale / assets in disposal groups

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**
Assets classified as available for sale in the year	1,245	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**1,245**	**-**

The Trust anticipates the sale of properties at MacMillan Close, Nottingham. The close comprises town house premises and associated garages that have in the past been adapted for use to house and support mental health rehabilitation patients, but which have been unused and surplus for some time, incurring unavoidable costs of ownership. Alternative uses have been investigated and commercial opportunities explored, and the most appropriate course of action determined to be sale on the open market. Negotiations are ongoing with a buyer and there is high confidence that sale will be achieved early in the new financial year.

Note 19.1 Cash and cash equivalents

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.

	2017/18	2016/17
	£000	£000
At 1 April	**37,414**	**38,006**
Net change in year	1,210	(592)
At 31 March	**38,624**	**37,414**
Broken down into:		
Cash at commercial banks and in hand	66	63
Cash with the Government Banking Service	38,558	37,351
Total cash and cash equivalents as in SoFP	**38,624**	**37,414**
Total cash and cash equivalents as in SoCF	**38,624**	**37,414**

Note 19.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by 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.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	1,865	1,724
Total third party assets	**1,865**	**1,724**

Note 20.1 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	2,451	2,891
Capital payables	3,490	2,334
Accruals	20,269	21,486
Receipts in advance (including payments on account)	-	14
Other taxes payable	-	2,494
PDC dividend payable	392	-
Other payables	4,393	4,431
Total current trade and other payables	**30,995**	**33,650**
Non-current		
Other payables	176	190
Total non-current trade and other payables	**176**	**190**
Of which payables from NHS and DHSC group bodies:		
Current	5,062	4,883
Non-current	-	-

Note 21 Other liabilities

	31 March 2018	31 March 2017
	£000	£000
Current		
Deferred income	244	167
Total other current liabilities	**244**	**167**

Note 22 Borrowings

	31 March 2018	31 March 2017
	£000	£000
Current		
Obligations under finance leases	7	6
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	787	786
Total current borrowings	**794**	**792**
Non-current		
Obligations under finance leases	169	176
Obligations under PFI, LIFT or other service concession contracts	19,146	19,933
Total non-current borrowings	**19,315**	**20,109**

Note 23 Finance leases

Note 23.1 Nottinghamshire Healthcare NHS Foundation Trust as a lessee

Obligations under finance leases where Nottinghamshire Healthcare NHS Foundation Trust is the lessee.

	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	**345**	**375**
of which liabilities are due:		
- not later than one year;	30	30
- later than one year and not later than five years;	120	120
- later than five years.	195	225
Finance charges allocated to future periods	(169)	(193)
Net lease liabilities	**176**	**182**
of which payable:		
- not later than one year;	7	6
- later than one year and not later than five years;	38	33
- later than five years.	131	143

Note 24.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,483**	**269**	**4,283**	**6,035**
Change in the discount rate	86	-	165	**251**
Arising during the year	-	304	-	**304**
Utilised during the year	(135)	(117)	(193)	**(445)**
Reclassified to liabilities held in disposal groups	-	-	-	**-**
Reversed unused	(51)	(207)	-	**(258)**
Unwinding of discount	4	-	10	**14**
At 31 March 2018	**1,387**	**249**	**4,265**	**5,901**
Expected timing of cash flows:				
- not later than one year;	134	249	194	**577**
- later than one year and not later than five years;	530	-	774	**1,304**
- later than five years.	723	-	3,297	**4,020**
Total	**1,387**	**249**	**4,265**	**5,901**

The "Other" category consists of provisions for permanent injury awards.

Due to the inherent nature of provisions, the timing and value of cash flows are uncertain.

Note 24.2 Clinical negligence liabilities

At 31 March 2018, £6,751k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Nottinghamshire Healthcare NHS Foundation Trust (31 March 2017: £7,022k).

Note 25 Contingent assets and liabilities

The trust has no contingent assets nor liabilities.

Note 26 Contractual capital commitments

Commitments under capital expenditure contracts at 31 March 2018 were £nil (31 March 2017 £nil)

The trust has assets under construction at 31 March 2018 of £16.3m (31 March 2017: £10.8m), however this is spread across a large number of schemes, none of which include a legally binding contractual obligation at the Statement of Financial Position date.

