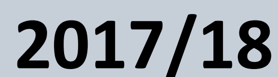
Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts



2017/18

Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts 2017/18

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Statement from the Chair

The last year has been one of continued improvement and growth, building on the journey over the last four years. It has also been a year of increased pressure, including supporting the health and care needs of an increasingly elderly population. We have seen changes across health and social care as, together with our partners, we seek to provide integrated and compassionate services. Sherwood Forest Hospitals is at the centre of many of these initiatives whether as part of the Nottingham and Nottinghamshire Integrated Care System (ICS) or the Mid Nottinghamshire Better Together programme.

The way in which the Trust has responded to the challenges and opportunities is down to the staff and volunteers working at King's Mill, Newark and Mansfield Community hospitals. It has been a privilege to see and hear from staff about their ideas and aspirations. Any organisation stands or falls on the quality of its staff, and I have never failed to be impressed by the compassion, dedication and determination of our workforce. Combining this with strong leadership and a culture of engagement, learning and listening is what will help us achieve our ambition of becoming outstanding.

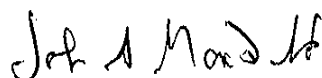
For the first time in many years we have a stable leadership team. Richard Mitchell took over from Peter Herring in July 2017. I would like to thank Peter for all his work and leadership in setting the Trust on the journey of improvement. Richard has brought immense energy, enthusiasm and strategic vision to the Trust and I look forward to continuing to work with him in the coming years.

I would also like to thank our dedicated team of Governors, headed by Lead Governor Sue Holmes, who represent the communities and people that we serve. We have made a very conscious effort this year as a Trust to spend more time engaging with and listening to the people who use our services and the partners that we work with, and we will continue to build on this.

Our strong team of over 600 fantastic volunteers play a critical role both in the day to day running of our hospitals, and in raising funds for important project that help improve patient care and experience. Most notably this year raising vital funds for our dementia appeal at Newark Hospital, and I know working hard in 2018/19 to raise £5,500,000 for a new gamma scanner.

Finally, I would like to take this opportunity to pay tribute to Non-Executive Director and vice chair of the Board, Ray Dawson, who sadly passed away shortly before the time of writing. Ray was a Board member for five years and made a significant contribution to the Trust. He will be sadly missed.

Thank you to everyone who has contributed to making the last 12 months so positive, and I look forward to the next year working with you all in continuing to provide safe, high quality services for the people we serve.



John McDonald
Chair

Statement from the Chief Executive

I joined Sherwood Forest Hospitals as Chief Executive in July 2017 and I have thoroughly enjoyed my first year here.

We are currently waiting for the findings of our CQC inspection which took place in April 2018, but irrespective of the formal result, I believe we had a good year. I think our services today are better than they were 12 months ago, and will be better again in another year's time. Thank you to the staff and volunteers who individually and collectively played a key role in providing safe patient care over the last 12 months.

We know engaged, well supported employees deliver safe care and we are evidence of that, and our employee engagement results last year were some of the best in the NHS. October 2017 was the first time that we offered all staff the opportunity to complete the anonymous national NHS staff survey, and 57% of our staff responded, which was the eighth highest in the NHS.

An impressive 78% of our staff said they would recommend Sherwood as a place for friends and family to receive treatment and 70% said they would recommend Sherwood as a place to work. These are good results. In March 2018 we ran our quarterly staff survey and our scores improved to 90% and 77% respectively. These are very good results.

Our colleagues provide safe, personalised care to our patients and many quality, safety and patient experience indicators improved last year. We are fortunate to work in buildings which are very clean and, in general, across our three hospital sites are modern and spacious.

Working closely with partners in health and social care, we have again bettered our financial control total, delivered our cost improvement plan, and driven a reduction in our agency spend. The £12million reduction in agency usage, whilst delivering safe care, is particularly important because fewer agency staff and more permanent staff means greater continuity of care for patients – "our staff caring for our patients", all of this is impressive at a time when the NHS and social care has never been under so much pressure.

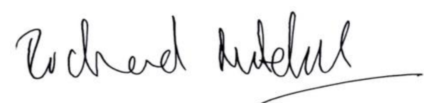
Whilst patients on cancer pathways and diagnostic pathways continue to receive timely care at Sherwood, the last year has been difficult for providing timely care consistently on the emergency care and elective (planned) care pathways.

We understand the reasons for this and it is not because of a lack of effort. Many hospitals have struggled for years to deliver timely care on the emergency care pathway and culturally have come to accept this. We do not want to be one of those organisations and I do not believe we are one. Timeliness of care is an important indicator of the overall quality of care that a patient receives, and improving emergency care and elective care is a priority for us in 2018. It will not be easy, but it is possible.

As well as improving care to emergency and elective patients, I hope we can make our colleagues working life calmer this year. This is not an aspirational pledge nor does it detract from the requirements to make difficult decisions that not everyone will like nor support all of the time, but I am committed to supporting all ideas that make life at Sherwood better for patients and colleagues.

I worry about the pressure colleagues have been under, in particularly but not exclusively this winter, and I do not feel good about the length of time some patients have waited for their treatment or admission. I am aware

of the impact this has on patients and colleagues lives and we will make further improvements at Sherwood over the next 12 months.



Richard Mitchell
Chief Executive

Performance Report

Overview

This section summarises our organisation's purpose, history, objectives and key risks.

Our History and Structure

Sherwood Forest Hospitals was formed in 2001 and gained Foundation Trust status in 2007. We provide acute healthcare services for 420,000 people across Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire. We employ 4,500 people across our three hospital sites - King's Mill, Newark and Mansfield Community, and we also run some services from Ashfield Community Village. We have five clinical divisions: Urgent and Emergency Care, Medicine, Surgery, Women's and Children's, and Diagnostics and Outpatients. Each division benefits from clinical and managerial leadership and is supported by the corporate function.

Our Trust is managed by the Board of Directors, which is responsible for setting the vision and strategy for the Trust and ensuring their effective implementation. As a Foundation Trust we have a Council of Governors, which represents the interests of both public and staff members, and which holds the Board of Directors to account.

During the past year we have built upon the successes of 2016/17 by maintaining our focus on safety and quality in pursuit of our vision to deliver outstanding healthcare for our patients and communities. We have consolidated and strengthened our position as a standalone organisation through completing our recruitment of fully substantive Executive and Divisional Management teams.

Our Purpose

We are committed to fulfilling our vision by delivering our strategic priorities and acting in accordance with our values:

Our activities

We deliver an extensive range of healthcare services based both in hospital and within the community. These are tailored to meet the needs of our local population and include planned and emergency surgery, 24/7 emergency and urgent care departments, maternity care, and rehabilitation. During the past year we held over 440,500 outpatient appointments, more than 98,550 people attended our Emergency Department at King's Mill Hospital 23,900 patients were seen and treated at the Urgent Care Centre at Newark Hospital, and we delivered around 3,400 babies.

As a large provider of hospital services within Nottinghamshire and beyond, we also have a key role to play in improving the quality of local health and care services, enhancing the provision of healthcare activities across the wider region, as well as making a social contribution to the quality of local lifestyles, health and wellbeing. We are therefore an active partner in the mid-Nottinghamshire Better Together programme and the Nottinghamshire Sustainability and Transformation Partnership (STP). In Nottinghamshire, our STP is evolving to form an Integrated Care System (ICS), which represents even closer collaboration, through the delivery of a number of joint work streams. The development of the ICS will involve working with NHS and local authority partners to take collective responsibility for managing resources, delivering NHS standards and improving the health of the local population. Working in such a way will facilitate better, tailored and more joined-up care for patients.

Risks to delivery of objectives

Our vision, values and strategic priorities express our dedication to providing outstanding care throughout our hospitals and services. We are committed to the NHS Constitution and the nationally mandated standards described within. Nevertheless, as with other Trusts across the country, we have experienced unprecedented

pressures over the last year and whilst our performance compares favourably with other Trusts, our ability to meet the constitutional standards has been compromised (see *Performance Report* for further information). We expect to return to meeting the standards in the coming year, but the combination of demand and constrained resources present a risk to this objective.

Working in partnership as part of the Better Together programme and within the ACS is a fundamental mitigation to this risk, as is our continued focus on improving our internal working processes and practices to ensure patients receive high quality care in a timely manner.

Patient Care

We are dedicated to delivering outstanding care for our patients and communities. This vision statement articulates our commitment and ambition to excel and continually improve the quality of our services. Our four core values underpin this and describe the way in which we will operate: communicating and working together, aspiring and improving, respectful and caring, and efficient and safe.

We develop our services and improve patient care based on evidence. We proactively seek and use feedback from patients and staff, as well as analysing data that benchmarks the performance of our services against other Trusts'. In addition, our Advancing Quality Programme ensures that we are focus on delivering those programmes of improvement that will have the greatest impact on patient's quality of care.

Any significantly revised services

In the last year, we have worked with our partners to introduce a new Musculoskeletal (MSK) service for mid-Nottinghamshire. As a result of the new developments, which are underpinned by improved collaboration, patients experience a number of benefits including:

- Ability to self-refer
- Reduced waiting times
- Better information about treatment choices
- Access to the most appropriate clinical at the right time
- Care closer to home
- Access to evidence-based self-care information
- A named case manager

We recognise that in order to meet the health and social care needs of local communities fully, we need to work in partnership with other organisations in the area. We are an active partner in the mid-Nottinghamshire *Better Together Alliance*, which brings together health and social care partners from across mid-Nottinghamshire with the joint aim of transforming services and improving financial efficiency. The core priorities of the alliance include preventing avoidable hospital admissions, supporting self-care, strengthening services within primary care and the community, delivering care closer to patients' homes, and facilitating the closer integration of the various health and social care services run by partner organisations.

The *Better Together Alliance* is a local partnership within a wider system of health and care organisations across Nottinghamshire. The Nottinghamshire system has been identified as an Integrated Care System (ICS), within the first cohort of ICSs. This represents a further enhancement of partnership working across health and social care, with organisations taking 'collective responsibility for managing resources, delivering NHS standards and

improving the health of the population'[1] This collaboration enables local services to provide improved and coordinated care for patients and helps staff to work together across organisational boundaries.

We continue to build a strong and strategic partnership with Nottingham University Hospitals (NUH), seeking opportunities to work more closely together in areas that will benefit patients and staff.

Two services that have benefited from collaboration with NUH in the last year are Neurology and Urology. In Neurology, plans have been developed for NUH to run the service on our premises, to overcome the sustainability challenges that we have continued to experience. For Urology, a joint on-call arrangement has been developed and protocols are in place to transfer patients who require an emergency admission from King's Mill Hospital to NUH.

[1] NHS England (2018), available at: https://www.england.nhs.uk/accountable-care-systems/

Performance Analysis

Throughout 2017/18 we have seen consistent performance against the majority of the operational access standards.

Referral to Treatment

The NHS Constitution sets out that (as a minimum) 92% of our patients should wait no longer than 18 weeks from GP referral to treatment (RTT). Our performance in 2017/18 has deteriorated in year and we have an improvement plan in place to deliver the standard from Quarter 2 2018/19. This will be delivered by working collaboratively with the STP Elective Care Work stream and the Better Together Elective Care Programme Delivery Board to deliver improvements across outpatients, peri-operative, post-operative and theatre productivity.

Referral to Treatment	2016/17	2017/18
Q1	92.60%	92.73%
Q2	92.30%	91.58%
Q3	92.10%	90.59%
Q4	92.80%	88.78%

Diagnostics – 'DMO1'

Known as 'DM01', this national target means that 99% of all diagnostic tests relating to physiology, radiology and endoscopy need to be completed within six weeks. We have performed relatively well throughout 2017/18 balancing the demands of routine diagnostic referrals with urgent and cancer activity.

DM01	2016/17	2017/18
Q1	98.80%	99.68%
Q2	96.00%	99.32%
Q3	98.00%	99.14%
Q4	99.40%	96.59%

Cancer standards

Cancer Waiting Times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. There are seven operational standards; our performance against each target is shown in the table below. In 2017/18 year we have consistently delivered the two week wait standards and 31 day to 1st treatment and 31 day subsequent drug standards. We know we have further work to do to sustainably deliver the 62 day referral to treatment target and are working closely with tertiary providers and system partners via the STP and Cancer Alliance to support earlier diagnosis, the implementation of national optimal pathways and improving outcomes for our patients.

	Target	2016/17	2017/18
2 week wait all cancers	93%	95.90%	96.10%
2 week wait breast symptomatic	93%	96.60%	97.20%
31 day wait from diagnosis to 1st treatment	96%	97.80%	98.60%
31 day wait for subsequent treatment - surgery	94%	100.00%	90.90%
31 day wait for subsequent treatment - drugs	98%	98.90%	100%
62 day wait urgent referral to treatment	85%	83.60%	84.10%
62 day wait for first treatment from screening	90%	89.20%	84.90%

Stroke

The SSNAP is a tool used to capture and measure different parts of a patient's journey, from the moment they arrive in the Emergency Department and their admission to the stroke unit, through to rehabilitation and discharge. It consists of 10 domains, such as scanning and thrombolysis, and measures the time taken to undertake a scan and, if applicable, perform thrombolysis from the moment the patient arrives at hospital. It also considers the amount of input provided by various therapists, including those from occupational therapy, physiotherapy and speech and language, all of whom are integral to the effective rehabilitation of a stroke survivor. Each domain is closely monitored by our stroke team so that areas of the pathway needing further attention can be addressed, and to maintain areas of good practice. We consistently perform well in this audit programme and are now one of the best in the country and top in the East Midlands for recognising and treating patients who have had a stroke.

	Sentinel Stroke National Audit Programme
August – November 2016	A
December 2016 – March 2017	A
April – July 2017	A
August – November 2017	A

Urgent and Emergency Care

Performance of the urgent and emergency care we provide is measured through a number of clinical indicators. These include the four-hour waiting standard, time-to-triage, time-to-assessment, re-attendance rates, admission rates, total number of attendances, the number of patients conveyed by ambulance, and ambulance handover times.

The primary indicator, both locally and nationally, is that at least 95% of patients attending the Emergency Department should be seen, treated and either admitted or discharged within four hours.

We formally monitor performance in this area evaluate it on a daily, weekly and monthly basis through robust reporting mechanisms. This approach allows performance against all clinical indicators to be evaluated and assessed by our clinical and operational teams, as well as by various groups such as the divisional management board and those attending service, performance review meetings. Our teams use these forums to initiate various actions, which have helped to ensure sustainable performance against the required clinical indicators. Achieving these targets is highly dependent on effective working both across our hospitals and with other local providers of health and care services. For this reason, members of our Urgent and Emergency Care division and the Executive Team also discuss performance, including any key challenges, at system-wide forums such as the partnership Accident and Emergency Delivery Board, where partners collaborate in undertaking trend and root-cause analysis as necessary.

Emergency Department (ED) 4-hour performance

We achieved this standard in the first quarter of 2017/18 and continue to perform well nationally, although we acknowledge our own performance has dropped. Great focus is placed on achieving this standard as good patient flow is a marker of quality and patient experience.

ED 4-Hour Performance	**2016/17**	**2017/18**
Q1	93.74%	96.04%
Q2	95.16%	94.19%
Q3	95.10%	90.70%
Q4	94.00%	88.28%
Total for year	94.51%	92.33%

Accident and emergency attendances
2017/18 saw an increase in A&E attendances overall.

Number of Accident & Emergency Attendances (Primary Care 24, KMH Emergency Department and Urgent Care Centre, Newark Hospital)	**2016/17**	**2017/18**
Q1	37,487	38,234
Q2	37,865	37,572
Q3	37,325	38,131
Q4	36,349	36,824
Total for year	**149,026**	**150,761**

Ambulance arrivals

The number of patients arriving via ambulance has increased by 1.13% since the previous year. We measure handover performance, which is the time taken from the moment the ambulance crew arrives, to the safe handing over of the patient to the team in the Emergency Department.

Relevant metrics are monitored in real-time within the department and reviewed at all bed meetings, which take place throughout the day. We escalate issues and take timely actions to mitigate concerns when we foresee a potential delay.

Number of ambulances bringing patients to hospital in an emergency	2016/17	2017/18	Increase /Decrease
Q1	8,123	8083	-0.49%
Q2	8,253	8265	0.15%
Q3	8,661	8825	1.89%
Q4	8,617	8860	2.82%
Total for year	**33,654**	**34,033**	**1.13%**

Emergency admissions from the Emergency Department

Emergency admissions from ED have decreased by 4% this year; this has mainly been in surgery and paediatrics. We have developed a suite of performance indicators to help improve our understanding about the admissions along with our partners. Our clinicians within ED work to ensure that patients get the right onward care that they need be that within the wards, within alternatives such as an ambulatory care service, or within the community.

Emergency Admissions from the Emergency Department	2016/17	2017/18	Increase /Decrease
Q1	7691	7238	-5.9%
Q2	7666	7640	-0.3%
Q3	8364	7769	-7.1%
Q4	7944	7755	-2.4%
Total for year	**31665**	**30402**	-4.0%

Patient flow

Being able to have a capacity to ensure the effective movement of patients through our hospitals to the beds and care they need, including the safe and timely discharge of patients, results in a better quality of care and experience for our patients as well as an increase in our available capacity to see and treat new patients. A great deal of work has been undertaken by our all our Divisions to support this in the past year and working with our partners we continue to focus on this crucial area working across three clinically led programmes to ensure we have inpatients capacity meet demand.

Financial Analysis

We are reporting a retained surplus in the year of £13.3m. Our regulators, NHS Improvement, issued us with a control total for 2017/18 of a maximum deficit of (£37.6m). After adjusting the retained surplus for a reversal of an impairment of £36.5m, which reflects the revaluation of our assets to the current market value and other items not included in the control total of £0.4m, our deficit on a control total basis is (£23.6m), £14.0m better than required. The improvement was driven by a change in the accounting policy regarding the PFI, which in turn attracted additional matched incentive Sustainability and Transformation Funding (STF) of £10.3m.

During the year we received £16.9m of Sustainability and Transformation Funding, which was our allocation of national funds made available to support the delivery of financial plans and performance targets relating to emergency care. Available initially was a maximum of £8.8m, of which we received £6.6m. A further £10.3m was awarded to us for achieving a year-end financial position that was better than planned.

We have successfully delivered a number of transformational initiatives that have improved patient care as well as reducing our costs. These Cost Improvement Programmes (CIPs) delivered £16.3m of savings in total which met our annual savings target. Among the key improvements realised are more effective use of staff rosters, reduction in agency costs through recruitment to vacancies, better use of our theatres and reduced costs in Corporate services. Plans are in place to continue to build on this good work and deliver further savings in 2018/19.

NHS Improvement has set our 2018/19 control total to be a maximum deficit of £34.0m. We are confident that we can achieve this, building on the success of our savings programmes this year in conjunction with the improvements we have made to our financial governance and cost control. Key to success is increased system wide engagement with operating plans fully aligned between providers and commissioners.

Income and expenditure

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that our financial statements shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

Operating income

Total operating income for the year was £304.7m which represented an increase of 3.1% from the previous year (£295.4m). Income received from patient care activities was £249.7m (£238.0m) in 2016/17). Non-clinical income received contributes directly to the provision of healthcare services as well as our operating.

Income Disclosures

We have met the requirement under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purpose. Other income generated by us was used to support the provision of our health services.

Operating expenses

Our total operating expenses (excluding impairments) fell during the year to £313.4m from £325.6m in 2016/17, a decrease of 3.7%. Costs of £12.6m were incurred last year to support the proposed merger between the Trust and Nottingham University Hospital. Employee costs fell by £0.6m driven by a fall in agency spend following recruitment to vacant posts and tighter controls in expenditure. Notable increases in High Cost Drugs, Devices and Clinical Supplies resulted from the growing number of patients seen and treated.

More than half of our operating expenses - £195.5m (62%) - were spent on employee costs. A total of £47.7m (15%) of our expenditure (excluding impairments) paid for prescription drugs, clinical supplies and services. The majority of the remaining £70.2m (22%) was spent on items relating to the PFI and mandatory contributions to the Clinical Negligence Scheme for Trusts.

Fixed assets

During 2017/18 we invested £9.5m in our fixed asset infrastructure, which compares with £9.2m the previous year. This comprised £2.6m invested in buildings and the estate, £3.1m in equipment, and £3.8m in IT infrastructure. Of this expenditure, £5.6m was sourced from the Department of Health as a repayable loan.