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

Note 27.1 Imputed finance lease obligations

Nottinghamshire Healthcare NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**34,812**	**36,891**
Of which liabilities are due		
- not later than one year;	2,038	2,080
- later than one year and not later than five years;	8,093	8,193
- later than five years.	24,681	26,618
Finance charges allocated to future periods	(14,879)	(16,172)
Net PFI, LIFT or other service concession arrangement obligation	**19,933**	**20,719**
- not later than one year;	787	786
- later than one year and not later than five years;	3,542	3,455
- later than five years.	15,604	16,478

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	138,366	145,444
Of which liabilities are due:		
- not later than one year;	7,311	7,245
- later than one year and not later than five years;	29,244	28,978
- later than five years.	101,811	109,221

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	6,358	7,245
Consisting of:		
- Interest charge	1,295	1,330
- Repayment of finance lease liability	785	725
- Service element and other charges to operating expenditure	3,521	4,474
- Capital lifecycle maintenance	11	46
- Contingent rent	746	670
Total amount paid to service concession operator	**6,358**	**7,245**

Note 27.4 Off-SoFP PFI, LIFT and other service concession arrangements - details

Newark PFI

The Newark PFI scheme involves an arrangement for the design, build, finance and operation (non-clinical services), through a private sector operator, of a facility for 25 years, providing a mental health and learning disability resource centre and mental health day care centre and was developed on Trust-owned land.

At the expiration of the arrangement, the underlying asset will remain with the private sector operator and the Trust will have the following three options.

1) Enter into a new project agreement with the operator for a further 25 years;
2) Take an under lease for a term of 25 years;
3) Take vacant possession on payment of the 'Break Sum' (presumed to be 'market value').

The infrastructure asset associated with the scheme will, under IFRS, fall to be recognised on the Statement of Financial Position, based on the application of IFRIC 12 (*Service concession arrangements*), which requires the Trust to:

a. control or regulate what services the operator must provide with the infrastructure, to whom it must provide them and at what price; and to

b. control – through beneficial entitlement or otherwise – any significant residual interest in the infrastructure at the end of the term of the arrangement.

It is considered that the requirements of above are complied with. In particular, the availability of the options, listed 3 above, indicate potential control of a significant residual interest in the infrastructure asset at the end of the term of the arrangement. IFRIC 12 therefore applies and this scheme should be recognised on the Statement of Financial Position.

Highbury PFI

The payment mechanism for the contract allows for charging for services from inception, with incremental charges for new or altered buildings as they become available at each phase completion. The Unitary Charge is calculated to ensure that the Trust owns the PFI facilities at no further cost at the end of the contract.

The facilities provided under the scheme include those for in-patient and day patient activities, as well as ancillary facilities including canteen, kitchen and laundry. In addition, certain Soft and Hard facilities management services are provided to a number of other Trust properties on the site.

The project commenced in December 2004 and comprises 3 phases. Services commenced at the inception of the contract in December 2004, and at the opening Statement of Financial Position date (1 April 2009), phases 1 and 2 were complete and in use.

Certain Trust-owned buildings (to be demolished) were transferred to the private sector operator at no cost. Certain other Trust-owned buildings (“alteration buildings”) were transferred for development by the private sector operator.

Non-property non-current assets, such as IT equipment and software and telecommunications equipment have been and will be acquired separately and are not part of the scheme.

As part of the arrangement, the Trust has entered into certain guarantees with the Royal Bank of Scotland concerning the private sector operator’s financial performance. These guarantees are underwritten by The Secretary of State for Health by a Deed of Safeguard, dated 6 December 2004. No financial guarantee is recognised at the opening Statement of Financial Position date.

The scheme's cash flows change in line with the UK Retail Prices Index (RPI). The embedded derivative is considered to be closely related to the host contract and is therefore not separately accounted for.

Benchmarking, market testing, and variable charging arrangements are in line with Standard Form applicable at commencement. Benchmarking opportunities are scheduled at year 2, 5 and each 5th year subsequently.

Changes to Trust accommodation requirements in the final phase are completed and were handed over to the Trust in April 2011. The leased element was handed over in August 2010, and capitalised at £5,925,000, with the subsequent part funded by capital injection. Incremental construction costs arising from the Trust requirement changes were funded through capital injection, and the contract will still complete at the original planned completion date of 31st January 2039.