Charitable funds

We recognised £0.2m (£0.1m in 2016/17) of charitable income in the statement of comprehensive income to match the value of purchasing equivalent medical equipment from charitable funds.

The Charitable Funds' Trustees were able to make further grants of £0.3m (£0.3m in 2016/17) to enhance the welfare of patients and staff, and support our activities. Included in these figures are the generous donations received from the local community, voluntary services and local charity partners including; Leagues of Friends, for Mansfield and Sutton, and Newark.

Projects supported Include:

- Bluebell Room refurbishment of a specialist sensory room within the Emergency Department.
- Therapy Services Gym to provide state of the art gym equipment for patient use following treatment within cardiology services.
- Parents' Room on ward 25 –refurbishment includes a kitchen, bathroom bedroom and supported living facilities. The project is currently underway and was also supported by Pentagon Motors as their charity of the year for 2017.
-

PFI

As a result of the adoption of International Financial Reporting Standards (IFRS) in 2009/10, the PFI scheme is included within our Statement of Financial Performance (SOFP). This continues to have a significant adverse impact on the SOFP, because the associated value of the building is low in comparison to the remaining debt outstanding. Following a review of our policy for accounting for PFI in 2017/18 borrowings on the SOFP associated with PFI have reduced to £269.2m (£280.4m in 2016/17 restated). This is as a result of more accurately reflecting the lifecycle costs paid to the PFI provider for maintaining buildings to an agreed standard. These costs rise through the course of the contract. Overall, the scale of the PFI liability, along with the increasing income and expenditure deficit reserve, is the reason that the total taxpayers' equity amounts to a

negative £171.4m. Payments of £44.4m were made in year relating to the PFI, of which £33.1m (2016/17 £33.9m) was recognised in the Statement of Comprehensive Income (SOCI).

Cash, liquidity and financial support

Our planned deficit for the year meant that we required cash borrowings from the Department of Health to meet our planned expenses. To support the income and expenditure position a number of borrowings, supported by revenue term loans, were agreed and drawn. These amounted to £43.4m, £37.7m for revenue and £5.6m to support investment in fixed assets.

Principal risks and uncertainties

We continued to strengthen our approach to risk management during the year, with the Board's Risk Committee ensuring that strategic risks have been identified, addressed and managed effectively. These include risks and opportunities within the organisation, such as those associated with treating and caring for patients, employing staff, innovation, reputation, maintenance of premises and managing finances.

Financial risks

As mentioned earlier, we plan to achieve NHS Improvement's control total of £34.0m in 2018/19. However, we face a number of risks in doing so, as follows:

- Our CIP target is £17.3m, which represents a total of 5.2% of turnover. To deliver this we will require support from our partners in the wider healthcare economy, as well as the successful realisation of ongoing internal change programmes.
- There is increasing emphasis nationally on system-wide planning and working and as such we are working on £17.7m of commissioner led schemes to improve efficiency within patient pathways. Work on these schemes will progress including full understanding of proposed operational model, action plans to deliver and full financial modelling for the whole system.
- Our plan includes the receipt of £12.4m from Sustainability and Transformation Funding. To gain access to these monies we will need to deliver the 95% 4-hour emergency standard as well as our financial plan, both of which represent challenges as described above. £3.6m is dependent on the wider local health system delivering its overall control total.
-

Going concern

In preparing the annual accounts, we are required to assess the basis of their preparation, specifically questioning our status as a sustainable trading entity. This assessment takes into consideration all available information relating to our future prospects, and covers financial, governance and commissioner-requested (mandatory) service risks. We continue to adopt the presumption of going concern in the preparation of our accounts.

In adopting the going concern basis for preparation of the financial statements, the directors have considered the organisation's business activities as well as the principal risks and uncertainties. Although access to cash support has not yet been finalised, we have agreed to the deficit control total set by NHS Improvement. On this basis, the Board is satisfied that the organisation will be able to operate within the level of its facilities for the foreseeable future. Therefore after making enquiries, the directors have a reasonable expectation that the

organisation has adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing the accounts, however a material uncertainty exists which may cast significant doubt about the Trust's ability to continue as a going concern. More detail has been provided within Note 1 of the accounts

Sustainability Report

'Sustainability' means spending public money well, making smart and efficient use of natural resources, and contributing towards building healthy, resilient communities. By making the most of social, environmental and economic assets, we can improve health both in the immediate and long-term despite the rising cost of natural resources.

We are committed to demonstrating leadership in sustainability and the Sustainable Development Management Plan (SDMP) represents our route map to deliver significant improvements in the sustainability of our organisation over the coming years. This is through a combination of quick wins, investment in low carbon technologies and a staff awareness and behavioural change programme to embed a sustainable culture across the organisation.

To ensure the actions in the SDMP are followed through, we have recently appointed a Programme Manager (Environment & Sustainability) on a 12 month secondment to assist in progressing the journey towards our sustainable vision.

As an NHS organisation and spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve in the interests of achieving sustainability. Demonstrating that we consider relevant social and environmental impacts also shows that we are responding to the legal requirements set out within the Public Services (Social Value) Act (2012).

In addition to these responsibilities, we also have an obligation to reduce our carbon footprint. Based on a 1990 baseline, the Climate Change Act sets a target to reduce this footprint by 34%, to be achieved by 2020. This equates to a 28% reduction in carbon emissions when using 2013 as the baseline year, and as an NHS organisation we are committed to achieving this.

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Our specific commitments as a NHS provider are reflected within our contracts with local healthcare commissioners.

We recognise our responsibilities in helping to create a sustainable future. To help engage staff and local people in this mission we have taken part in a number of awareness campaigns to promote the benefits of sustainability; for example, we worked with our PFI partners, Skanska, to undertake a sustainability day at a local school which focused on the importance of local wildlife.

The challenges of climate change

Climate change poses new challenges for our organisation, both with respect to our estate as well as to patient health. Examples in recent years include the impact resulting from heat waves, extreme temperatures and prolonged periods of cold, floods and drought, with the frequency of such events being expected to increase. Our lead for emergency planning and business continuity continues to work collaboratively with other NHS organisations and agencies to develop policies, protocols and plans to respond to these and other potential challenges.

Actions include adapting the way we manage and deliver our services to enable us to respond to adverse weather events and climate change overall.

We have also formed an Adaptation Committee to evaluate weather conditions, staffing levels, energy consumption and patient activity to determine the level of impact on the organisation and our operations.

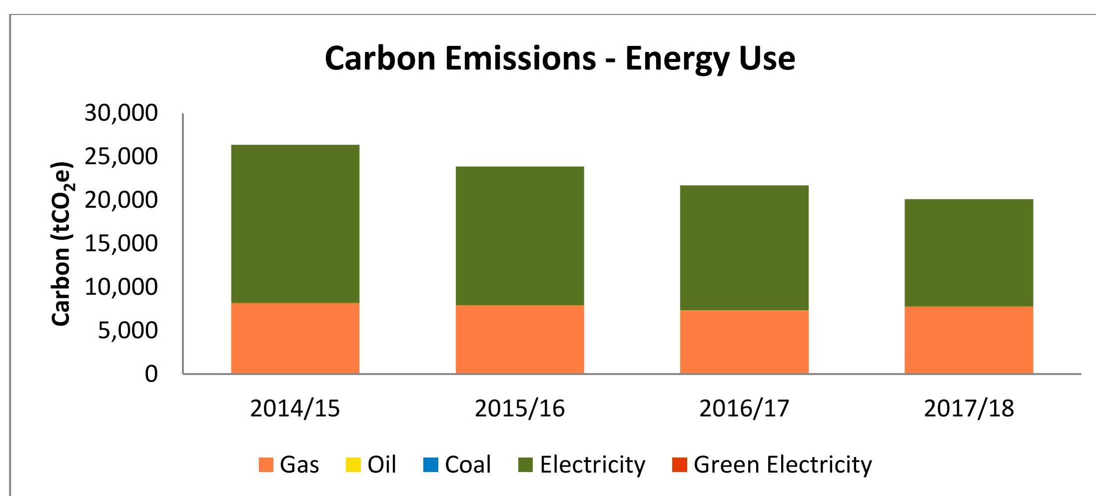
Policies

The following table shows the areas that are relevant to our work and confirms that sustainability is considered within each related policy:

Area	Is sustainability considered?
Travel	Yes
Business Cases	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

Energy and carbon emissions

The following graphs and supporting narrative demonstrate how we have successfully contributed towards achieving the 2020 target in a number of key areas of our activity.



Since 2014 we have continued to reduce our overall energy emissions (expressed as tCO2e in the table below), which represents creditable progress towards the 2020 target. Our estimated total carbon footprint for 2017/18 is 20,100 tonnes of equivalent carbon emissions, which is 19.1% lower than the baseline year of 2013/14.

Our total spend on energy over the past year amounted to £3.6m, a 14.2% increase when compared with the previous year. The extreme weather conditions experienced during the 2017/18 winter period compared to the mild winter of 2016/17 will be a determining factor.

Resource		2013/14	2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	39,752,274	38,895,055	37,768,434	34,943,410	36,680,435
	tCO_2e	8,433	8,160	7,904	7,303	7,777
Oil	Use (kWh)	93,102	15,001	51,056	24,326	0
	tCO_2e	30	5	16	8	0
Electricity	Use (kWh)	28,383,949	29,389,922	27,722,561	27,855,578	27,648,648
	tCO_2e	15,892	18,202	15,938	14,396	12,324
Green Electricity	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Total Energy CO_2e		**24,355**	**26,367**	**23,859**	**21,706**	**20,100**
Total Energy Spend		**£ 3,542,701**	**£ 3,697,048**	**£ 3,789,474**	**£ 3,149,924**	**£ 3,597,936**

These calculations are derived from a scaled model, which is based on work carried out by the NHS Sustainable Development Unit (SDU). More information can be found on the SDU's website at www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx

Although our carbon emissions are reducing, our spend on energy is increasing due to a number of factors, including distribution and transmission costs from the utility providers and inflation. The elongated winter period and increased patient numbers also affected our energy consumption.
We are in the process of planning to install a connection from the local alkane gas plant to the King's Mill energy centre to enable us to use coal mine methane (CMM) gas as a source of energy. This is a type of gas present in active, working mine sites, which can be re-directed to produce energy and so result in less waste and other benefits for the environment.
Improvements are also planned to the geothermal system within the King's Mill reservoir to increase its efficiency. This system offers an environmentally efficient means of providing heating and cooling to King's Mill Hospital.
We continue to devise and implement initiatives targeted at reducing energy related emissions across our hospital estate.

Travel

We can improve local air quality and so improve the health and wellbeing of our local community by promoting 'active travel' to our staff and those who use our services. Active travel includes walking, cycling and any other means of travel that involves physical activity. As well as the health benefits, there is an obvious benefit to the environment in terms of reducing noise and carbon emissions linked to most motorised vehicles.
The following table shows the estimated carbon footprint relating to staff travelling to work. 2017/18 represents a slight increase above normal owing to the additional numbers of staff employed during this year.

Category	Mode	2013/14	2014/15	2015/16	2016/17	2017/18
Staff commute	miles	3,121,633	3,266,100	3,266,100	3,621,528	3,794,439
	tCO_2e	1,153.36	1,200.06	1,181.14	1,308.86	1,352.05

We have installed electric vehicle charging points at the King's Mill hospital site to reduce our environmental impact even further. One is for use by our PFI service provider Skanska, who have invested in an electric van for use across our Hospital sites, the other is situated in the main visitor's car park. Further electric vehicle charging point locations are being considered.

Waste

As a large provider of hospital services we have many opportunities to improve the way in which we deal with the waste produced in relation to our activities. Whilst comparable figures are not available over recent years relating to general waste, we have monitored our recycling activities closely and figures are shown in the table below. The amount we recycle has more than doubled in the past two years and we have also made significant efforts this year to reduce the amount of waste requiring high temperature disposal. We have implemented a proactive approach to auditing hazardous waste and have introduced an effective behavioural change

programme, which includes training and raising awareness across the organisation to ensure that colleagues and hospital users are disposing of waste in the most appropriate way.

Waste recycled		2013/14	2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	140.00	149.56	321.16	323.00	336.00
	tCO_2e	2.94	3.14	6.42	6.78	7.31

We continue to review opportunities to dispose of waste effectively, including a more recent arrangement with a local supplier who is disposing of our 'co-mingled' waste. Our significant programme of recycling sees cardboard packaging separated at source and compacted on-site. As a result of these initiatives, we are ensuring that minimal waste is incinerated or sent to landfill.
Since going live in March 2015, our waste management programme has delivered a significant reduction in carbon emissions. As a result, we were delighted that, following a joint entry with our estates partners, we were selected as finalists for the NHS Sustainability Waste Award, May 2017.
Specific achievements include:

- 599 tonnes of clinical waste segregated.
- 12973 clinical bins exchanged across all three hospitals.
- 45 tonnes of cardboard sent for recycling.
- 10 tonnes of metal segregated and sent for recycling.
- 425 tonnes of domestic waste.
- 45 tonnes of dry mixed recycling.
- 44 tonnes of bulk furniture segregated.
- 86 tonnes of confidential waste segregated.
- 43293 waste audits conducted across three hospitals.
- 48 tonnes of medical equipment donated to Syria.

Finite resource use – Water

Water		2013/14	2014/15	2015/16	2016/17	2017/18
Mains	m^3	129,275	145,608	137,442	155,423	150,537
	tCO_2e	118	133	125	141	137
Water and Sewage Spend		£334,597	£290,419	£312,508	£333,805	£246,285

Water consumption rose significantly in 2016/17 with a slight decrease in 2017/18. Overall, we have seen a continuous increase in emissions since the 2013/14 base year. The main likely cause of this is the legionella minimisation programme, which requires additional flushing to keep water flowing and temperatures maintained. A number of water leaks have also been identified within the system, and these were resolved quickly.

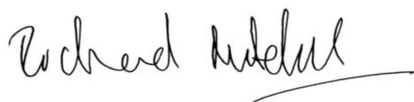
We have entered into an agreement with an organisation known as Aquafund, who are presently undertaking a full review of our use of water. This involved in installing additional water meters to assist in the identification of excessive use or leaks, several water control measures and invoice validation. A substantial reduction in cost can already be seen.

Social, Community, Anti-Bribery and Human Rights

We are committed to treating all our patients and colleagues with dignity and respect. Embracing diversity supports the delivery of our strategic vision and helps to ensure that we are providing effective services that meet the needs of our community. We have an Equality Strategy, which is a public declaration of how we will demonstrably take forward our commitment to ensuring that equality is embedded within all aspects of the organisation. Our approach is to have an inclusive approach to supporting aspects of social, community, anti-bribery and human rights underpinned by our Equality approach. The effectiveness of policy documents are reviewed regularly ensuring feedback is obtained from users to inform future policy decisions.

We have agreed that no policy, procedure or process can be approved until an Equality Impact Assessment (EIA) has been carried out. An EIA is the detailed and systematic analysis of the potential or actual effects of a policy, procedure or process, which is undertaken in order to establish whether the policy, procedure or process has a differential impact on different groups of people. The aim of the EIA is to eliminate discrimination and produce positive outcomes for equality. Our EIA process was reviewed in 2016/2017 and a revised process was implemented to ensure compliance with the Public Sector Equality Duty.

We have a Conflicts of Interest Policy which informs colleagues of how to declare interests in order to minimise exposure to any potential perceptions of bribery. All decision making employees are required to make a declaration including a nil declaration if they have nothing to declare. This provides transparency with regard to procurement and tendering processes.



Richard Mitchell
Chief Executive

29 May 2018

Accountability Report

Directors' Report

Board of Directors

The Board of Directors is the team responsible for the management and performance of the organisations and also for setting the future strategy. Our Board has overall responsibility for the preparation and submission of the Annual Report and Accounts. The Board considers the Annual Report and Accounts to be fair, balanced, and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's strategy, business model and performance.

The primary responsibility of our Board of Directors is to promote the long-term success of the organisation by creating and delivering high quality services within the funding streams available. Our Board seeks to achieve this through setting strategy, monitoring strategic priorities and providing oversight of implementation by the Executive Management team. In establishing and monitoring its strategy, our Board considers, where relevant, the impact of its decision on wider stakeholders including staff, suppliers and the environment.

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

The individuals who served at any time during the financial year as directors were as follows: John MacDonald (Chair) Tim Reddish (Senior Independent Director), Ray Dawson (Vice Chair), Claire Ward, Neal Gossage, Ruby Beech, Sean King and Graham Ward, all Non-Executive Directors. Peter Herring (Chief Executive),Richard Mitchell (Chief Executive), Dr Andrew Haynes, Suzanne Banks, Paul Robinson, Julie Bacon, Roz Howie, Denise Smith, Simon Barton, Peter Wozencroft, Paul Moore, Shirley Higginbotham (Company Secretary), Marcus Duffield and Kerry Beadling-Barron. Full biographies of our current directors and non-executive directors, together with their terms of office can be found on our website.

The balance, completeness and appropriateness of our board membership is reviewed periodically and upon any vacancies arising amongst either the executive or non-executive directors. The balance of skills is appropriate to the requirements of the organisation. Board directors are required to declare any interests that are relevant and material on appointment, or should a conflict arise during the course of their term. A register of board members' interest is maintained by the Company Secretary and is updated annually as covered later in this Annual Report. Board directors are also required to meet the Fit and Proper Persons test and this is evidenced in their individual personal files.

The Chair declared on appointment a significant commitment as Chair of University Hospitals North Midlands; this appointment ended in August 2017. The Chair is also the Independent Chair of the Alliance Board for Mid-Nottinghamshire. The Chair has no other significant commitments.

Attendance at Board meetings

	Public		Private	
Name	Actual	Possible	Actual	Possible
John MacDonald	12	12	12	12
Peter Herring	3	3	3	3
Richard Mitchell	9	9	9	9
Suzanne Banks	11	12	11	12
Paul Robinson	11	12	11	12
Dr Andrew Haynes	10	12	10	12
Peter Wozencroft	8	12	8	12
Paul Moore	11	12	11	12
Julie Bacon	12	12	12	12
Shirley A Higginbotham	11	12	11	12
Ray Dawson	12	12	12	12
Tim Reddish	11	12	11	12
Sean King	5	6	5	6
Neal Gossage	11	12	11	12
Claire Ward	11	12	11	12
Ruby Beech	5	7	5	7
Graham Ward	11	12	11	12
Kerry Beadling-Barron	7	9	7	9
Marcus Duffield	1	4	1	4
Simon Barton	3	3	3	3
Denise Smith	6	6	6	6
Roz Howie	3	4	3	4

Register of interests

The Register of Interests for all members our Board is reviewed regularly and published annually on our website. The register is maintained by the Company Secretary, who is based at Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, Kings Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, HG17 4JL.

All members of our Board and Council of Governors must disclose details of company directorships or any other positions held, in general and more specifically with organisations who may trade with the organisation.

We maintain NHS Litigation Authority insurance, which gives appropriate cover for any legal action brought against our directors to the extent permitted by law.

Political donations

In accordance with historical and intended future practice, no political donations were made during the year ended 31st March 2018.

Well-Led Framework

NHS Improvements well –led framework was introduced in June 2017. In response we have undertaken a self-assessment against each of the Key Lines of Enquiry (KLOE). Each of the KLOE has an executive lead who has developed a brief response. Our Board has implemented a robust Board Development programme during the year which has focussed on the following areas:

- Performance
- Strategy Development
- Culture
- System Working
- Recruitment, training and appraisal
- Board Effectiveness

Objectives have been defined and actions agreed, some of which have been implemented during the year, for example enhanced performance reporting to Board, to provide an integrated view of the organisation. These will be further developed into insight reports to provide further clarity and transparency.

The Care Quality Commission will be undertaking a well led assessment of us during May 2018 and we will procure an external review in the autumn.

Patient Care

We are continuing our journey to outstanding. Our four values of communicating and working together, aspiring and improving, respectful and caring, and efficient and safe are now well-embedded across all our hospital sites underpinning our continuous improvement work.

SFH colleagues across our sites have engaged at all levels with our continuous improvement journey. The importance of challenging how we deliver care, recognising where we excel and where we need to focus is recognised by all staff groups and is the basis on how we identify and agree our safety and quality priorities.

How we engage with our patients, their families and carers and our wider external partners has been a focus of our improvement work this year and how we better involve them not only in our improvement work but in the design of our services will be key to our future success.

Quality Improvement Plan Summary

Following the success of the Quality Improvement Plan we implemented our Advancing Quality Programme in April 2017. This programme has been developed using a variety of intelligence sources and builds on the improvement work of the previous workstreams stretching our ambition to further improve the safety and quality of care delivered.

For 2017-2018 we have focussed on seven key areas:

- Progressing the impact of the Patient Safety Culture work.
- Ensuring the effective implementation of Nervecentre as the electronic mechanism for recognising and responding to our acutely unwell patients.
- Implementing the National 'Learning from Deaths' Guidance to understand and improve the care delivered to our patients in the weeks or days prior to death.
- Managing medicines safely.
- Standardising the way in which we manage our hospitals 24 hours a day, seven days a week, particularly in relation to 8pm-8am, weekend and Bank Holiday periods.
- Increasing awareness and improving care delivered across all our hospitals for patients with a mental health or learning disability need and for patients admitted with dementia and delirium.
- Engaging with our patients, their families and carers to ensure that the information we provide is current, evidence based and enables them to make informed choices about their care and treatment.

We have continued to robustly monitor progress of our improvement work through our safety and quality governance framework, including working much more closely with other improvement processes across the organisation and wider health and social care footprint.

As our improvement journey has matured colleagues have gained confidence in implementing small changes and improvements within their local areas that has positively contributed to the current position where we are recognised regionally and nationally for exemplar practice, benchmarking above the regional or national average in a significant number of indicators.

Colleagues can recognise and are proud of the care they are able to deliver to their patients, despite significant operational challenges. The 2017 Staff Satisfaction Survey demonstrates for the second consecutive year that our staff feel valued and feel they make a positive contribution to the care of their patients.

Improvements in Quality Governance

We have continued to refine and develop the Trust Governance Framework. There is a clear line of sight from 'Ward to Board' with an effective, well-led Governance Structure in place.

A significant improvement throughout this year has been the timelines of recognising and responding when things go wrong. We now have a robust system for instigating investigations ensuring we identify learning at the earliest possible opportunity.

There are a number of mechanisms in place where outcomes from incidents are discussed, the learning shared as widely as possible and teams can demonstrate where changes to practice and improvements to care have been implemented as a consequence.

Local governance processes have strengthened with effective and constructive discussion at specialty and divisional level common place. The Patient Safety Quality Group is the conduit for escalation and assurance to the Quality Committee and then onto the Board of Directors. It has been identified as the single most effective Patient Safety Forum within the Governance Framework.

The comprehensive quality dashboard developed from the Single Oversight Framework has been further refined to reflect quality indicators for specialties and divisions and forms an integral part how our performance is monitored and managed as it is discussed monthly at the Board of Directors meetings.

Involvement of Governors

Our Council of Governors plays an important role in the delivery of safe, high quality care. Members of the Governing Body act as observers on the Board sub-committee and are also members of our Forum for Patient Involvement. Governors take an active role in our formal and informal visits to wards and departments, and provide an invaluable, impartial and observational perspective on how we conduct business. They also provide a vital link between the organisation, our members and local communities, and support our engagement and communication activities.

Patient Care: Improvements in patient/carer information

Great strides have been made in 2017/18 on our patient and carer information. All patient leaflets are now stored in one central place and are created and reviewed using one process overseen by the newly appointed Patient Information Officer.
An amnesty was held in order to create the master log which involved working with all departments across the organisation as well as specialist roles such as the Learning Disability Specialist Nurse. A new policy which follows best practice and includes using members of the public to review leaflets and a readability test was approved in March 2018. This is in line with the current principles of the Accessible Information Standard which we will work towards attaining in 2018/19 if NHS England re-opens the scheme.

Our website has also had new accessibility tools added to it and is due a whole refresh in 2018/19. The public leaflet information section will be included as part of this.

Stakeholder relations – Consultation with local groups and organisations

A renewed focus on engagement and involvement with local communities has been in place during 2017/18. An Engagement and Involvement Strategy has been created which aims to build a culture that actively encourages public participation and a two-way dialogue. We believe that by doing this it will improve patient experience, make services more open and build better relationships between us and the communities we serve. This is then underpinned by the Patient and Carer Engagement Plan and the Public Engagement and Involvement Plan. A key

part of our Quality Strategy is involving patients and the community and so this renewed focus will be in place in 2018/19 and beyond.

In November 2017 we organised and held our first Forum for Public Involvement. We went out to Foundation Trust members and members of the public to invite them to take part. Around 45 members registered their interest. A draft Terms of Reference has now been updated as part of the group's work and they have given suggestions on the Quality Priorities for 2018/19 and what they would like to achieve as a group in 2018. Meetings are held monthly at King's Mill Hospital with one in four held in Newark Hospital.

We also utilise the learning from complaints, concerns, compliments to improve and enhance services in line with patient and public feedback. One consistent theme is on car parking and our Estates Department is now looking at what other options are available to try and improve car parking for our patients. The results from the survey on our website are being used to inform the content and design of the new website.

We also regularly undertake public surveys on a variety of issues to engage with our stakeholders. In the last 12 months the below surveys have been issued. This would usually be advertised through a number of methods including on social media, via email to Foundation Trust members and since December 2017 via the Forum for Public Involvement.

Survey name	Date	Summary
Equality and Inclusivity Patients, Carers and Communities Survey (in relation to EDS2)	May 2017	To ask members of the public how the Trust was performing in line with EDS2.
Web Development Questionnaire	August 2017	To ask members of the public what they like about the current website and what they would like changed to help design the new website.
Day in the Life of Survey	September 2017	To ask members of the public which facts and figures they would like to know about the Trust.
Surgical Services Feedback	October 2017	To ask members of the public for their views on surgical services to feed into the Trust's peer review programme.
Maternity Services Feedback	December 2017	To ask members of the public for their views on maternity services to feed into the Trust's peer review programme.
Medical Services Feedback	March 2018	To ask members of the public for their views on medical services to feed into the Trust's peer review programme.

We have also worked with our CCG on public events on service changes such as to the neuro-rehabilitation service on Chatsworth Ward at Mansfield Community Hospital and the proposal for an Urgent Treatment Centre at Newark Hospital. The models for both these services are now being worked up by the CCG using the public

feedback. Colleagues have also attended our Health Scrutiny Panel to update on these two key areas as well as on our relationship with Nottingham University Hospitals NHS Trust.

As well as this we have also established regular meetings with stakeholders including our local MPs, GPs and Healthwatch Nottinghamshire. A stakeholder audit was completed in March 2018 and the results from this will be used to improve how we engage with them in 2018/19.

Cost allocation

We have complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Trust performance against the Better Payment Practice Code – measure of compliance

The Better Payment Practice Code is a non-mandatory target to pay 95% of all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice.

	2017/18		2016/17	
	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	81,585	191,970	93,138	194,924
Total non-NHS trade invoices paid within target	45,355	152,048	78,306	177,427
Percentage of non-NHS trade invoices paid within target	56%	79%	84%	91%
Total NHS trade invoices paid in the year	2,507	27,340	2,606	39,625
Total NHS trade invoices paid within target	1,430	23,675	2,013	35,306
Percentage of NHS trade invoices paid within target	57%	87%	77%	89%

Remuneration Report

Scope of the report

The Remuneration Report summarises our remuneration policy and, particularly, its application in connection with the executive directors. The report also describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration as defined in the NHS FT Code of Governance, in sections 420 to 422 of the Companies Act 2006 and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ('the Regulations') as interpreted for the context of NHS Foundation Trusts, Parts 2 and 4 of Schedule 8 of the Regulations and elements of the Foundation Trust Code of Governance.

Annual Statement on Remuneration from the Chair of the Remuneration Committee

The Remuneration Committee met twice during the year and key decisions made included the secondment of our previous Chief Operating Officer and the recruitment and remuneration of our current Chief Operating Officer in August 2017. NHSI had endorsed a 1% pay award effective from 1st April 2017 for all those executive and corporate directors engaged on the Trust's Very Senior Manager (VSM) pay arrangements, this was discussed and approved by the committee in November 2017. The committee also formally approved the appointment of Dr Andrew Haynes, Medical Director as the Deputy Chief Executive. The Terms of Reference for the committee were also reviewed and approved by the committee.

Senior Managers' Remuneration Policy

To achieve our goals, we must attract and retain staff and senior managers of a high calibre, and ensure we are positioned to deliver our strategy and business plans.

During the year we adhered to the principles of the agreed pay framework that remunerated the performance of the executive directors and corporate directors based on the delivery of objectives as defined within the Annual Plan. However, there are no contractual provisions for performance-related pay for executive and corporate directors and, as such; no payments were made relating to 2017/18.

Our approach to remuneration is intended to provide the rigour necessary to deliver assurance and the flexibility necessary to adapt to the dynamics of an ever changing NHS. It is fundamental to business success and is modelled upon the guidance in The NHS Foundation Trust: Code of Governance and the Pay Framework for Very Senior Managers in the NHS (Department of Health).

The key principles of the approach are that pay and reward are firstly assessed relative to the financial performance of the Trust as a whole, and secondly in line with available benchmarks, including NHS Providers and the wider pay policies of the NHS.

Executive appointments to the Board of Directors continue under permanent contracts. During the year our non-executive directors, as members of the Remuneration Committee successfully appointed our Chief Operating Officer. In addition, the committee confirmed the Executive Medical Director formally as the Deputy Chief Executive and approved an executive secondment.

Governance for the approval of remuneration packages, in line with the policy, is in place through the Remuneration Committee, which considers pay on an individual basis attributed to scope and remit of role. Through the Remuneration Committee, the Board assures itself that salaries are commensurate with other organisations of similar size and complexity. It also considers the nature of the patient, quality and safety challenges to provide assurance that any given salary reflects the degree of responsibility and accountability.

Senior Manager Remuneration Table

Set out below are the components of the senior managers' remuneration package. All substantive senior managers receive basic pay and business expenses. They also receive the employer's contribution to the NHS pension scheme where they are eligible to join it. A lease car allowance or cash equivalent benefit was withdrawn for new appointees in 2016.

Relocation expenses are paid in accordance with the Trust's general relocation policy, where an appointee is required to maintain two properties or move their primary residence to take up their position.

	Basic pay	Pension	Business expenses	Relocation Expenses
	All senior managers receive a basic pay element to their	The Trust pays employer contributions for all senior managers who	Refund of business mileage and subsistence expenses incurred on official duties in	Up to £6,000 is available to newly appointed senior managers in accordance with the

	remuneration, which is pro-rata for part time staff	are enrolled in the NHS pension scheme	line with Agenda for Change: National NHS terms	terms of the Trust's general relocation scheme
Supports the short and long term strategy	Recruitment and retention of a capable and competent board with the skills to lead a successful organisation and fulfil the Well-led requirements of CQC and NHSI to deliver the strategic objectives of the organisation. Performance is assessed through an annual appraisal framework. Recently appointed Executive Directors who exceed the £150,000 threshold are subject to the standard 10% clawback clause should they not achieve their objectives.			

The senior manager remuneration policy does not provide for automatic annual inflation-related increases. Any such increase needs to be expressly approved by the Remuneration Committee. With effect from 1 April 2017, the committee approved a 1% pay award for Very Senior Managers. This was in accordance with NHS Improvement's (NHSI) letter to all NHS Trusts and NHS Foundation Trusts on 8th November 2017 , in which it stated that NHSI and the Department of Health, agreed that a 1% consolidated pay award should be applied to VSMs in all Trusts.

Senior Managers Paid More than £150,000 per annum

Where a senior manager is paid more than £150,000 per annum, our Remuneration Committee has taken robust steps to provide assurance that this remuneration is reasonable. This is done by applying the principles of good corporate governance as described in the NHS FT Code of Governance, in Sections 420 to 422 of the Companies Act 2006 and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations") as interpreted for the context of NHS Foundation Trusts, Parts 2 and 4 of Schedule 8 of the Regulations. In addition, benchmark information is used, particularly that appertaining to the NHS, such as remuneration surveys conducted and supplied by NHS Providers.

The Remuneration Committee also seeks approval from HM Treasury, NHS Improvement, the Department of Health and the Minister of State for Health for salaries that exceed £150,000 per annum, as required by NHS Improvement's guidelines on pay for Very Senior Managers in NHS Trusts and Foundation Trusts.

Any salary approved in excess of £150,000 is subject to a 10% claw-back in the event of under-performance of the post-holder.

Non-executive directors' Remuneration Table

Fee	Car allowance	Pension	Business expenses	Relocation Expenses
All non-executive directors received a fee	Not applicable	Not applicable	Refund of business mileage and subsistence expenses incurred on official duties in line with Agenda for Change: National NHS terms	Not applicable

The remuneration for non-executive directors has been determined by our Council of Governors and is set at a level to recognise the significant responsibilities of non-executive directors in NHS Foundation Trusts, and to attract individuals with the necessary experience and ability to make an important contribution to the organisation.

Our non-executive directors each have terms of no more than three years and are able to serve two concurrent terms (i.e. no more than six years), dependent on formal assessment and confirmation of satisfactory on-going performance. Non-executive directors are able to apply for a further three years through an annual request if the Council of Governors are in agreement. The removal of a non-executive director requires the approval of three-quarters of the members of the Council of Governors.

Their remuneration framework, as agreed previously by our Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2017/18 has been consistent with that framework. Benchmarking is provided via the NHS provider annual remuneration survey. There were no cost of living increases applied for non-executive directors during 2017/18.

None of the non-executive directors are employees of the Trust; they receive no benefits or entitlements other than fees and expenses incurred whilst on SFH business, and are not entitled to any termination payments. The Council of Governors as a whole determines the terms and conditions of the non-executive directors.

The Trust does not make any contribution to the pension arrangements of non-executive directors. Fees reflect individual responsibilities, including chairing the committees of the Board, with all non-executive directors otherwise subject to the same terms and conditions.

During the 2017/18 one non-executive director resigned. The balance of the Board complies with the Code of Governance, which requires the Chair and at least five other non- executive directors determined by the Board to be independent; and the Trust's constitution, which states the number of executive directors, is less than the number of non-executive directors. We are currently in the process of recruiting into our two vacant Non-Executive positions, and have appointed an interim specialist clinical advisor to the Board to ensure clinical representation at Board level. The advisor position is non-voting.

Termination Payments for Senior Managers and Policy on Payment for Loss of Office

Termination payments for senior managers are contained in the contract of employment with regard to notice periods. Notice periods set out under senior managers' substantive employment contracts are in line with statutory requirements. Interim contractors and fixed term senior managers have a notice period of one month.

Entitlements to severance payments are in line with those of other employees within the organisation, namely those provisions contained in section 16 of Agenda for Change: National NHS terms. This is based on length of continuous and reckonable NHS service and basic pay. The basic pay element had a salary cap of £80,000 during 2017/18.

Statement of Consideration of Employment Conditions elsewhere in the Foundation Trust

The pay and conditions of other Trust employees were taken into account when setting the remuneration policy for senior managers. The 1% pay award given to one senior manager mirrored the Agenda for Change: National NHS terms pay award that was received by other employees of the Trust and the NHS in general with effect

from 1 April 2017. All other national NHS terms are mirrored for Trust senior managers, including annual leave and sick pay.

Annual Report on Remuneration **(not subject to audit)**

Service Contracts

Senior managers' service contracts do not contain any obligation on the trust.

Name	Title	Start Date	Expiry	Notice Period
Ray Dawson	Non-Executive Director	01.06.2013	31.05.2019	1 month
Claire Ward	Non-Executive Director	01.05.2013	30.04.2019	1 month
Tim Reddish	Non-Executive Director	08.07.2013	31.10.2018	1 month
Neal Gossage	Non-Executive Director	01.05.2015	30.04.2020	1 month
Graham Ward	Non-Executive Director	01.12.2015	30.11.2020	1 month
John MacDonald	Non-Executive Director (Chair)	01.03.2017	28.02.2020	1 month
Ruby Beech	Non-Executive Director	01.11.2015	31.10.2017	
Sean King	Non-Executive Director	01.06.2017	31.12.2017	
Richard Mitchell	Chief Executive	01.07.2017		6 months
Dr Andrew Haynes	Medical Director/Deputy CEO	01.07.2014		6 months
Suzanne Banks	Chief Nurse	06.02.2017		3 months
Paul Robinson	Chief Finance Officer	23.03.2015		6 months
Simon Barton	Chief Operating Officer	01.01.2018		3 months
Julie Bacon	Executive Director HR & OD	01.12.2016		3 months
Peter Wozencroft	Director of Strategy and Commercial Development	02.12.2013		6 months
Paul Moore	Director of Governance and Quality Improvement	01.03.2017		3 months
Shirley A Higginbotham	Company Secretary	04.04.2013		3 months
Kerry Beadling-Barron	Head of Communications	03.07.2017		3 months
Roz Howie	Chief Operating Officer	01.10.2016	03.09.2017	
Peter Herring	CEO	19.11.2015	30.06.2017	
Denise Smith	Acting Chief Operating Officer	04.09.2017	31.12.2017	
Marcus Duffield	Acting Head of Communications	01.04.2017	30.06.2017	

Note: Barbara Brady was employed as a specialist advisor to the Board in March 2018 for a period of 6 months

Major Decisions on Senior Managers' Remuneration

There were no major decisions on senior managers' remuneration during 2017/18.

Substantial Changes to Senior Managers' Remuneration during the Year and the Context for These

There were no substantial changes to senior managers' remuneration during 2017/18.

Remuneration and Nominations Committees

We have two remuneration and nominations committees: one which serves as a committee of the Board and is responsible for recruiting and appointing the Chief Executive and executive directors; and the other which serves as a committee of the Council of Governors and is responsible for recruiting and appointing the Chair and non-executive directors and approving the appointment of the Chief Executive.

Our Board appoints the Remuneration and Nominations Committee and its membership comprises only non-executive directors. The committee meets to determine, on behalf of the Board, the remuneration strategy for the organisation, including the framework of executive and senior manager remuneration.

During the year, the following non-executive directors have served on the committee, which has met twice during the year:

Name	Meetings attended out of possible total
John MacDonald (Chair)	2/2
Tim Reddish (Senior Independent Director)	2/2
Ray Dawson	1/2
Graham Ward	2/2
Neal Gossage	2/2
Ruby Beech	0/1
Claire Ward	2/2
Sean King	1/1

The committee also invited the assistance of our Chief Executive (Richard Mitchell), Executive Director of Human Resources and OD (Julie Bacon), and the Company Secretary (Shirley A Higginbotham). None of these individuals, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

Our Council of Governors appoints the Remuneration and Nominations Committee and its membership comprises of the Chair, public, staff and appointed governors. The committee meets to determine, on behalf of the Council of Governors, the remuneration for the Chair and non-executive directors, the composition of the Board with regard to skills and experience, and to agree the recruitment process for the Chair and non-executive directors.

During the year, the following have served on the committee, which has met three times:

Name	Meetings attended out of possible total
John MacDonald (Chair)	1/3
Ray Dawson (Vice Chair)	1/3
Sue Holmes (Lead Governor)	3/3
Jim Barrie (Public Governor)	1/3
Martin Stott (Public Governor)	1/3
Jayne Leverton (Public Governor)	2/3
Keith Wallace (Public Governor)	3/3
Cllr David Payne (Appointed Governor)	2/3
Roz Norman (Staff Governor)	3/3

The committee also invited the assistance of our Company Secretary (Shirley A Higginbotham). Neither she, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

Through an open recruitment process the committee successfully recommended appointment of a new non-executive director with a clinical background to enhance the challenge and debate at Board and Council of

Governors. The committee also successfully recommended the re-appointment of non-executive directors who had reached the end of their tenure.