Rampton Boiler Replacement and Effluent Treatment Plant scheme

The Rampton Boiler Replacement and Effluent Treatment Plant scheme is a Public Private Partnership venture facilitated by the Carbon Energy Fund through their framework arrangements. It involves the development by a Private Sector Partner (PSP) using private finance it has secured and on land licenced to it by the Trust for the purpose, of installations comprising Energy Facilities including a Combined Heat and Power Unit (CHP), a Biomass Boiler, two dual fuel boilers, and a new Effluent Treatment Plant (ETP), followed by provision of services therefrom by the PSP for a 15 year operational term to commence on the later of the Actual Completion Date in relation to the Energy Facilities Works and the Actual Completion Date in relation to the ETP Works.

The PSP will provide Energy Services utilising the Energy Facilities provided, managed and procured by it. The PSP will be responsible for the provision of electricity and heat to the Hospital and the operation, maintenance and replacement of the Energy Facilities in accordance with the terms of the Project Agreement for the 15 years of the operational term.

PSP staff will operate and manage the energy plant to output specifications agreed by and solely for the benefit of the Trust incentivised by a payment mechanism based on a guaranteed savings model that punishes poor savings performance and shares the rewards of savings performance greater than the contract specification. This is stiffened by a Service Failure and Availability Deductions mechanism.

The PSP will provide Effluent Treatment Services under the terms of the agreement being a comprehensive service for the processing and treatment of effluent leaving the hospital utilising the ETP provided, managed and procured by it. The PSP will be responsible for the monitoring, management, operation, maintenance and replacement of the ETP facilities for the 15 years of the operational term.

Under the terms of the Project Agreement no payment would be made to the company for the facilities until the facilities were complete and handed over (Actual Completion) in accordance with the project agreement. Payment for the facilities and services will be made to the PSP by the Trust through a Unitary Payment which will comprise an element each for property (lease rental) and service charge. The first Unitary Payment covering the first quarters composite charge fell due at commencement of the operational term, and Unitary payments will continue to be paid quarterly in advance for remainder of the 15 year operational term.

The facilities and associated finance costs will have been paid for in their entirety through the Unitary Payment at expiry of the agreement, at which point the company will cease to have in interest in facilities and plant and ownership will lie with the Trust.

The capital cost of purchase and installation of the facilities agreed at commencement of the Project Agreement is £5,049,000 and the annual unitary charge £841,000, both figures exclusive of VAT.

The Trust entered into the Project Agreement with the PSP on the 13th December 2013, and works to prepare the site for the new developments commenced shortly thereafter. All construction works and delivery of plant on site took place in 2014/15, with Practical Completion and handover of both the Energy Facilities works and ETP works, and Actual Completion under the terms of the contract and commencement of the operational term being achieved on the 4th February 2015. The first quarters Unitary Payment fell due at that point, being a quarter of the annual Unitary Payment as agreed at commencement of the project agreement adjusted for contractually agreed inflation, equating to £863,505 pa exclusive of VAT.

Note 28 Financial instruments

Note 28.1 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 the Nottinghamshire Healthcare NHS Foundation Trust (the Trust) has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups 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 some powers to borrow or invest surplus funds. 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. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust 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.

Interest rate risk

The Trust borrows from government for capital expenditure. 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

Because the majority of the Trust's income comes from contracts with other NHS and non-NHS public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from its own self-generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

	Loans and receivables
	£000
Assets as per SoFP as at 31 March 2018	
Trade and other receivables excluding non financial assets	17,704
Cash and cash equivalents at bank and in hand	38,624
Total at 31 March 2018	**56,328**

	Loans and receivables
	£000
Assets as per SoFP as at 31 March 2017	
Trade and other receivables excluding non financial assets	17,212
Cash and cash equivalents at bank and in hand	37,414
Total at 31 March 2017	**54,626**

Note 28.3 Carrying value of financial liabilities

	Other financial liabilities
	£000
Liabilities as per SoFP as at 31 March 2018	
Obligations under finance leases	176
Obligations under PFI, LIFT and other service concession contracts	19,933
Trade and other payables excluding non financial liabilities	26,210
Total at 31 March 2018	**46,319**

	Other financial liabilities
	£000
Liabilities as per SoFP as at 31 March 2017	
Obligations under finance leases	182
Obligations under PFI, LIFT and other service concession contracts	20,719
Trade and other payables excluding non financial liabilities	26,869
Total at 31 March 2017	**47,770**

Note 28.4 Fair values of financial assets and liabilities

In all cases, the carrying values of financial assets and liabilities represent a reasonable approximation of their fair value.