Disclosures required by Health and Social Care Act

Governor and Director Expenses

During the year the total number of directors who served on our Board was, 22 and the total number of governors serving on our Council of Governors totalled 31. The Trust reimbursed expenses incurred in respect of Trust business as follows:

Directors		**Total paid 2017/18 £'00**	**Total paid 2016/17 £'00**
Sean Lyons	Chairman	N/A	8.6
John MacDonald	Chair	27.8	N/A
Louise Scull	Chair	N/A	No claim
Peter Marks	Non-executive director	N/A	3.6
Ray Dawson	Non-executive director	9.4	11.9
Claire Ward	Non-executive director	7.6	3.5
Tim Reddish	Non-executive director	2.5	3.9
Neal Gossage	Non-executive director	8.2	14.0
Ruby Beech	Non-executive director	No claim	No claim
Graham Ward	Non-executive director	No claim	No claim
Sean King	Non-executive director	No Claim	N/A
Barbara Brady	Specialist Advisor to the Board	No Claim	N/A
Peter Herring	Chief Executive	2.6	0.3
Richard Mitchell	Chief Executive	3.4	N/A
Peter Homa	Chief Executive	N/A	No claim
Suzanne Banks	Chief Nurse	4.9	26.3
Barbara Beal	Chief Nurse	No claim	N/A
Julie Bacon	Executive Director of HR & OD	5.6	0.6
Peter Wozencroft	Director of Strategic Planning and Commercial Development	11.1	4.4
Roz Howie	Chief Operating Officer	2.4	No claim
Denise Smith	Chief Operating Officer	No claim	N/A
Simon Barton	Chief Operating Officer	No claim	N/A
Dr Andrew Haynes	Executive Medical Director	No claim	No claim
Paul Robinson	Chief Financial Officer	4.8	7.8
Paul Moore	Director of Governance	No claim	No claim
Shirley Higginbotham	Head of Corporate Affairs and Company	No claim	0.3

	Secretary		
Kerry Beadling-Barron	Head of Communications	No claim	N/A
Marcus Duffield	Head of Communications	No claim	N/A
	TOTAL	**90.3**	**85.2**

Governors	Constituency	Area	Total 2017/18 £'00	Total 2016/17 £'00
Amanda Brown	Appointed Governor	Ashfield District Council	No claim	No claim
Amanda Sullivan	Appointed Governor	NHS Newark & Sherwood and Mansfield & Ashfield CCG	No claim	N/A
Andrew Berridge	Public Governor	Derbyshire	No claim	N/A
Angie Emmott	Staff Governor	Newark Hospital	0.7	0.7
Ann Mackie	Public Governor	Newark & Sherwood	5.9	3.3
David Payne	Appointed Governor	Newark & Sherwood District Council	No claim	No claim
Dilip Malkan	Staff Governor	King's Mill & Mansfield	No claim	No claim
Carol Atkinson	Co-opted Governor	Derbyshire	0.05	0.1
Morgan Thanigasalam	Staff Governor	King's Mill & Mansfield	No claim	N/A
Ian Holden	Public Governor	Newark & Sherwood	No claim	1.9
Jackie Hewlett-Davies	Public Governor	Ashfield	No claim	No claim
Jane Stubbings	Public Governor	Ashfield	0.2	N/A
Jayne Leverton	Public Governor	Ashfield	No claim	No claim
Jim Barrie	Public Governor	Newark & Sherwood	No claim	3.3
John Doddy	Appointed Governor	Nottinghamshire County Council	No claim	N/A
John Barsby	Public Governor	Mansfield	No claim	No claim
John Roughton	Public Governor	Mansfield	No claim	N/A
John Wood	Public Governor	Mansfield	No claim	No claim
Keith Wallace	Public Governor	Mansfield	0.3	No claim
Kevin Stewart	Public Governor	Ashfield	No claim	No claim
Louise Knott	Appointed Governor	Vision West Notts	No claim	No claim
Martin Stott	Public Governor	Newark & Sherwood	1.4	3.0
Morgan Thanigasalam	Staff Governor	King's Mill & Mansfield	No claim	N/A
Nick Walkland	Public Governor	Rest of East Midlands	5.4	6.6
Ron Tansley	Volunteer Governor	King's Mill & Mansfield	No claim	No claim
Roz Norman	Staff Governor	King's Mill & Mansfield	No claim	No claim
Samantha Annis	Staff Governor	Newark Hospital	No claim	No claim
Sharron Adey	Appointed Governor	Mansfield District Council	No claim	No claim
Susan Holmes	Public Governor	Ashfield	2.2	0.3

Valerie Bacon	Public Governor	Derbyshire	3.5	1.5
Yvonne Woodhead	Appointed Governor	Nottinghamshire County Council	No claim	No claim
TOTAL			**19.65**	**20.7**

Annual Report on Remuneration (subject to audit)

Senior managers' disclosure

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefit (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefit (bands of £2,500)	Total
	£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
Executive Directors												
Mr R Mitchell (Chief Executive Officer) Appointed 1 July 2017	125 - 130	300	0	0	70 - 73	195 - 200	N/A	N/A	N/A	N/A	N/A	N/A
Mr P Herring (Chief Executive Officer) Appointed 19 November 2015 (Managing Director 11 June to 31 October 2016) - left 30 June 2017 - Note 1	65 - 70	300	0	0	0	65 - 70	350 - 355	2500	0	0	0	355 - 360
Mr P Robinson (Chief Financial Officer)	150 - 155	500	0	0	0	150 - 155	150 - 155	800	0	0	0	150 - 155
Ms S Banks (Chief Nurse) Appointed 18 January 2016 - left 31 August 2016 Re-appointed 6 February 2017 - Note 2	125 - 130	500	0	0	75 - 78	200 - 205	65 - 70	2600	0	0	87.5 - 90	155 - 160
Ms B Beal (Chief Nurse) Appointed 7 November 2016 - left post 5 February 2017	N/A	N/A	N/A	N/A	N/A	N/A	20 - 25	0	0	0	0	20-25
Dr A Haynes (Executive Medical Director)	180 - 185	0	0	0	7.5 - 10	190 - 195	180 - 185	0	0	0	20 - 22.5	200 - 205
Ms S Higginbotham (Non-voting Director of Corporate Affairs / Company Secretary)	90 - 95	0	0	0	30 - 33	125 - 130	85 - 90	0	0	0	55 - 57.5	145 - 150
Mr P Moore (Non-voting Director of Governance) Appointed 18 January 2016 - left 1 July 2016 - re-appointed 1 March 2017	100 - 105	0	0	0	35 - 38	135 - 140	50 - 55	0	0	0	0	50 - 55
Mr P Wozencroft (Non-voting Director of Strategic Planning and Commercial Development)	105 - 110	1,100	0	0	67.5 - 70	175 - 180	105 - 110	400	0	0	57.5 - 60	165 - 170
Ms J Bacon (Director of Human Resources)	110 - 115	600	0	0	0	110 - 115	160 - 165	300	0	0	0	160 - 165
Mr S Barton (Chief Operating Officer) Appointed 1 January 2018 - Note 3	30 - 35	0	0	0	72.5 - 75	100 - 105	N/A	N/A	N/A	N/A	N/A	N/A
Mrs D Smith (Chief Operating Officer) Acting from 4 September - 31 December 2017 - Note 3	30 - 35	0	0	0	282.5 - ##	315 - 320	N/A	N/A	N/A	N/A	N/A	N/A
Mrs R Howie (Chief Operating Officer) Appointed 1 October 2016 - left post 3 September 2017 Note 4	50 - 55	200	0	0	252.5 - ##	300 - 305	50 - 55	0	0	0	212.5 - 215	265 - 270
Mr J Scott (Chief Operating Officer) Appointed 23 November 2015 - left 28 September 2016	N/A	N/A	N/A	N/A	N/A	N/A	170 - 175	0	0	0	0	170 - 175
Ms Kerry Beadling-Barron (Non-voting Head of Communications) Appointed 3 July 2017 - Note 3	50 - 55	0	0	0	35 - 38	85 - 90	N/A	N/A	N/A	N/A	N/A	N/A
Mr M Duffield (Non-voting Head of Communications) Acting from 1 April - 30 June 2017	15 - 20	0	0	0	0	15 - 20	N/A	N/A	N/A	N/A	N/A	N/A
Ms J Yeaman (Non-voting Director of Communications) Appointed 1 October 2016 - left 31 March 2017	N/A	N/A	N/A	N/A	N/A	N/A	100 - 105	4000	0	0	0	105 - 110
Ms B Brady (Non-voting Specialist Advisor to the Board of Directors) Appointed 26 March 2018	0 - 5	0	0	0	0	0 - 5	N/A	N/A	N/A	N/A	N/A	N/A
Mrs S Bowler (Executive Director of Nursing and Quality) Left post 30 October 2015 - Note 5	N/A	N/A	N/A	N/A	N/A	N/A	40 - 45	N/A	N/A	N/A	N/A	40 - 45
Non-Executive Directors												
Mr J MacDonald (Chair) Appointed 1 March 2017	50 - 55	2,800	0	0	0	50 - 55	0 - 5	0	0	0	0	0 - 5
Mr S Lyons (Chair) Left 10 June 2016 - Note 6	N/A	N/A	N/A	N/A	N/A	N/A	10 - 15	900	0	0	0	10 - 15
Ms L Scull (Chair) Appointed 11 June - left 23 October 2016 - Note 6	N/A	N/A	N/A	N/A	N/A	N/A	10 - 15	0	0	0	0	10 - 15
Dr P Marks (including Acting Chair from 24 October 2016 to 14 February 2017) Left 14 March 2017 - Note 6	N/A	N/A	N/A	N/A	N/A	N/A	25 - 30	900	0	0	0	25 - 30
Mr R Dawson (including Acting Chair from 14 to 28 February 2017)	15 - 20	900	0	0	0	15 - 20	10 - 15	1200	0	0	0	15 - 20
Mr T Reddish	15 - 20	300	0	0	0	15 - 20	10 - 15	400	0	0	0	15 - 20
Ms C Ward	10 - 15	800	0	0	0	10 - 15	10 - 15	400	0	0	0	10 - 15
Mr G Ward	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Ms R Beech - left 31 October 2017	5 - 10	0	0	0	0	5 - 10	10 - 15	0	0	0	0	10 - 15
Mr N Gossage	15 - 20	800	0	0	0	15 - 20	10 - 15	1400	0	0	0	15 - 20
Dr S King Appointed 24 July 2017 - left 31 December 2017	5 - 10	0	0	0	0	5 - 10	N/A	N/A	N/A	N/A	N/A	N/A

Notes

1 - Mr P Homa (Chief Executive Officer, Nottinghamshire University Hospitals (NUH)) performed the role at both NUH and Sherwood Forest Hospitals from 11 June to 31 October 2016, during which time Mr P Herring performed the role of Managing Director

2 - 2016/17 costs disclosed for Ms S Banks relate to recharges from substantive employer during period of secondedment, plus substantive salary. Pension increase is due to effect of part year appointment in 2016/17 Ms M Sunderland (Chief Nurse, Nottinghamshire University Hospitals (NUH)) performed the role at both NUH and Sherwood Forest Hospitals from 1 September to 6 November 2016

3 - Pension increase is due to the effect of part year appointment in 2017/18 - it is a notional calculation of the pension entitlement to retirement age as defined in the NHS Business Services Authority disclosure instructions

4 - 2016/17 costs disclosed relate to recharges from substantive employer during period of secondment, plus substantive salary. 2016/17 pension increase is due to effect of part year appointment in 2016/17

5 - Salary relates to payments made up to the period of August 2016

6 - Ms L Scull (Chair, Nottinghamshire University Hospitals (NUH)) performed the role at both NUH and Sherwood Forest Hospitals from 11 June to 23 October 2016

All staff costs noted above exclude non-recoverable VAT where charged.

Expenses relate to travel/subsistence claims which may be taxable dependent on value/type

Pensions-related benefit is disclosed for the full year for all senior managers, regardless of their period of time in post

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 the Foundation Trust in the financial year 2017-18 was £180,000 - £185,000 (2016-17, £350,000 - £355,000). This was 7.94 times (2016-17, 15.70 times) the median remuneration of the workforce, which was £22,683 (2016-17, £22,458). In 2017-18, no employees (2016-17, 0) received remuneration in excess of the highest-paid director. Remuneration ranged from £6,648 to £180,000 excluding the highest paid director.

Total remuneration includes salary, non-consolidated performance related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

	2017/18	**2016/17**
Band of highest paid director's remuneration (£000s)	180 – 185	350 – 355
Median total remuneration (£)	22,683	22,458
Ratio of median to highest paid director	7.94	15.70
No. of employees paid more than highest paid director	0	0

The median remuneration is based on annualised, full-time equivalent remuneration of all staff as at the reporting date. This has been calculated excluding any enhancements or overtime payments.

The 2016/17 ratio to highest paid director was calculated based on the mid-point of the reported payments in respect of the highest paid director. These payments reflected invoiced payments made excluding non-recoverable VAT, and as such do not reflect an annualised equivalent salary. On an annualised equivalent salary basis the median remuneration would have been 11.8 times.
There were no agency board members as at 31 March 2018.

Pension disclosure

2017/18

Name and Title		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
Executive Directors		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr R Mitchell	*	2.5 - 5	2.5 - 5	30 - 35	65 - 70	286	49	354	0
Ms S Banks		2.5 - 5	10 - 12.5	45 - 50	140 - 145	798	128	934	0
Dr A Haynes		0 - 2.5	2.5 - 5	75 - 80	230 - 235	1621	112	1750	0
Ms S Higginbotham (nee Clarke)	*	0 - 2.5	0	10 - 15	0	159	36	196	0
Mr P Moore	*	0 - 2.5	0 - 2.5	25 - 30	75 - 80	384	35	423	0
Mr P Wozencroft	*	2.5 - 5	5 - 7.5	35 - 40	90 - 95	565	69	640	0
Mr S Barton	*	0 - 2.5	0 - 2.5	20 - 25	50 - 55	273	13	327	0
Mrs D Smith	*	2.5 - 5	10 - 12.5	30 - 35	85 - 90	333	75	565	0
Mrs R Howie	*	5 - 7.5	10 - 12.5	40 - 45	110 - 115	508	87	716	0
Ms K Beadling-Barron	*	0 - 2.5	0 - 2.5	10 - 15	20 - 25	104	16	126	0

2016/17

Name and Title		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
Executive Directors		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Ms S Banks		0 - 2.5	5 - 7.5	40 - 45	125 - 130	721	44	798	0
Dr A Haynes		0 - 2.5	5 - 7.5	75 - 80	225 - 230	1531	90	1621	0
Ms S Higginbotham (nee Clarke)	*	2.5 - 5	0	10 - 15	0	129	30	159	0
Mr P Moore	*	0 - 2.5	0 - 2.5	25 - 30	70 - 75	428	0	384	0
Mr P Wozencroft	*	2.5 - 5	0 - 2.5	30 - 35	85 - 90	492	73	565	0
Mrs R Howie	*	0 - 2.5	2.5 - 5	25 - 30	85 - 90	343	27	508	0

Notes

Employer's contribution to stakeholder pension has been restated for 2016/17 - it relates to Partnership pension accounts and is not applicable to the Trust

* These members' pension entitlements relate to the total values under two different NHS schemes

The Trust made no payments and the directors are not entitled to receive any benefit under share options or money assets under long-term incentive schemes. In addition, no advances, credits or guarantees have been made on behalf of any of the directors.

The defined benefit pension liability is uplifted in line with the Consumer Price Index (CPI) to calculate the minimum pension increases for index-linked pensions.

Related party transactions

No related party transactions have been identified from a review of the register of interests.

Compliance statement

In compliance with the UK Directors Remuneration Report Regulations 2002, the auditable part of the remuneration report comprises executive director's remuneration and non-executive director's fees

Richard Mitchell
Chief Executive

29 May 2018

Staff Report

The largest group employed by us is nursing, midwifery and health visiting staff, followed by administration and estates staff, then healthcare assistants and other support staff, and medical and dental staff. The smallest group is those employed as healthcare science staff.

Our average workforce numbers from 1 April 2017 to 31 March 2018 are:

Average number of persons employed (Whole Time Equivalent) Subject to Audit

		2017/18		2016/17
	Total	Permanent	Other	Total
Medical and dental	**530**	437	93	**577**
Administration and estates	**1,016**	1,000	16	**1,026**
Healthcare assistants and other support staff	**916**	916		**845**
Nursing, midwifery and health visiting staff	**1,260**	1,127	133	**1,342**
Nursing, midwifery and health visiting learners	**0**	0	0	**1**
Scientific, therapeutic and technical staff	**380**	353	27	**355**
Healthcare science staff	**110**	110		**108**
Other	**9**	9		**29**
Total average numbers	**4,221**	**3,952**	**269**	**4,283**

*Other -relates to the wte of agency staff employed during the financial year

Breakdown of staff (actual headcount as at 31 March 2018)

	Male	Female
Director	11	5
Other Senior Manager	62	124
Employee	823	3667
Total	**896**	**3796**

Staff Costs- Subject to audit

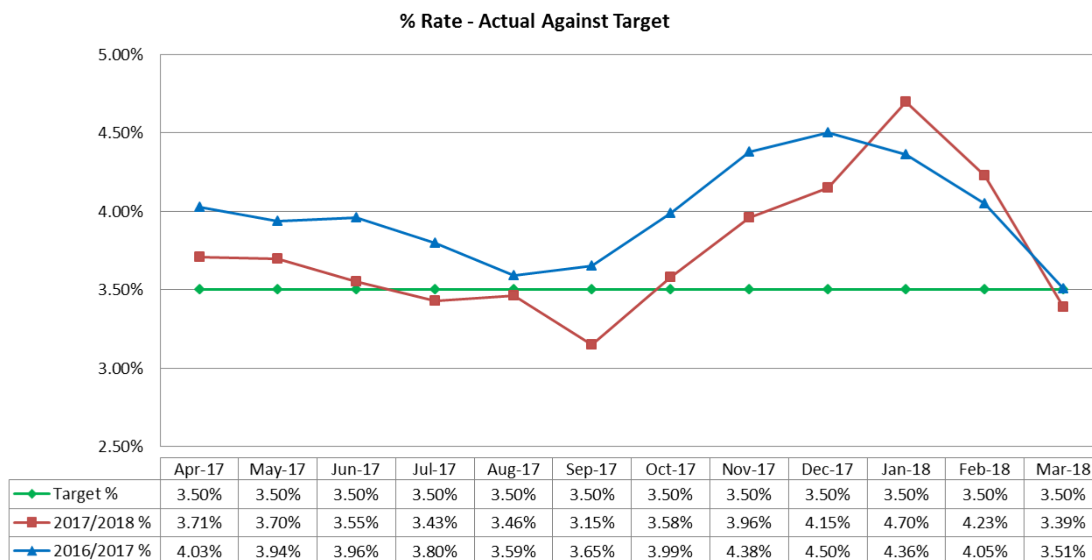
	2017-18			2016-17
	Total	Permanent	Other	Total
	£000	£000	£000	£000
Wages &Salary	147,131	147,001	130	137,365
Social Security Costs	13,693	13,693		13,178
Contributions to NHS Pensions	17,125	17125		16228
Other Pension Costs	29	29		52
Apprenticeship Levy	713	713		0
Agency / Contract Staff	16,774		16,774	29,576
Total	**195,465**	**178,561**	**16,904**	**196,399**

Sickness absence

Our target sickness absence for 2017/18 remained at 3.50%.

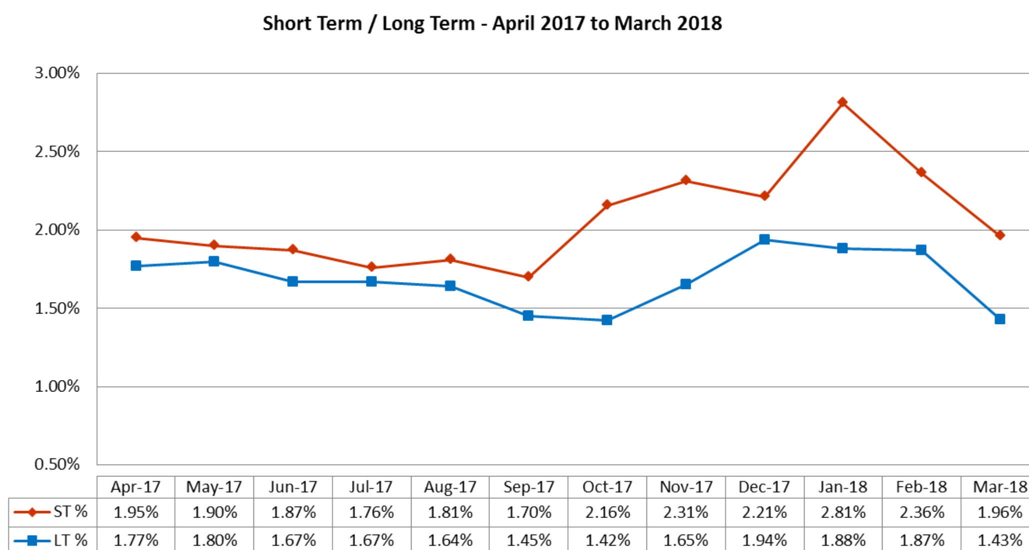
The total sickness absence rate for 2017/2018 was 3.75%, compared to 3.98% in 2016/17. The estimated cost of paying absent staff stood at £4.62m, compared to £4.58m in 2016/2017.

The chart below details our performance against target in month for 2017/2018 against 2016/2017:



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target %	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%
2017/2018 %	3.71%	3.70%	3.55%	3.43%	3.46%	3.15%	3.58%	3.96%	4.15%	4.70%	4.23%	3.39%
2016/2017 %	4.03%	3.94%	3.96%	3.80%	3.59%	3.65%	3.99%	4.38%	4.50%	4.36%	4.05%	3.51%

The graph below shows a comparison of sickness absence rates in terms of short and long-term rates for 2017/2018:



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
ST %	1.95%	1.90%	1.87%	1.76%	1.81%	1.70%	2.16%	2.31%	2.21%	2.81%	2.36%	1.96%
LT %	1.77%	1.80%	1.67%	1.67%	1.64%	1.45%	1.42%	1.65%	1.94%	1.88%	1.87%	1.43%

We maintain our focus on managing short-term sickness absence, with HR business partners supporting divisional managers to monitor trends and carry out absence reviews when required. In 2017 we also launched the Happy Healthy Here campaign to highlight to all the ways we support employees in their health and wellbeing so that they feel fit and well enough to do their job and deliver outstanding patient care.

There is a continuing emphasis on managing long-term sickness with cases being proactively managed according to Trust policy. This approach is supported by occupational health services to ensure that colleagues receive the support and intervention needed to improve their attendance and facilitate their return to work in a constructive way.

Further sickness absence information is outlined below:

	WTE days lost	**Previously reported**				
Staff sickness absence	**2017/18**	**2016/17**	**2015/16**	**2014/15**	**2013/14**	**2012/13**
Days lost (long-term)	24,188	24,387	28,292	24,754	36,945	27,904
Days lost (short-term)	29,723	30,154	27,666	29,761	22,604	29,850
Total days lost	53,911	54,541	55,958	54,515	59,549	57,754
Total Full Time Equivalent (FTE)	3983	3875	3706	3677	3564	3375
Average working days lost	13.54	14.07	15.09	14.83	16.71	17.11
Totals staff in period (headcount)	4692	4558	4357	4301	4500	4312
Total absence rate	**3.75%**	**3.98%**	**4.17%**	**4.12%**	**4.63%**	**4.73%**

Our sickness absence data is outlined below. Please note the figures given are in calendar years (January 2017 to December 2017)

	Figures converted by DH to Best Estimates of Required Data Items		**Statistics Published by NHS Digital from ESR Data Warehouse**		
	Average FTE 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
Sherwood Forest Hospitals NHS Foundation Trust	4,108	36,638	8.9	1,499,478	59,434

Key priorities for 2018/19 in relation to managing sickness absence are:

- Continue to support managers to manage sickness absence effectively, especially targeting new managers by providing key training.
- Continue promotion of Happy Healthy Here and developing other health and wellbeing initiatives to support staff to maintain healthy lifestyles, so preventing future absences.
- Ensure that timely and effective return to work interviews are undertaken by managers.

Staff policies and actions applied during the financial year

We follow a clear governance structure for the approval and ratification of policies and procedures for matters relating to current and prospective staff members. Each policy document has a complete Equality Impact Assessment covering all relevant equality strands. This ensures that we are able to mitigate any possible areas of direct or indirect discrimination as part of the approval and ratification process.

The associated staff member policies capture aspects from the commencement of employment, identifying relevant statutory and mandatory training, and ensuring development to support career progression. Our policies also establish minimum expectations in relation to conduct, behaviour and performance, as well as supportive approaches to allow staff members to raise matters of concern in a safe and protected way.

As at 31 March 2018 we had 38 live policies relating to supporting and developing current and prospective staff. During 2017/18, nine were reviewed and some were consolidated as part of the planned review cycle, making sure that any amendments were aligned with relevant legislative changes and best practice.

We continue to operate fair recruitment practices to ensure equal access to employment opportunities for all. We have been awarded the 'Disability Confident Employer' status which replaced the 'Two Ticks' symbol. This is used on our recruitment material to show we encourage applications from applicants with disabilities. As an employer this status means we are committed to the following:

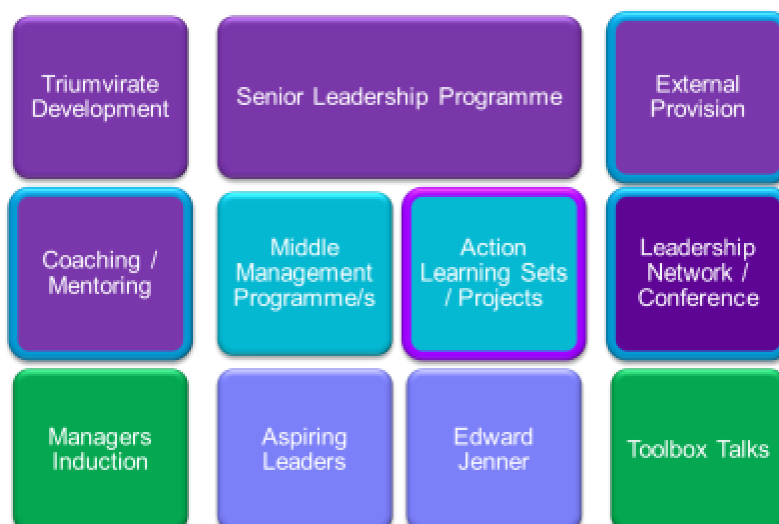
- Interviewing all applicants with a disability who meet the essential criteria for a job vacancy, after any reasonable adjustments are made
- Asking employees with a disability at least once a year what can be done to make sure they can develop and use their abilities at work, usually asked as part of the appraisal process
- Making every effort when employees become disabled to make sure they stay in employment
- Taking action to ensure that all employees develop the appropriate level of disability awareness
- Reviewing these commitments every year and assessing what has been achieved, planning ways to improve on them and letting employees and Jobcentre Plus know about progress and future plans

We continue to be a signatory to the Charter for Employers who are *Positive about Mental Health*, reflecting the general philosophy of *Mindful Employer*. This Charter helps us to support staff who experience mental ill health. This has also been supported through the embracing the "Time to Change" agenda with focus of supporting employees with the opportunities to take about the mental heath agenda. At the end of 31st March 2018 we have 28 employees registered as time to change champions.

We are committed both to providing and maintaining an absolute standard of honesty and integrity in dealing with our assets, and to the elimination of fraud and illegal acts within our organisation. Rigorous investigation and disciplinary or other actions are applied as appropriate. We use best practice, as recommended by NHS Protect and have policies and procedures for colleagues to report any concern about potential fraud. This is reinforced by awareness training.

In 2017, we developed a leadership development framework which sets out leadership career paths and aligns the training to leadership levels. This has now been translated into differing training offerings for staff to progress and develop. The framework describes our blended approach to development, which includes coaching, mentoring and action learning sets.

The leadership development programme has been linked to our annual appraisal programme and aligned to our Workforce Strategy "Maximising our Potential" which delivers our strategic priority 'to support each other to do a good job'.



We have completed a pilot of senior talent conversations using a nin box grid tool. This has been incorporated into the revision of the appraisal system for leaders at 8a and above. Talent conversations for bands 1 to 7 have also been introduced using a simpler tool and embedded into appraisals. The revised appraisals will be supported by a new training programme.

Talent mapping and succession planning work was also undertaken with the deputy tier colleagues as part of the pilot. This is also being rolled out to the tier below in conjunction with the talent conversation training. This is now overseen by a quarterly executive talent group.

This approach has enabled a focus on ensuring consistent achievement of our 95% appraisal rate target with all colleagues having a personal development plan aligned with their appraisal as well as organisational objectives. We ensure that all colleagues attend mandatory training along with having individual personal development plans to ensure we can maximise their potential. Clinical skill developments in conjunction with the Practice Development Team has been refocused and aligned to ensure the clinical standards and competences are aligned to enhancing employee performance.

Occupational Health Services

Our Occupational Health (OH) Service is a comprehensive Nurse led in-house multidisciplinary team. The team plays an active role in supporting staff in return to work and minimising the impact of sickness absence. The service has seen increased activity year on year with a 56.7% increase overall in total number of contacts over the last five years.

Key OH achievements

- A finalist in the 2017 Healthcare People Management (HPMA) Excellence Awards for the range of comprehensive occupational health and wellbeing services available.
- Identified as a best practice case study in relation to provision of occupational health and wellbeing services by NHS Employers.

- Achievement of all national Health &Wellbeing and CQUIN's
- Extremely successful influenza vaccination campaign resulting in a 78.4% front line staff uptake.

Quality

The quality of the OH service is monitored both quantitatively and qualitatively.

Quality is monitored quantitatively via participation in national audit (MoHaWK). This is a national web based benchmarking tool which supports local audit for OH services and measures evidence based clinical practice and processes in order for services to identify if improvements are required. It also allows us to benchmark against our peers. Main results from, Round 11, August 2017, the latest information available, were very positive with national indicator targets for protection of infection, long term case management and reports being released within two days of appointment date surpassed.

Quality is monitored qualitatively by an annual anonymous OH client satisfaction survey (last undertaken May 2017), which provided clear overwhelming evidence that clients rate their experience of OH intervention extremely positively. Results demonstrated that 100% of clients felt listened to, had confidence and trust in the OH professional they saw, felt were involved as much as they wanted in decisions about their care, were treated with respect and dignity and considered that overall, the care they received was either excellent, very good or good.

These results not only demonstrate the exceptional professional knowledge and credibility that our OH staff have, it also reflects that they clearly work in a way that reflects our values and behaviours and are providing outstanding care.

Health and Safety at Work 2017/18

We recognise the importance of ensuring the health and safety of our employees as enshrined within the NHS Constitution. We strive to provide colleagues with a healthy and safe working environment.

Our health and safety team works collaboratively with a wide range of line managers, specialist teams and individuals to secure the health and safety of staff, patients, visitors and contractors. This is in keeping with the ethos of the Health and Safety at Work etc. Act 1974 which recognises that everybody needs to play their part in ensuring that all who come in to contact with our work are kept safe.

We encourage divisional management teams and staff side representatives to work in partnership to ensure that all parties are engaged in health and safety management across the organisation. An additional two days per week have been allocated to appoint a staff side officer for health and safety to complete joint workplace safety audits with our managers to ensure the working environment remains in a safe condition.

Our Health and Safety Committee is the main mechanism for consultation on work related health and safety matters. This forum reports to the Risk Committee which is chaired by the Chief Executive. The Health and Safety Committee also works closely with the Health and Wellbeing group, the Estates Governance Group and the Infection Prevention Committee to ensure that the full range health and safety related risks are properly identified and suitable and sufficient controls are put in place.

We use a range of measures to monitor health and safety performance. One measure adopted is the rate of non-fatal injuries occurring that require reporting to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)2013.

In 2017/18 we reported 12 staff injuries and one patient injury under RIDDOR. We employed 4,692 people in March 2018. The rate of RIDDOR reportable non-fatal injury per 100,000 employees for us was 255.75 against a reported latest national average rate for the human health activities sector of 329 non-fatal injuries per 100,000 employees.

In line with National Health and Safety priorities the work plan for the coming year will focus on the prevention of ill health, with a focus on work related musculoskeletal disorders and work-related stress.

Expenditure on consultancy

Consultants have been used where specific expertise is required which is not available in- house or where the capacity to complete a time limited exercise does not exist. No consultancy has been used for Executive level appointments. We spent £0.09m on consultancy during the year

Off-payroll engagements

The following tables disclose the number of staff with a significant influence over the management of the organisation where payment has been made directly to these staff or their companies, rather than via the Trust payroll.

Table 1
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	Nil
Of which...	
No. that have existed for less than one year at time	Nil
No. that have existed for between one and two years at time of reporting.	Nil
No. that have existed for between two and three years at time of reporting.	Nil
No. that have existed for between three and four years at time of reporting.	Nil
No. that have existed for four or more years at time of reporting.	Nil

Table 2

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	Nil
Of which...	
Number assessed as within the scope of IR35	Nil
Number assessed as not within the scope of IR35	Nil
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	Nil
Number of engagements reassessed for consistency/assurance purposes during the year	Nil
Number of engagements that saw a change to IR35 status following the consistency review	Nil

Table 3

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.	1
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.	1

Process for off-payroll arrangements

Our policy is to avoid the use of off-payroll arrangements for engaging highly paid staff. The only event in which they are used, exceptionally, is where there is a business need to secure skilled expertise we do not currently have for a specific short-term purpose within a defined timescale, and where for whatever reason it is not feasible to engage someone as a direct employee. These appointments will be retained only for the minimum possible time until the requirement for the work is concluded, or a permanent recruitment has been secured. Any off-payroll engagement is subject to approval by a board member on the basis of a clear case of need, and is followed up to ensure that the arrangement has been concluded within the expected timescale.

Exit packages- Subject to Audit

We confirm that there have been no redundancy and termination payments made to serving senior officers within 2017/18. Three Contractual payments in lieu of notice were made totally £22k.

	2017/18			2016/17		
	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band
<£10,000	0	3	3	0	0	0
£10,001 - £25,0000	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of packages by type	0	0	3	0	0	0
Total resource used	0	0	22	0	0	0

	2017/18		2016/17	
	Agreements Number	**Total Value of Agreements £000**	**Agreements Number**	**Total Value of Agreements £000**
Voluntary redundancies including early retirement	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	3	22	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMRC approval	0	0	0	0
Total	3	22	0	0
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

2017 National NHS Staff Survey

We participate in the national NHS Staff Survey on an annual basis. The most recent survey was undertaken in September to December 2017.

We chose to survey all employees and over 2,500 responded giving a response rate of 57%. This was the highest in the East Midlands and joint 7th in England for acute NHS Trusts, where the average was 44%. The 57% response rate compares well with our response rate of 41% in 2016, which was based on a random sample percentage of colleagues being offered the chance to take part.

Survey response rate

Year	Ranking compared to other acute trusts in England	Response rate		Trust improvement or deterioration on previous year
		SFH	(all Trusts in England)	
2016	Below Average	41%	44%	-4%
2017	Highest 20% - 4th in East Midlands Joint 7th in England	57%	44%	+16%

Areas identified for action following the 2016 staff survey

Our 2017 NHS Staff survey responses were largely an improvement on the previous year. This had been influenced by some of the initiatives that we undertook in response to the 2016 NHS Staff Survey findings (see below for examples).

The 2016 results were initially reported to our Organisational Development and Workforce Committee and divisional action plans were developed together with key strands being linked into our Workforce Strategy: Maximising our Potential. Many of the actions during 2017/18 focused on the following areas:

Staff engagement

This continued to be a high priority with activities set out in the Organisational Development and Engagement Plan element of the Workforce Strategy, supported by our Communications Strategy. A formal launch event for Maximising our Potential was held at both Kings Mill Hospital and at Newark Hospital, with all colleagues invited to attend.

Our CEO Richard Mitchell holds a monthly staff briefing across all three sites which makes sure SFH employees receive regular and honest information about our performance, the CQC rating, quality and improvement activities and celebrating achievements.

This was complemented by our senior leaders increasing their engagement. Different tactics were used including CEO and executive open briefing and drop-in sessions held at each hospital site, executive attendance at board rounds on wards and Trust Board member workplace visits designed to increase visibility.

We also launched a reformatted Staff Brief and Staff Bulletin and increased the social media presence of the Executive Team. Our new CEO also introduced his own weekly blog to all employees. From January 2018 a different one of our executive directors writes a monthly blog on their role and a different executive director features in a short video on the Trust performance. We have also refreshed our Star of the Month awards so there are separate categories for clinical and non-clinical staff and it is now judged by members of our Staff Communications and Engagement Forum which is made up of colleagues with different roles from all our sites

These initiatives continue to provide staff with an opportunity to see, hear from and question senior leaders, with divisional representation on the Staff Communications and Engagement Forum continuing to prove beneficial by providing a facility through which to monitor staff engagement, ‘test the temperature’ and explore new initiatives.

Our new Vision and strategic priorities were launched in spring 2017. This was underpinned by work which refreshed our CARE values, which set the professional and behavioural expectations for all employees. Our newly established Organisational Development Team which supports the employee engagement and culture change agenda developed an engagement initiative based on reaffirming these values. This was delivered to workplaces during 2017/18 enabling staff to explore how they live the CARE Values in their daily work and pledging what they will enhance or do differently to contribute to our improvement journey.

Staff well-being and safety activities

These are set out in the Staff Health, Safety and Wellbeing Plan of Maximising our Potential and include embedding as business as usual the CQUIN Staff Health & Wellbeing work undertaken the previous year.

The link between engaged, well-motivated, happy and healthy employees and the delivery of high quality patient care is well documented and pivotal to our engagement philosophy. The 'Happy, Healthy, Here' initiative designed to achieve the CQUIN Staff Health and Wellbeing targets for 2017-18 included an in-house fast-track staff physiotherapy service and health and wellbeing drop-in sessions.

We linked up with the national 'Time to talk' initiative and introduced it to support the mental health and wellbeing of staff, with events held to raise awareness and training provided for Time to Talk Champions.

Creating and maintaining a safe environment is important to us and therefore ensuring that all employees attend high quality mandatory training that reflects best practice is a priority. For all of 2017/18, the compliance rates for attendance on this training continually exceeded the 90% target.
We encourage our colleagues to raise concerns through appropriate mechanisms and to have a culture where they are confident that they will be listened to and have their concern considered. This is achieved by adopting an open door policy with senior leaders being accessible to hear concerns and ideas and promoting a no blame culture.

We initially appointed two Freedom to Speak Up Guardians, increasing this capacity in 2017/18 with the appointment of two more guardians and one champion. Their role and contact details continue to be widely publicised through Staff Brief, the Orientation Day, Staff Bulletins, posters, pop up banners and drop-in sessions. Where colleagues raise concerns we ensure that these are addressed appropriately and that feedback is provided to the person raising the concern. The concerns raised are monitored for themes and trends, periodically reported to the Executive Team and the Trust Board and triangulated with Key Performance Indicators, findings from pulse surveys and feedback from leavers.

Valuing staff

These initiatives were set out in the Recruitment, Reward and Retention Plan of Maximising our Potential and the organisations Communication Strategy. We reviewed how we engaged with potential recruits and refreshed our recruitment branding, microsites and our presence on social media. Alternative approaches to selection including assessment centres and values based recruitment have offered personalised approaches to the selection and appointment of future members of #TeamSFH.

In addition, we actively engage with new starters prior to them commencing employment through our Welcome Assure Reassure Meet (WARM) principals. This means that staff feel welcome and valued from the start of their employment journey at Sherwood.

Retention initiatives were introduced designed to promote the key benefits available to Trust staff, together with further investment in the Occupational Health Department, particularly to create targeted wellbeing at work activities which draw on the benefits of early intervention.

Developing Trust Leaders and Staff

The Leadership, Talent Management and Succession Plan and Training, Learning and Development Plan set out initiatives for improving the development of our leaders and employees. A formal leadership talent mapping and succession planning system was created and piloted which documents and supports the readiness of our existing senior leaders for progression. It also identifies areas of risk. This will be integrated into the appraisal

process next year, when the process is revised to include talent conversations for staff at all levels. This follows on from the work in 2017/18 which introduced a management appraisal for our colleagues who are in formal medical leadership roles.

In 2017/18 we refreshed our leadership development programmes and introduced a leadership framework. Our facilitators have been instrumental in the delivery of the first Mary Seacole Leadership Development programme for the wider health and social care system, through effective cross-organisational partnership working. We also introduced an interactive networking Managers Induction Programme for new managers and leaders in order to ensure a seamless transition into their leadership role. In total, more than 400 of our leaders accessed a range of leadership and management courses throughout 2017/2018.

Summary of performance for 2017 NHS staff survey

Much of the work undertaken during the first half of 2017/18 will have had a positive impact on the 2017 NHS Staff Survey. However, in keeping with all other NHS Trusts in the country, we continued to operate against a backdrop of significant financial pressures and continued high demand on services. Despite these pressures we have made significant and sustained improvement.

The survey is comprised of different sections, or 'key findings', which pursue a specific line of questioning, for example, Job Satisfaction, Patient Experience and Care. Our results improved in three key findings with no change in 28 key findings, with deterioration in only one key finding.

The following tables show how the findings for us compare with the national average for similar Trusts in England, demonstrating at a high level the overall improvement achieved particularly over the last three years.