Note 28.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	27,004	27,661
In more than one year but not more than two years	895	908
In more than two years but not more than five years	2,685	2,723
In more than five years	15,735	16,478
Total	**46,319**	**47,770**

Note 29 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	7	12	10	3
Bad debts and claims abandoned	40	27	49	25
Total losses	**47**	**39**	**59**	**28**
Special payments				
Ex-gratia payments	83	103	63	86
Special severance payments	-	-	-	-
Total special payments	**83**	**103**	**63**	**86**
Total losses and special payments	**130**	**142**	**122**	**114**

Note 30 Related parties

The trust is part of the National Health Service within the UK government; its parent department is the Department of Health and Social Care. The main entities within the public sector with whom the trust has dealings are:

NHS England
NHS Nottingham City CCG
NHS Mansfield & Ashfield CCG
NHS Newark & Sherwood CCG
NHS Bassetlaw CCG
NHS Nottingham North & East CCG
NHS Rushcliffe CCG
NHS Nottingham West CCG
Health Education England
Department of Health & Social Care
Nottingham University Hospitals NHS Trust
NHS Leicester City CCG
NHS West Leicestershire CCG
NHS East Leicestershire & Rutland CCG
Sherwood Forest Hospitals NHS Foundation Trust
NHS Hardwick CCG
NHS Southern Derbyshire CCG
University Hospitals of Leicester NHS Trust
NHS Erewash CCG
NHS Property Services Ltd
Derby Teaching Hospitals NHS Foundation Trust
Derbyshire Healthcare NHS Foundation Trust
NHS Doncaster CCG
Leicestershire Partnership NHS Trust
Community Health Partnerships
Doncaster and Bassetlaw NHS Foundation Trust
NHS Resolution (previously NHS Litigation Authority)
Care Quality Commission
NHS Lincolnshire East CCG

The trust has also received revenue and capital payments from Nottinghamshire Healthcare Charitable Trust Funds, the trustee of which is the trust. This amounted to £77,000 (2016/17: £142,000) towards staff and patient welfare and amenities. An administration charge of £12,000 (2016/17: £12,000) was made by the trust to Nottinghamshire Healthcare Charitable Trust Fund.

Additional information on compensation and expenses paid to senior management can be found in the staff and remuneration section of the trust's annual report.

During the year none of the Department of Health and Social Care ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the trust.

The trust's executive director of finance is also chair of the East Midlands branch of the Healthcare Financial Management Association (HFMA),which provides training courses, guidance and publications to its members. Purchases from the HFMA during 2017/18 amounted to £26,000 (2016/17: £12,000).

The trust's chair is also the chair of United Lincolnshire Hospitals NHS Trust (ULH). Although the trust has had dealings with ULH during the year, none of these are connected to this arrangement.
The Chair is also a governor of Portland College to which the Trust provides Speech and Language services for which it received income of £188,000 (2016/17: £149,000) during the year.
The Trust's Medical director is also a Board member of the NHS Confederation Mental Health Network. The Trust received income of £57,000 (2016/17: £37,000) during the year from NHS Confederation. This income was not connected with this arrangement.

One of the Trust's Non-Executive Directors (NEDs) is also a NED at Derbyshire Health United Limited. The Trust spent £104,000 (2016/17: £105,000) during the year with Derbyshire Health United Limited.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. These material transactions have been with the University of Nottingham, Nottinghamshire County Council, Nottingham City Council and Leicester City Council. A number of directors of the trust have held positions with various universities during the year, but transactions with these universities have been on an 'arms length' basis during the normal course of business.

Note 31 Prior period adjustments

There have been no prior period adjustments.

Note 32 Events after the reporting date

There have been no events after the reporting date having a material impact on the financial statements.