Summary of all key findings for 2014, 2015, 2016 and 2017

	2014 (29)	**2015 (32)**	**2016 (32)**	**2017 (32)**
Best 20%	1	2	8	8
Better than the average	5	3	8	10
Average	4	9	6	9
Worse than the average	11	6	7	2
Worst 20%	8	12	3	3

Overall indicator of staff engagement

Very positively, the overall indicator of staff engagement for us was 3.87, which was well above average when compared to Trusts of a similar type. This was a further increase on the previous year's score of 3.85, when we were again above average, demonstrating significant and sustained improvement.

NHS Staff Survey Comparison for Overall Staff Engagement for 4 years			
Overall Staff Engagement 2014	3.66	Average for acute Trusts in England	3.74
Overall Staff Engagement 2015	3.68	Average for acute Trusts in England	3.79

Overall Staff Engagement	Score	Comparison	Average
Overall Staff Engagement 2016	3.86	Average for acute Trusts in England	3.81
Overall Staff Engagement 2017	3.87	Average for acute Trusts in England	3.79

Where staff experience has improved

- Key Finding 23 - Percentage of staff experiencing physical violence from staff in the last 12 months
- Key Finding 10 - Support from immediate managers
- Key Finding 6 - Percentage of staff reporting good communication between senior management and staff

Our work during 2017 to support staff engagement and senior leadership visibility, together with an awareness programme relating to physical violence is likely to have had an impacted here.

In 2016 Key Finding 6 - Percentage of staff reporting good communication between senior management and staff, was worse than average. However it has moved from 29% in 2016 to 34% in 2017 which is now in the average category for acute Trusts in England.

Where staff experience has deteriorated

- Key Finding 28 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month.

This is of concern and will be picked up in action plans arising from the survey.

Highest and lowest ranking scores

The rankings show how our 2017 staff survey results compare with other acute Trusts in England.

2017 Top five ranking scores

- Key Finding 2 - Staff satisfaction with the quality of work and patient care they are able to deliver. No change. We are in the highest (best) 20% of acute trusts in England. **4th nationally and top in the East Midlands.**
- Key Finding 9 - Effective team working. No change. We are in the highest (best) 20% of acute trusts in England. **4th nationally and top in the East Midlands.**
- Key Finding 21 - Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. No change. We are in the highest (best) 20% of acute trusts in England. **6th nationally and top in the East Midlands.**
- Key Finding 11 - Percentage of staff appraised in the last year. No change. We are in the highest (best) 20% of acute trusts in England. **7th nationally and top in the East Midlands**.
- Key Finding 20 - Percentage of staff experiencing discrimination at work in the last 12 months. No change. We are in the lowest (best) 20% of acute trusts in England. **10th nationally and second in the East Midlands.**

These scores evidence a much more positive culture emerging in the Trust.

2017 Bottom five ranking scores

- Key Finding 22 - Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months. No change. We are in the highest (worst) 20% of acute trusts.
- Key Finding 24 - Percentage of staff/colleagues reporting most recent experience of violence. No change. We are in the lowest (worst) 20% of acute trusts.
- Key Finding 18 - Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves. No change. We are in the highest (worst) 20% of acute trusts.
- Key Finding 27 - Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse. No change. We are below (worse than) average for acute trusts.
- Key Finding 28 - % of staff witnessing potentially harmful errors, near misses or incidents in the last month. Increase (worse than 2016). We are above (worse than) average.

On a positive note, these are the only five scores that were actually worse than average. The percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months, Key Finding 22 and Key Finding 18 – the percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves were also amongst our bottom five scores in 2016. Steps were taken during 2017 to make staff more aware of reporting procedures if they experience physical violence together with general awareness. This appears to have resulted in a positive reduction in the percentage of staff experiencing physical violence from other staff in the last 12 months which is one of our significant areas of improvement. However, it is clear that there is still an issue with staff experiencing physical violence from patient and relatives.

We have a rigorous sickness absence management policy which is actively implemented which may be leading to the high score for the percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves. During 2017 the Trust increased its staff wellbeing events and interventions which will continue during 2018.

Staff recommending the Trust as a place to work or receive treatment

This is one of the significant measures in the NHS staff survey results. Questions Q21a, Q21b,Q21c and Q21d feed into the overall score of Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment.”

	2015	2016	2017	**2017 av.
Q21a “Care of patients/service users is my organisation’s top priority”	71%	82%	81%	76%
Q21b “My organisation acts on concerns raised by patients/service users”	65%	76%	76%	73%
Q21c “I would recommend my organisation as a place to work”	48%	68%	70%	61%
Q21d “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation”	57%	74%	78%	71%
KF1 Staff recommendation of the organisation as a	3.54	3.87	3.93	3.76

place to work or receive treatment*

** Possible scores range from minimum 1 to maximum 5*

The results of this show a marked improvement in all areas to well above the **national average for acute Trusts in England. Staff recommending us as a place to work is now 9% above this average and staff being happy with the standard of care provided by SFH is 7% above the average. This places us in the top 20 acute Trusts in England for this important measure and second in the East Midlands

Staff Friends and Family Test

The Staff Friends and Family Test (FFT) has been in place since April 2014 and was designed as a tool to support local improvement. Results are submitted to NHS England and are published nationally. All staff must have the opportunity to respond at least once in the year. The survey has to be undertaken in quarters one, two and four (there is no requirement for quarter three because the NHS Staff Survey is undertaken at this time).

The Staff FFT asks our staff to rate how likely (using a scale between extremely likely and extremely unlikely) they would be to recommend the organisation to family and friends as a place to:

1. Receive care or treatment
2. Work

The following table summarises the FFT results from 2017/18.

	Q1 FFT	Q2 FFT	Q3 Staff Survey	National Average
How likely would you be to recommend this organisation to friends and family if they needed care or treatment?	85.71%	89.69%	78%	71%
How likely would you be to recommend this organisation to friends and family as a place to work?	71.43%	71.82%	70%	61%
Number of respondents	21	291	2,515	

The Q3 NHS Staff Survey questions are slightly different:

1. *"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"*
2. *"I would recommend my organisation as a place to work"*

It is a requirement to provide a free-text follow up question for each of the two areas, to request the main reason for the answer given. This enables our staff to provide more detailed feedback should they wish. Although the free-text responses are not submitted to NHS England, we use this feedback to inform and support improvements to benefit both staff and the patient experience.

Pulse survey

In quarters one and two we asked additional questions in the staff FFT to help us better understand our employees' views on:

- Q1 – Bullying, harassment, violence and aggression
- Q2 – Health and wellbeing with a particularly focus on mental health

The findings informed aspects of our action plan in response to the 2016 Survey. Additionally the feedback was used alongside the information gained from exit interviews, to monitor progress of our action plans and to inform future initiatives, to improve the experience of staff and patients.

Leaver interviews

Colleagues leaving our employment are offered a leaver interview. This can be with their line manager, higher line manager or a trained volunteer. Alternatively, staff can complete a leaver questionnaire, which can be done online or via a paper copy which is then returned to the Human Resources (HR) Team.

This feedback is valued and triangulated with Key Performance Indicators (KPI's) as well as results from both the staff survey and the quarterly staff FFT. This helps us to understand our colleagues experience more effectively. HR Business Partners (HRBP) and Assistant HR Business Partners (AHRBP) utilise this information to identify trends, inform initiatives and support the coaching and mentoring work they undertake with managers.

Where a leaver's feedback raises a concern or identifies an issue, work is undertaken discretely to explore and address the problem. Any significant concerns initiate an investigation.

The number of colleagues agreeing to give feedback as they leave has decreased and remains low. Following a review of the leaver feedback process and questionnaire, the option for staff to complete a questionnaire on-line was introduced from 1 April 2016. However, this has not increased the number of completed leaver questionnaires. In an attempt to increase feedback the questionnaire has been revised and leavers will now receive an email with a link to the leaver questionnaire inviting them to give feedback. The option for an interview is still offered. The revised system is due to be launched in April 2018.

Future priorities, targets and monitoring

The 2017 staff results have been communicated to staff in an electronic briefing, supported by further communications, including a video message from the CEO and divisional videos, detailing the actions that will be taken as a result of the staff survey feedback. There were also a number of individual suggestions for improvement that were captured in the free text which are being explored.

The results were discussed at the Staff Communication and Engagement Forum to obtain their views on priority actions. In addition, the Director of Human Resources and Organisational Development held four hour long drop-in session across all three sites during March 2018 with an open invitation for any employee to attend and offer further feedback. The quarter four pulse survey in March 2018 also contained a number of follow-up questions.

Our clinical divisions have scrutinised their staff survey results to identify actions which were shared at the Senior Leadership Team Development day in February 2018. Delivery of those actions will be monitored at the monthly Divisional performance meetings with Executives.

Following the release of the staff survey information the Trust Board meeting and a number of communications / events were held with colleagues such as:

- Headline results communicated through the Chief Executives weekly blog
- Drop-in sessions held by the Director of HR and OD
- Results contained in the weekly bulletin
- Videos shared with colleagues of the main points, including positive findings and areas for action by each of the clinical divisions.

The Director of Human Resources and Organisational Development has also taken responsibility for a number of Trust wide actions relating to the following:

- A review of our sickness absence policy, toolkit and training in order to find a balance between rigorous management of sickness and a compassionate approach so that colleagues do not feel pressure to attend work when they are unwell.

- Development of an approach to tackle nepotism and preferential treatment in the organisation as this was an issue raised in a number of free text remarks.

- Promotion of more inclusive team working. Although we scored highly in the staff survey for team working, occasionally teams have a culture that is so strong that people around them can feel excluded and it can be difficult for new team members to settle in. These are often high performing teams. We want to preserve the motivation and enthusiasm shown by these teams but at the same time encourage them to become more inclusive.

In addition to this, divisional areas have identified, agreed and committed to take the following actions forward:

- Facilitated feedback sessions to gather more background to the staff survey information.
- The Divisional Management Team (DMT) members now participate in a 'back to the floor' session
- The Divisional General Managers have written to all staff in the Division in order to update on outcomes and ask for suggestions for actions; feedback posters are also to be put up around the Division where colleagues can add suggestions.
- Colleagues have been given the opportunity to shadow senior managers and to attend divisional board meetings
- Communication plans for the Division, service lines and teams are being reviewed to ensure every employee is included and exploring use of social media such as a Divisional What's App groups. There are also "You said: We Did" communications.
- A Star of the week has been introduced
- CARE values sessions are to be delivered in specific areas
- a monthly divisional newsletter has been introduced

- "Thank you" post cards are to be sent from the division to staff outside of the division who have helped and supported the division in some way, thereby promoting inert team working. Further staff awards are still being considered by the DMT.

There are also initiatives for incorporation into the Workforce Strategy 2018/19 Implementation Plans. These include continuation of engagement activities, a focus on staff health and well-being and diversity and inclusivity. Some of the results will also feature in our recruitment campaigns. Additionally we will be working with NHS Elect to develop a new senior leadership development programme, to support our talent management and succession planning approach, which will commence in late 2018.

In conclusion the improvements in the 2017 staff survey results, especially the positive overall score for staff engagement, are heartening and give us a good platform upon which to both consolidate and build upon, to support our journey to outstanding. The measures that have been identified from the staff survey identify clear opportunities for further progress and act as a clear platform for medium term development.

Equality Reporting

We are committed to providing an environment where all staff, service users and carers enjoy equality of opportunity. We understand the importance of being compliant with equality legislation, and acknowledge the benefits and contributions that managing equality and diversity make to the achievement of our business objectives in the areas of employment, service planning and service delivery.

We have a Diversity and Inclusivity Group to support activities within the Trust to ensure the statutory board responsibilities and obligations under law relating to equality and diversity are met, plus raise awareness and promote diversity and inclusivity across the Trust. The Diversity and Inclusivity Group has continued to take forward the equality and diversity agenda by ensuring that equality legislation is embedded across the organisation whilst also working at operational levels within divisions and corporate areas. Our objectives reflect an inclusive approach to the protected characteristics of the Equality Act 2010.

We have a number of Time to Change Mental Health employee champions in addition to our BAME (Black, Asian and Minority Ethnic) and LGBT (Lesbian, Gay, Bisexual and Transgender) support networks. They provide an appropriate opportunity for staff and patients either to raise their concerns safely and confidentially, or to offer suggestions on how to improve the working environment and patient care in relation to mental health, BAME and LGBT groups.

The Diversity and Inclusivity Group regularly review reports on equality data, including workforce information, recruitment data, the workforce race equality standard, the equality delivery system (EDS2) and the staff survey. An Equality Dashboard was created in 2017/2018 with this data and is reviewed by the group on a six monthly basis, investigating equality patterns to improve the experience of staff and patients. An EDS2 working group to further analyse the EDS2 results from 2017 is in the process of being developed.

We continue to operate fair recruitment practices to ensure equal access to employment opportunities for all. We have been awarded the 'Disability Confident Employer' status for a further two years and have also signed up to the Time to Change, Dying to Work and Safe Places charters in 2017/2018. We continue to be a signatory for an eight year to the Mindful Employer Charter for Employers who are positive about Mental Health. This Charter helps us to support staff who experience mental ill health, along with the Time to Change charter.

Valuing our Members

		Total membership (March 2018)
Mansfield	includes the geographic boundaries of Mansfield District Council and the ward of Welbeck from Bassetlaw District Council	5242
Ashfield	includes the geographic boundaries of Ashfield District Council and the wards of Ravenshead and Newstead from Gedling District Council	5100
Newark and Sherwood	includes the geographic boundaries of Newark and Sherwood District Council plus wards from Bassetlaw, South Kesteven and Rushcliffe District Councils	4110
Derbyshire	includes wards from Bolsover and North East Derbyshire District Councils	1757
Rest of East Midlands	includes the remainder of the East Midlands region which is not covered in the other constituencies	901
Rest of England		151

Public membership breakdown at 31 March 2018

	Number of Members	**Membership Profile**	**Population Profile**	**Trend**
Age (years)				
0 – 16	1	0.01%	19.6%	↓
17 – 21	97	0.56%	6.27%	↓
22+	15,913	92.08%	74.13%	↑
Not Stated	1,270	7.35%	0%	→
Ethnicity				
White	15,519	89.80%	89.09%	↑
Mixed	32	0.19%	1.90%	↓
Asian	87	0.50%	6.44%	↓

Black	35	0.20%	1.79%	↓
Other	8	0.05%	0.78%	↓
Not stated	1,600	9.26%	0%	→
Gender				
Male	6,297	36.44%	49.42%	↓
Female	10,767	62.31%	50.58%	↑
Not stated	217	1.26%	0%	→

Membership activity throughout the year

As part of our commitment to having an active membership, we have worked with the Governors' Membership and Engagement Committee during 2017/18 to improve our knowledge of our membership through surveys and events to enable us to build a stronger, more fulfilling membership experience. The focus has been on how we can best engage with members and what their key areas of interest might be, in order to utilise our loyal membership to support us in understanding how the Trust is perceived externally and where we need to focus our improvement efforts.

As in previous years we have actively communicated and engaged with members and potential members throughout the year using a variety of methods, including:

Member Events

These are held at locations across the area including King's Mill, Newark and Mansfield Community hospitals and are open to all members.

- **Meet your governor events:**

These events, undertaken across all three hospital sites on a monthly basis, enable governors to engage directly with members and to gain feedback on the quality of services provided at each location. Comments received, both positive and negative, are fed back to the relevant service areas to promote learning and improvement.

- **Member engagement events:**

These events were delivered across all three hospital sites. Member events included dementia and falls, dementia friends training and an older person event. Going forward for 2018, we will be introducing digital events to showcase our services and reach out to more members.

- **Community member engagement:**

We continue to work closely and engage with our members and community and attended the Newark Hospital open day, West Nottinghamshire College open evening and also the King & Miller to Kingfisher project with the opportunity to provide first aid and dementia friends training sessions.

- **Annual General Meeting/Annual Members' Meeting:**

Held on 25 September 2017 at King's Mill Hospital, this event was attended by members who visited the interactive display stands as well as attending the "Neil's story members' event" and the Annual General Meeting itself.

We will continue to work closely with our members to help us to be truly accountable for the quality of the services we provide to our local communities.

Members can contact their governors either through our website or by contacting the Head of Corporate Affairs/Company Secretary, Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, HG17 4JL.

Valuing our Governors

As an NHS Foundation Trust we are accountable to the Council of Governors, which represents the views of members. The two key statutory duties of the Council of Governors are:

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- To represent the interests of our members and of the public.

In addition, the Council of Governors, amongst other matters, is responsible for making decisions regarding the appointment or removal of the Chairman, the non-executive directors and our External Auditors.

The Trust's Constitution makes clear the process to appoint or remove the Chair and the other non-executive directors, including the governors' role in deciding the remuneration and allowances and other terms and conditions of office of the non-executive directors.

The Council met a number of times during the year (see table). The meetings were well attended, with wide ranging debate across a number of areas of interest.

During the year the Chair and the Council of Governors have agreed and implemented a new process to enable a more robust approach for 'holding the non-executive directors' to account. This means there are now at least two governors, acting as observers, on each of the Board committees and the Governor, Performance and Strategy and Patient Quality and Experience Committees have been suspended until a review of the new process is undertaken later in 2018. The governors also agreed the Membership and Engagement Committee should include all Council members and has therefore been re launched as the Membership and Engagement Group. The Nominations and Remuneration committee remains and reports to the Council with recommendations regarding appointments, removal and any other requirements appropriate to their role

During the year, the Council also recruited a new non-executive director with a clinical background to enable a wider debate in Board and at the Council.

Attendance at Council of Governor meetings

There have been four general Council meetings and one extra-ordinary meeting during the year. The following table details the governors, the constituency they represent, their attendance and the date of their appointment.

NAME	AREA COVERED	CONSTITUENCY	TERMS OF OFFICE	DATE ELECTED	NUMBER OF MEETINGS ATTENDED
Amanda Sullivan	M&A and N&S CCG	Appointed	1	01.06.17	3/5
Andrew Berridge	Derbyshire	Public	3	01.11.17	1/2
Angie Emmott	Newark Hospital	Staff	3	01.05.16	4/5
Ann Mackie	Newark & Sherwood	Public	3	01.05.16	5/5
Carol Atkinson	Derbyshire	Co-Opted	1	01.11.16	2/3
Councillor Amanda Brown	Ashfield District Council	Appointed	1	25.07.17	0/3
Councillor David Payne	Newark & Sherwood District Council	Appointed	1	01.06.17	5/5
Councillor John Doddy	Nottinghamshire County Council	Appointed	4	25.07.17	1/3
Councillor Sharron Adey	Mansfield District Council	Appointed	4	01.06.15	0/5
Dilip Malkan	King's Mill Hospital	Staff	3	01.05.16	0/5
Ian Holden	Newark & Sherwood	Public	3	01.05.16	4/5
Jackie Hewlett-Davies	Ashfield	Public	3	01.05.16	5/5
Jane Stubbings	Ashfield	Public	3	01.11.17	1/2
Jayne Leverton	Ashfield	Public	3	01.05.16	4/5
Jim Barrie	Newark & Sherwood	Public	3	01.05.16	5/5
John Barsby	Mansfield	Public	3	01.11.14	2/3
John Roughton	Mansfield	Public	3	01.11.17	1/2
John Wood	Mansfield	Public	3	01.05.16	2/5
Keith Wallace	Mansfield	Public	3	01.05.16	4/5
Kevin Stewart	Ashfield	Public	3	01.11.14	1/3
Louise Knott	Vision West Notts	Appointed	3	01.03.15	2/5
Martin Stott	Newark & Sherwood	Public	3	01.05.16	3/5
Morgan Thanigasalam	King’s Mill Hospital	Staff	3	01.11.17	2/2
Nick Walkland	Rest of East Midlands	Public	3	01.05.16	4/5
Ron Tansley	King's Mill Hospital	Volunteer	3	01.05.16	3/5
Roz Norman	King's Mill Hospital	Staff	3	01.05.16	2/5
Samantha Annis	Newark Hospital	Staff	3	01.05.16	4/5
Susan Holmes – Lead Governor	Ashfield	Public	3	01.11.17	4/5
Valerie Bacon	Derbyshire	Public	3	01.08.16	4/5

It has been a very busy year for our governors who, together with attending the Council of Governors meetings as indicated in the table above, also attended numerous governors' training and development sessions both internal and external, membership engagement events, and various committees. These included Trust Board committees where governors act as observers and report back to Council of Governor meetings. A focused development session was held with the governors with regard to the refresh of the two year annual plan and governors contributed to the discussion and debate utilising the knowledge received from their engagement with members and the public.

This reflects another excellent year of working together, with governors and Board members being involved in a number of visits across local healthcare settings. This activity supports us in our continuous efforts to improve healthcare delivery, as well as enabling governors to be visible within both their constituencies and the organisation so they can engage with members and the general public.

We acknowledge and respect the unique contribution of individual governors and the Council of Governors as a whole in contributing to our future development. We are also grateful for the support of the Lead Governor, Sue Holmes, who has supported the Chair and Company Secretary to enhance the relationship between the Board of Directors and the Council of Governors.

Governor elections 2017

Governor elections took place in the summer of 2017, with four public governors: two governors from the Ashfield constituency, one governor from the Mansfield constituency and one governor from the Derbyshire constituency together with one Staff governor for Kings Mill and Mansfield Community Hospital being elected for three years. Unfortunately there remain two unfilled vacancies on the Council for one public Governor for the Mansfield Constituency and one Staff Volunteer governor for Newark Hospital. The Council of Governors agreed to hold these vacancies until the next scheduled election in 2019 unless further vacancies arise before then, when the Council will review the situation.

Both new and existing governors have undertaken their statutory duties with enthusiasm and we appreciate their commitment as we continue our improvement journey into 2018/19.

Lead Governor Annual Report 2017/18

It has been another busy but fascinating year as Lead Governor. Below are some of the key events and my personal highlights from the last 12 months.

I was privileged to be involved in the judging of the Staff Excellence Awards in October and was amazed to find there had been around 350 nominations. Reading them made me very proud to be a governor of hospitals with such dedicated and caring staff. The night was a celebration of their successes and was one of the highlights of my year.

Another favourite moment was attending the long service awards presentations for our volunteers. Again I am amazed that so many people – around 600 – give so freely of their time to make our hospitals the friendly places that they are. The volunteers provide so much support for us, including their current appeal to raise £550,000 needed for a new scanner. Knowing the support they have out in the community, I'm in no doubt they will be successful with this.

We held a round of elections for six governors, with one staff governor required to cover King's Mill and Mansfield Community Hospital sites and five vacancies for public governors in the Mansfield (x2), Ashfield (x2) and Derbyshire constituencies.

More than 1,100 votes were cast across the constituencies and the following candidates were elected:

- Morgan Thanigasalam, Staff Governor for King's Mill and Mansfield Community Hospitals
- John Roughton, Public Governor for Mansfield
- Jane Stubbings, Public Governor for Ashfield
- Sue Holmes, Public Governor for Ashfield
- Andrew Berridge, Public Governor for Derbyshire

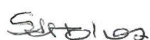
We welcomed our new governors on 1 November 2017.

One of our main functions is to interact with our constituents and we have been looking at how we can improve this. One of the exciting changes has been to introduce Meet Your Governor events.
For one week every month the governors take it in turns to spend hour-long sessions across our three sites to speak to our members as well as members of the public. We have now engaged with hundreds of patients and visitors on our 'Meet the Governor' days – mainly we ask 'How was your visit today?' We have had many positive comments but any negative ones are either raised with the Patient Experience Team at the time if they are serious, or are collated and discussed at the Membership and Engagement Group. This system only started in January 2018 and so we are planning to evaluate it in autumn 2018 to see how it has gone but so far, so good!

The Meet Your Governor events are good for speaking to public and patients in the organisation but we also want to increase our visibility in the community. Many governors are now members of their GPs Patient Participation Group and I have received many requests from others. Again this is an excellent way of obtaining feedback on our services as well as promoting the role of governors and why people should become members.

We've also continued to support the Trust in a number of ways this year by becoming observers on Board committees. Although this has only recently started, it provides us with a channel for learning more about the workings of the organisation which is useful for our roles, and supports us in one of our key duties which is to hold the non-executive directors to account.

In the next 12 months we will be focusing on another governor election in March 2019 and reviewing our new engagement methods to see which are working and which need further tweaking



Sue Holmes
Lead Governor

NHS Foundation Trust Code of Governance

Sherwood Forest Hospitals 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.

Relating to	***Code of Governance* reference**	**Summary of requirement**	**Reference** **Page numbers**
Board and Council of Governors	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.	74 78 -79
Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the 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.	24 35-36 24
Council of 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.	66-67
Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	66-67

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.	23
Board	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.	23 (refer to website for profiles)
Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	33
Nominations Committee(s)	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.	31
Nominations Committee(s)	n/a	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.	36
Chair/Council of Governors	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.	24
Council of Governors	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.	67-68
Council of Governors	n/a	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	N/A

		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)	
Board	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.	30 32 73-76 82
Board	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.	N/A
Board	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. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.93.	23
Board	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.	85
Audit Committee/control environment	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	79 77-79 90 92

		internal control processes.	
Audit Committee/ Council of Governors	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.	N/A
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • 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 • 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.	76 79 79
Board/Remuneration Committee	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.	N/A
Board	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	65

		council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	
Board/Membership	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.	63 -65
Membership	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.	65
Membership	n/a	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 [see also E.1.6 above], including progress towards any recruitment targets for members.	63 -65
Board/Council of Governors	n/a	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. See also ARM paragraph 2.22 as directors' report requirement.	25

Our Board of Directors is focused on achieving long-term success for the organisation and our vision of becoming an outstanding organisation, through the application of sound business strategies and the maintenance of high standards in corporate governance and corporate responsibility. The following statements explain our governance policies and practices, and provide insight into how the Board and management run the Trust for the benefit of patients, carers, the community and our membership.

Our Board of Directors brings a wide range of experience and expertise to its stewardship of the organisation and continues to demonstrate the vision, oversight and encouragement required to enable our organisation to thrive and improve on a continuous basis. During the past year we welcomed a number of substantive new members to the Board, each bringing excellent skills and expertise to the organisation and providing crucial stable leadership.

At the end of the year the Board comprised six non-executive directors including the Chair (holding majority voting rights), six executive directors (voting), including the Chief Executive, and four corporate directors (non-voting).

The Chair is responsible for the effective working of the Board, for the balance of its membership subject to board and governor approval, and for making certain that all directors are able to play their full part in setting and delivering our strategic direction and ensuring effective and efficient performance. The Chair conducts annual appraisals of the non-executive directors as well as the Chief Executive.

The Chief Executive is responsible for all aspects of the management of the organisation. This includes developing appropriate business strategies agreed by the Board, ensuring that related objectives and policies are adopted throughout, the effective setting of budgets, and monitoring performance. The Chief Executive is also responsible for conducting the annual appraisals of the executive and corporate directors of the Board.

The Chair, with the support of the Company Secretary ensures that the directors and governors receive accurate, timely and clear information. Directors are encouraged to update their skills, knowledge and familiarity with the organisations business through their induction, on-going participation at Board and committee meetings, attendance and participation at development events and through meetings with governors.

There is an understanding that any non-executive director, wishing to do so in the furtherance of their duties, may take independent professional advice through the Company Secretary at the organisation's expense. Our non-executive directors offer a wide range of skills and experience and bring an independent perspective on issues of strategy, performance and risk through their contribution at board and committee meetings. The Board considers that, throughout the year, each non-executive director has been independent in character and judgement and met the independence criteria set out within Monitor's (now part of NHS Improvement) Code of Governance. Non-executive directors have ensured they have sufficient time to carry out their duties. During the year, time has been spent with governors to help understand external views of the organisation and our strategies, and all Chairs of Board Committees and the Chief Executive attend the Council of Governors.

A number of key decisions and matters are reserved for the Board's approval and are not delegated to management. Our Board delegates certain responsibilities to its committees, to assist it in carrying out its function of ensuring independent oversight. The Board of Directors has a formal schedule of matters reserved for its decisions and has in-date and relevant terms of reference for all board committees. Monthly updates on our performance are discussed at the Board of Directors meetings. The Board delegates the management of overall performance to the Chief Executive who leads the setting of clear priorities so that the organisation is managed efficiently to the highest quality standards and in keeping with our values.

The Board committees report annually on their effectiveness and review their Terms of References and work plans to ensure alignment with organisations priorities and the Board work schedule.

Our engagement policy outlines the mechanisms by which the Council of Governors and Board of Directors communicate with each other to support engagement, ensure compliance with the regulatory framework and specifically provide for any circumstances where the Council of Governors may raise concerns about the performance of the Board of Directors, compliance with the Trust's Provider Licence, or other matters related to the overall wellbeing of the organisation.

Counter fraud

Our Board of Directors attaches significant importance to the issue of fraud and corruption. Reported concerns have been investigated by the local counter fraud specialists in liaison with NHS Protect. All investigations are reported to the Audit and Assurance Committee.

We continue to work to maintain an anti-fraud culture and we have in place a range of policies and procedures to minimise risk in this area. Staff have access to counter fraud awareness training, which forms part of staff induction training on joining the organisation and a number of bulletins were issued during the year to highlight how colleagues should raise concerns and suspicions. In November 2017 we took part in Fraud Awareness Month and a number of alerts were issued to employees' e.g. online fraud, telephone scams and a counter fraud staff survey. We also disseminates the counter fraud newsletter 'Fraudulent Times' which helps raise awareness of fraud cases: how to identify where and how fraud can occur.

NHS Resolution

The Trust's CNST premium has increased by £1.84m in 2017/18 (£8.74m to £10.58m). This represents a 21% increase, which compares with the average national increase of 17.5%.

Committees of the Board

All committees of the Board are chaired by a non-executive director. In 2017/18 these committees included:

- The Quality Committee, which enables the Board to obtain assurance regarding standards of care and to ensure that adequate and appropriate clinical governance structures, processes and controls are in place.
- The Finance Committee, which oversees the development and implementation of our strategic financial plan and the management of the principal risks to achieving that plan
- The Organisational Development and Workforce Committee, which enables the Board to obtain assurance concerning all aspects of strategic and operational workforce matters and organisational development.
- The Risk Committee, which provides assurance to the Board of Directors with regard to compliance with our risk management system and processes, and identifies relevant risks and mitigation plans that need to be brought to the attention of the Board.

A review of our governance structure was undertaken in 2017/18 and it was agreed the Risk Committee would become an Executive Committee, reporting to board via the Chief Executive's report on executive committees. The work of the Organisational Development and Workforce committee was aligned to the Quality and Finance Committee with quarterly focussed reports being submitted to the Board. These arrangements for the workforce committee will commence in March and April 2018.

Audit and Assurance Committee

The Audit and Assurance Committee was chaired by non-executive director Ray Dawson, who was a fellow of the Chartered Institute of Management Accountants and had extensive financial expertise. The Committee's Terms of Reference make it clear that membership exclusively comprises non-executive directors, with executives and others considered to be 'in attendance'. Attendance of non-executive members at meetings is detailed below:

- Ray Dawson 7/7
- Tim Reddish 6/7
- Graham Ward 6/7

The Audit and Assurance Committee's principal purpose is to enhance confidence in the integrity of our processes and procedures relating to internal control and corporate reporting.

In assessing the quality of our control environment, the Committee received reports during the year from the external auditors, KPMG, and the internal auditors, 360 Assurance, on the work they had undertaken in reviewing and auditing the control environment. PWC were appointed by the Governors in January 2018 as our external auditors and have presented their audit plan and updates to the committee.

The committee works with Counter Fraud Service and SFH colleagues to actively promote and raise awareness and encourage people to raise concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Counter Fraud Service has a standing invitation to all meetings, with relevant policies readily available on our staff intranet. The Audit and Assurance Committee routinely receives financial information, including cash and liquidity and the going concern status of the Trust, as well as operational information.

Key agenda issues discussed at the committee during the year were:

- Design and operation of the revised Board Assurance Framework document,
- Report with regard to delivery and performance against the internal audit plan for 2017/18, of the19 audit assignments undertaken, 11 were issued with Significant Assurance and were submitted to the relevant committee for discussion and monitoring and seven were issued with Limited Assurance. The lead executive presented these reports to the committee and discussed the actions providing assurance with regard to timelines and agreement to deliver the changes required. One report was issued as a follow up review and therefore did not have an opinion.
- Progress and achievement of actions against all internal audit reports are reported to committee.
- Counter Fraud progress reports are discussed at the committee and we were involved in the National Fraud Initiative for the first time during the year.
- The SRT process summary was completed and the submission rated as green with an overall improvement on the previous year.
- Information Governance is discussed at each meeting and the committee were updated with progress against the IG Toolkit requirements, General Data Protection Regulation (GDPR) requirements, where an action plan was developed and approved to ensure compliance by the May 2018 deadline.
- The Information Commissioner's Office (ICO) undertook an audit during the year. The report was received in September 2017, a number of actions were identified together with a number of areas of good practice. The actions were consolidated into one action plan with the GDPR actions and Cyber Security Standards actions.

- Freedom of Information requests are reported to the committee and themes identified which may impact on future delivery of service.
- Data Quality was also discussed in detail and resulted in a task and finish Data Quality Group being established which reports directly to the Risk Committee which in turn is an executive committee and therefore reports to Board via the Chief Executive's reports.
- Raising Concerns and our whistleblowing process and procedure were discussed by the committee with regular updates from the Senior Independent Director; no significant concerns were highlighted to committee during the year. Freedom to Speak Up Guardians were increased from two to five and a small working group established to review and escalate any themes arising from concerns raised.
- The Clinical Audit planning process was presented and agreed by the committee.
- As part of the year-end process and approval of the accounts to the Board for ratification, in order to assure themselves of the effective financial propriety of the Trust, the committee reviews and takes into account:
    - The head of internal audit opinion on both financial and non-financial matters
    - The external audit opinion on the accounts, including the external value for money opinion
    - The letter of representation to external audit
    - Going concern/principal risks and uncertainties
    - Review of accounts and external audits ISA260
        - Financial Statements – no unadjusted audit differences and one non-material audit adjustment relating to Property, Plant and Equipment, Annual report reviewed with no matters to raise.
        - Quality Account – A clean limited assurance opinion on the content of the Quality Account. The auditors were unable to give a clean limited assurance opinion on 2 standards due to discrepancies with clock start/stop times. Action plans had been agreed with the divisions and progress reports were received during the year.
        - Value for Money – no issues were reported which would delay the issue of the certificate of completion of the audit
        - The external auditors issued an unqualified Group Audit Assurance Certificate to the National Audit Office.

Standards of business conduct

The Board of Directors recognises the importance of adopting the organisation's Standards of Business Conduct. These standards provide information, education and resources to help staff make well-informed business decisions and to act on them with integrity.

Internal audit (360 Assurance)

The Audit Plan for 2017/18 was developed in line with the mandatory requirements of the NHS Internal Audit Standards. 360 Assurance, an external service, has worked with the Trust to ensure the plan was aligned to the risk environment. In accordance with the internal audit work plan, full scope audits of the adequacy and effectiveness of the control framework in place are either complete or underway. All audits with Limited Assurance are reported directly to the Audit and Assurance Committee and the lead director is asked to present the findings and confirm agreement of the actions and timescales. Audits with Significant Assurance are reported directly to the most appropriate committee, either Finance or Quality. However our Audit and Assurance Committee receives a report stating which reports have been reported to other committees.

Outstanding recommendations from internal audit are reported to our Audit and Assurance Committee. This ensures all recommendations are sustainably implemented within the organisation.

External audit service

KPMG has been the Trust's external audit provider since 2007, as a result of winning further tendering bids and the Audit and Assurance Committee exercising the options to extend the contracts.

The External Audit contract was retendered during 2017/18 and the Council of Governors, supported by the Chair of the Audit and Assurance committee, subsequently appointed PWC as our external auditors, for a period of 3 years, commencing with the 2017/18 Annual Accounts and Report.

We incurred £76,553 net of VAT in audit service fees in relation to the statutory audit of the accounts for the 12 month period to 31 March 2018 (£62,345 net of VAT for the period to 31 March 2017). Non-audit services amounted to £8,434 net of VAT (£7,150 net of VAT for the period to 31 March 2017).

PwC has provided the following non-audit services to the Trust during the year, all of which was approved by the appropriate partner and is permissible under the applicable ethical standards:

Work on the Quality report –this work is mandated by NHS Improvement as part of the audit appointment. The results of the previous year's quality accounts assurance work will inform the external audit risk assessment. Current year work will also be considered as part of the work on Revenue and the Annual Governance Statement. Work is conducted on an independent and objective basis in line with externally produced guidance from NHS Improvement.

In each case, PwC only provide support and advice to management and all decisions on these matters are ultimately taken by Trust management.

Remuneration and Nomination Committee

As at 31 March 2018 and on-going, membership of the Remuneration and Nomination Committee comprises John MacDonald as Chair and all non-executive directors. The attendance of non-executive directors is detailed within the Remuneration Report.

The primary role of the committee is to recommend to the Board the remuneration strategy and framework, giving due regard to the financial health of the organisation and to ensure the executives are fairly rewarded for their individual contributions to the organisation's overall performance. The Remuneration Report is set out in its own section of this report.

Remuneration and Nomination Committee of the Council of Governors

The Council of Governors' Remuneration and Nominations Committee comprises John MacDonald as Chair and representatives from the public, staff and appointed governor classes. The role of this committee is to ensure that appropriate procedures are in place for the nomination, selection, training and evaluation of non-executive directors and for succession plans. The committee is also responsible for setting the remuneration of non-executive directors, including the Chair. It considers board structure, size and composition, thereby keeping under review the balance of membership and the required blend of skills, knowledge and experience of the Board.

Compliance with the Code of Governance

The purpose of the Code of Governance is to assist the Board in improving governance practices by bringing together best practice in public and private sector corporate governance. The Code is issued as best practice advice, but also imposes some disclosure requirements.

The Board of Directors is committed to high standards of corporate governance. Throughout the year ending 31 March 2018, the Board considers that it was fully compliant with the NHS Foundation Trust Code of Governance with the following exceptions, where we have alternative arrangements in place.

The governance structure, which has evolved over the year to keep pace with an ever changing environment, will stand us in good stead and allow the Board to continue to learn and develop from the fresh skills and experiences of its members. During the year, board development sessions for the full Board of Directors have been included at each meeting of the Board. This helps to ensure that we continue to look to current and evolving best practice as a guide in meeting the governance expectations of patients, members and the wider stakeholder community.

In common with the health service and public sector as a whole, we are operating in a fast changing and demanding external environment. We recognise the need to deliver significant increases in efficiency whilst maintaining high quality care at a time when budgets are tight and demand is high. We will continue to build on the improvements made to date in responding to these challenges, working through our exceptional and dedicated members of #TeamSFH.

We made sure that due regard was taken to our legal obligations by developing and implementing governor development. This accorded with and ensured a detailed understanding of the requirements of the Health and Social Care Act to include equipping governors with the requisite knowledge and skills to deliver their responsibilities effectively. Governors were also supported in attending development session with external providers.

The roles and responsibilities of the Council of Governors are described in our Constitution, together with details of how any disagreements between the Board and Council of Governors would be resolved. The types of decisions taken by the Council of Governors and the Board, including those delegated to committees, are described in the approved Terms of Reference.

We have a detailed scheme of delegation, which was reviewed and updated during 2017/18. This sets out, explicitly, those decisions reserved to the Board, those which may be determined by standing committees and those which are delegated to managers.

All members of our Board are invited to attend all public meetings of the Council of Governors. Governors and non-executive directors take part in internal assurance visits to clinical areas across our sites and are involved in patient and staff engagement events.
Our Executive Team consulted with the Council of Governors during the year on matters such as the annual plan, quality account and quality indicator and other relevant strategies and reports.
In a NHS Foundation Trust, the authority for appointing and dismissing the Chair rests with the Council of Governors. The appraisal of the Chair is therefore carried out for and on behalf of our Council of Governors by the senior independent director, supported by the lead governor. Together they review the Chair's performance against agreed objectives and discuss any development needs before reporting the outcome of the appraisal to

the Nomination and Remuneration Committee of the Council of Governors. This committee in turn reports to the Council of Governors.

The directors of the Board are appraised by the Chief Executive who, in turn, is appraised by the Chair. The Council of Governors does not routinely consult external professional advisors to market test the remuneration levels of the Chair and other non-executive directors. The recommendations made to the Council of Governors are based on independent advice and benchmarking as issued from time to time by national body NHS Providers.

NHS Improvement 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.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitors Risk Assessment Framework (RAF) was in place. Information for the prior year and first two 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 remains in segment 3. The Trusts requirement for loans, the PFI debt burden and operating within a deficit mean the Trust can only achieve a score of 3 at best, as if any of the 5 measures in the Use of Resources scores a 4 then the overall score is limited to a 3.

The Trust has scored positively with regard to the I & E Margin as a result of achieving the control total and also positively for being under the agency ceiling

This segmentation information is the Trust's position as at 31 March 2018. The latest segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

<u>Finance and use of resources</u>

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	4	4	4	4	4	4
	Liquidity	3	4	4	4	4	4
Financial efficiency	I & E margin	4	4	4	4	4	4
Financial Controls	Distance from financial plan	1	4	2	1	1	1
	Agency spend	1	1	1	2	4	4
Overall Scoring		3	3	3	3	3	3

Foundation Trust License

Monitor applied a section 111 on the Trust in April 2015 with regard to concerns in respect of leadership and governance. It is expected this will be reviewed by NHS Improvement during 2018/19 as the Trust now has a substantive Board.

Statement of the Chief Executive's responsibilities as the accounting officer of Sherwood Forest Hospitals 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.

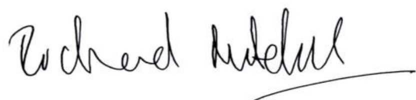
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Sherwood Forest Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sherwood Forest Hospitals 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
- 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 them 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.



Signed……………………………
Richard Mitchell **29 May 2018**

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

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

Regulation

The Care Quality Commission (CQC) will undertake a full announced inspection of our Core Services during April 2018, with a well- led review in May 2018. We have undertaken a self-assessment against the NHSI well led framework and this is referred to in the Director's report.

We are fully compliant with the registration requirements of the Care Quality Commission.
Monitor applied a section 111 on the Trusts license in April 2015; with regard to concerns in respect of leadership and governance. NHS Improvement will review the requirements of the S111 during 2018/19 in light of the substantive appointments to the Board of Directors and performance against the Single Oversight Framework requirements and Well-led reviews.

Capacity to handle risk

Our Board of Directors provides leadership on the overall governance agenda. On the Board's behalf our Risk Committee has maintained and kept under review a policy for the management of risk. Our Board of Directors is supported by a range of Committees that scrutinise and review assurances on internal control; such Committees include the Audit & Assurance Committee, Finance Committee, and Quality Committee. Our Risk Committee is an executive committee focussing on all high or significant risk exposures and oversees risk treatment to ensure: (a) the correct strategy is adopted for managing risk; (b) controls are present and effective; and (c) action plans are robust for those risks that remain intolerant. Our Risk Committee is chaired by myself as Chief Executive and comprises of selected members of the Senior Leadership Team. Senior managers and specialist advisors routinely attend each meeting. We have kept under review and updated risk management policies during the course of the year. The output the Risk Committee's work is reported to our Board through me; I also ensure the

Risk Committee works closely with front line divisional teams and all Committees of the Board in order to anticipate, triangulate and prioritise risk; working collectively to continuously balance and enhance risk treatment.

Training is provided to relevant colleagues on risk assessment, incident reporting and incident investigation. In addition, the Board has set out the minimum requirements for staff training required to control key risks as part of the requirements for mandatory training.

Incidents, complaints, claims and patient feedback are routinely analysed to identify risks and single points of failure, and learn from them. Lessons for learning are disseminated to staff using a variety of methods including customised briefings, bulletins and personal feedback where necessary.

I have ensured that all significant risk exposure, of which I have become aware, are reported to Board of Directors and Risk Committee at each formal meeting. All new significant risks are escalated to me as Chief Executive and subject to validation by the Executive Team and Risk Committee. The residual risk score determines the escalation of risk and this is clearly established and embedded.

The Board of Directors regularly scan the horizon for emergent opportunities or threats, and considers the nature and timing of the response required in order to ensure risk is kept under prudent control at all times.

The risk and control framework

The risk management process is set out in six key steps as follows:

1. **Determine priorities**
   The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

2. **Risk Identification**
   Risk is identified in many ways. We identify risk proactively by assessing corporate objectives, work related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation by the Trust.

3. **Risk Assessment**
   Risk assessment involves the analysis of individual risks, including any plausible risk aggregation (the combined effect of different risks) where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

4. **Risk Response (Risk Treatment)**
   For each risk, controls are established, documented and understood. Controls are implemented to *avoid risk*; *seek risk* (take opportunity); *modify risk*; *transfer risk* or *accept risk*. Gaps in control are subject to action plans which are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk, and expressed its appetite in the form of ‘target’ risk ratings in the Board Assurance Framework.

5. **Risk Reporting**
   Significant risks are reported at each formal meeting of the Board of Directors and Risk Committee. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to myself as Chief Executive and the Executive Team. The level at which risk must be escalated is clearly set out in the Risk Management Policy. The Audit and Assurance Committee and Board of Directors have led the acquisition and review of assurances, in line with the Board Assurance Framework, to keep risk under prudent control. The Board of Directors has in place an up-to-date Board Assurance Framework.

6. **Risk Review**
   Those responsible for managing risk regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. In addition risk profiles for all Division's remain subject to detailed scrutiny as part of a rolling programme by the Risk Committee. The purpose of the rolling programme of review is to track how the risk profile is changing over time; evaluate the progress of actions to treat risk; ensure controls are aligned to the risk; ensure risk is managed in accordance with the Board's appetite; check resources are reprioritised where necessary; and ensure risk is escalated appropriately.

Incident reporting and investigation is recognised as a vital component of risk and safety management. It is key to the success of a learning organisation. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and routine mandatory training programmes, regular communications, patient safety walk rounds or other visits and inspections that take place. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

The most significant strategic risks facing us continue to be: (i) the maintenance of sufficient numbers of skilled staff to deliver our full range of clinical services; (ii) financial sustainability as funding levels reduce in real terms year on year, whilst substantial cost pressures remain; and (iii) demand that overwhelms our capacity to deliver care effectively. These risks are interrelated and incorporated into the Board Assurance Framework (BAF). Should one or more of these risks materialise, or any other risk captured in the BAF, it may trigger a compound effect upon the safety/quality of care and/or financial sustainability. Our Board of Directors has focused throughout the year on delivering sustainable improvements in the quality and safety of clinical services, and strengthening our ability to meet demand, supported by refreshed recruitment and retention strategies and prudent financial management.

A breakdown of the risks addressed within the BAF, and how those risks are being mitigated, is captured in table 1 below.

Table 1: Clinical, Operational and Financial Sustainability Risks

Potential Risk	How the risk might arise	How the risk is being mitigated
Catastrophic failures in standards of safety and care.	*This may arise if safety-critical controls are not complied with, there are shortfalls in staffing to meet patient need, demand exceeds capacity for a prolonged period, or there is a loss of organisational focus on safety and quality within the governance of Sherwood Forest Hospitals.*	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's governance and performance management framework; striving for excellence and challenging unsatisfactory performance regarding organisational control; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently

		mitigating this risk.
Demand for care overwhelms our capacity to deliver care safely and effectively.	*This risk may arise if growth in demand for care exceeds planning assumptions and capacity in secondary care; primary care is unable to provide the service required or there is a significant failure of a neighbouring acute provider. The risk may also arise if there are unexpected surges in demand, such as those created by pandemic disease.*	Managing patient flow, developing and maintaining effective working relationships with primary and social care teams, working collaboratively across the wider health system to reduce avoidable admissions to hospital are some of the risk treatment strategies that will feature in how we mitigate this risk going forward.
A critical shortage of workforce capacity and capability.	*Due to the number of clinical staff eligible for retirement, the availability of newly qualified practitioners, and increasing competition for the clinical workforce, we anticipate the staffing challenges to be significant.*	The *Maximising our Potential* Strategy is specifically designed to help mitigate this risk. By focussing on attracting and retaining high calibre practitioners, building and sustaining high-performing teams, by engaging and developing clinical teams, and adapting to meet the needs of a changing workforce - we aim to make Sherwood Forest Hospitals the employer of choice.
A failure to maintain financial sustainability.	*The delivery of high quality care helps to mitigate financial risk by reducing avoidable expenditure, minimising harmful care that extends length of stay or requires additional treatment. This risk may arise if the trust is not able secure sufficient funds to meet planned expenditure, maintain or replace vital assets, and/or is not able to reduce expenditure in line with system-wide control totals.*	A local and system-wide Financial Improvement Plan is specifically designed to address the financial challenge and deliver financial outturn in accordance with agreed control totals, gradually progressing towards break-even (no surplus or deficit at the year-end). To safeguard quality, proposals to reduce expenditure are subject to Quality Impact Assessment – overseen by the Executive Medical Director and Chief Nurse..
A fundamental loss of stakeholder confidence.	*This risk may arise should: (i) the controls fail to mitigate the risks outlined above; (ii)there are periods of prolonged adverse publicity; (iii) the Trust fails to make sufficient progress on agreed quality improvement; and/or fails to comply with statutory/regulatory obligations.*	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's governance and performance management framework; striving for excellence and challenging unsatisfactory performance regarding organisational control; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk. The Board oversee compliance obligations.
A breakdown of strategic partnerships.	*This risk, which is currently being mitigated, may arise where strategic partners are unable to balance competing demands and/or work collaboratively across the whole health and social care system.*	Active participation and engagement with all STP stakeholders to ensure effective planning, implementation and governance at a system level. Continue to play a leading role in the Better Together Alliance.
A major disruptive event.	*This risk, which is currently being mitigated, may arise where there is unexpected event which could lead to rapid operational instability and put safety and quality at risk. Such events include fire, prolonged loss of utility (water, gas, electricity supplies).*	This risk is mitigated through planned preventative maintenance, proactive inspection, regular testing of business continuity arrangements.

The Internal Audit Plan and Counter Fraud plan are approved by Board members and are aligned, where appropriate, with the principal risks in the BAF. The Audit and Assurance Committee utilises the reports of management and internal audit reports in order to provide assurance to the Board as to the effectiveness of the BAF as a component of the internal control framework.

Clinical Audit

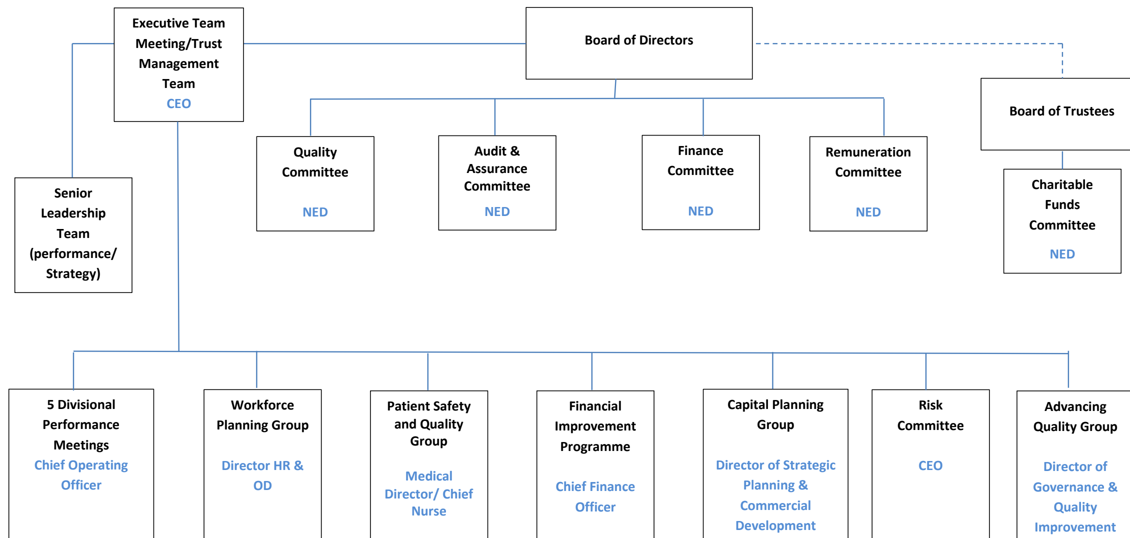
We actively participate in the National Clinical Audit Programme, and have done so for many years. This provides assurance to the Board of Directors and informs regulatory oversight. In 2017/18 the outcomes from national clinical audits can be summarised as follows:

- The Sentinel Stroke National Audit Programme (SSNAP) shows that we have improved and are now the second best Trust in England, Wales and Northern Ireland;
- The Myocardial Infarction National Audit (MINAP) Programme indicated that we are in line with expectations on all indicators, with the exception of receipt of angiography within 72 hours;
- The RCP National Lung Cancer Audit indicated the we are not significantly different from the national level overall, and significantly better that the national level for the proportion of patients with Small Cell Lung Cancer receiving chemotherapy;
- The RCP Falls and Frailty Audit Programme indicated we are performing as expected, except for perioperative medical assessment rate and crude overall length of stay;
- The National Bowel Cancer Audit indicated we are within the expected range for all indicators, except crude post-operative length of stay;
- The Intensive Care National Audit & Research Centre (ICNARC) indicated that we are within expected ranges for all indicators;
- The National Oesophago-Gastric Cancer Audit indicates we are in the bottom 25% in respect of the proportion of patients diagnosed after emergency admission, but the proportion of patients treated with curative intent in the Strategic Clinical Network is significantly higher (better) than the national level;
- The National Emergency Laparotomy Audit (NELA) indicates we have improved and are performing better than expected on all five process of care metrics, and within the expected range for 30-day risk adjusted mortality;
- The National Paediatric Diabetes Audit indicates we are better than expected for process measures and blood glucose control; and
- The Royal College of Emergency Medicine Audit indicates we are performing as expected against vital sign measurement, review by senior clinician and better than expected for oxygen administration, serum lactate measurement, blood culture within an hour, intravenous fluids within an hour, antibiotics within an hour, and urine output measurement.

Compliance with NHS Foundation Trust Condition 4 (Foundation Trust governance)

The Trust is compliant with NHS Foundation Trust Condition 4. Our governance committee structures has provided our Board of Directors with assurance during the year with regard to quality, including compliance with the CQC standards and finance, particularly with regard to specific issues raised by NHS Improvement in terms of loans and working capital facility.

Sherwood Forest NHS Foundation Trust –Committee Structure



During the year, our Board has received assurance regarding the performance through the Single Oversight Framework Integrated Performance Report and supporting exception reports for indicators rated as red on the performance dashboard, bringing together performance metrics and information relating to workforce, quality priorities, staffing and finance.

Reports to Board from the Audit and Assurance Committee and the Finance and the Quality Committee provide further assurance to the Board on the effectiveness of risk management and internal control, including the reporting of incidents through either quality committee for clinical incidents and Audit and Assurance committee for Information Governance incidents, reports from internal and external audit are reported to Board via the committee structure with any escalations being highlighted in the committee chair's report to Board.

The Trust is registered to provide healthcare on the following hospital sites – King's Mill Hospital, Newark Hospital, Mansfield Community Hospital and Ashfield Health Village. The registration requirements are reviewed on an annual basis with the Trust CQC Local Team. The Chief Nurse, Director of Governance and Quality Improvement and the Deputy Director of Governance and Quality Improvement facilitate a regular engagement meeting every six weeks with the Trust CQC Relationship Manager and the Lead Inspector. This meeting provides an opportunity for the Trust to demonstrate ongoing improvements in care but also an opportunity for CQC colleagues to gain assurance that timely and appropriate actions are in place to address issues raised through incident reporting, complaints and patient experience feedback. Since July 2017 CQC colleagues have visited a specialty area during the engagement meeting to enable them to meet staff and further understand about the care we provide to our patients. To date they have visited Radiology, Maternity, Ward 52 and the Intensive Critical Care Unit. These visits have been received very positively by both parties and have provided additional assurance that the Trust understands where it provides excellent care and where there is further work to do.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

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

accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

We have undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

Our Board of Directors performs an integral role in maintaining the system of internal control, supported by the Board Committees and internal and external audit.

The internal audit plan is agreed by the Audit and Assurance Committee and is focused on key risk areas, identified through our Board Assurance Framework and via escalation processes from other board committees. Follow up audits are also included in the plan to ensure that actions are implemented and improvements sustained.

We continue to struggle to maintain a full staffing establishment, in the main due to recruitment difficulties which are concentrated in the nursing and medical workforce. However we have been successful during the year to recruit a substantive CEO together with senior and divisional managers. Although the challenges in our nursing and medical workforce remain we have reduced our spending on agency and locum staff to within the ceiling set by NHS Improvement during 2017/18.

The Board receives a substantial amount of assurance concerning agency usage:

- **Executive-led Taskforces:** We have a Medical Taskforce and a Nursing Taskforce, both of which are core work streams within our Cost Improvement Programme (CIP). The Medical Taskforce is led by our Medical Director, and the nursing equivalent by our Chief Nurse. Fortnightly Work stream meetings are chaired by the executive lead
- **Cost Improvement Programme (CIP) Board:** Every month the CIP Board, chaired by the Chief Financial Officer, and featuring wider executive membership together with representatives from the programme management office and divisional management teams, seeks assurance of progress against the agreed savings trajectory for all workstreams including the executive led Taskforces.
- **Finance Committee:** The CIP Board presents an exception report to the Finance Committee detailing progress against savings trajectories, as well as core risks of non-delivery with respective mitigating solutions. The Finance Committee also receives detailed financial operating and outturn information, including pay spend and assurance about financial control.
- **Risk Committee:** This Committee receives assurance regarding the risks on the Board Assurance Framework, a number of which relate to workforce recruitment and retention, organisational sustainability and financial performance.
- **Trust Board**: The Trust Board receives assurance from its committees mentioned above. In particular, the Finance Committee provides assurance to the Trust Board about performance of the Trust's CIP programme and overall financial position. A comprehensive dashboard and report on agency spend is presented monthly.

As detailed elsewhere within this report, we have agreed a formal strategic partnership with Nottingham University Hospitals NHS Trust following the decision in October 2016 not to pursue a formal merger. These arrangements have been with the full agreement and support of NHS Improvement, with formal governance arrangements in place throughout and related resourcing approved by NHS Improvement.

We have ended the year with a surplus of £13.3m. Adjusting for a reversal of an impairment and other non-control total items gives a control total deficit of (£23.6m). Details relating to this position are included elsewhere in this report. Despite meeting our agreed financial control totals, we remain in a financially challenged position with a significant underlying deficit. We work closely with our commissioners and NHS Improvement to manage contractual risks and our liquidity position. We are working with partners to identify and implement health economy improvements to deliver financial savings across the regional footprint, whilst also delivering improvements in service provision and patient experience. Our partnership work in the mid Nottinghamshire Better Together programme is pivotal to achieving this, as is our participation in the Nottinghamshire-wide Integrated Care System.

Liquidity support has been agreed with NHS Improvement/the Department of Health in the form of loans and working capital facility. A total of £37.7m of revenue support term loans and £5.6m of capital loans have been drawn down during 2017/18. Liquidity is a significant factor in assessing an organisation's ability to continue as a going concern. At the date of this report there is no reason to conclude that liquidity support will not be available for 2018/19, we are planning to deliver the deficit control of £34.0m set by NHS Improvement. It is therefore our intention to prepare our accounts on a going concern basis. A detailed going concern paper was reviewed and approved by the Audit and Assurance Committee in support of this assessment, and is subject to an external audit review as part of the annual accounts process.

Our programme management office supported us in achieving our cost improvement programme of £16.3m for 2017/18. The programme was delivered through 15 key work streams, progress was reported monthly to the Finance Committee, with risks identified and mitigating actions agreed and implemented. The Programme for 2018/19 has been redesigned to focus on where there are opportunities to deliver efficiencies, including working with system partners. Delivery will be underpinned by the same robust governance process seen in 2017/18.

We have utilised the Model Hospital framework to benchmark activities, identifying opportunities for efficiencies and the monitoring of progress in achievement.

As a result of challenges with regard to recruitment of staff, we have a heavy reliance on agency staff, however during the year there has been a significant shift to improving and utilising bank staff. This together with successful negotiation with regard to rates paid to agencies means we have reduced agency expenditure by £12 million from 2016/17, ensuring an underspend against the agency ceiling set by NHSI.

Information Governance

Information Governance (IG) is the responsibility of both the Head of Corporate Affairs/Company Secretary and of the Chief Finance Officer, who our Senior Information Risk Owner (SIRO). The SIRO is supported by a network of information asset owners, who ensure the integrity of, and monitor access to, the systems for which they are responsible. The Head of Corporate Affairs and Company Secretary as Caldicott Guardian and the SIRO share the chair of the IG Committee. A working group also operates as part of the IG governance structure. The reporting and management of risks relating to data and security are safeguarded by ensuring all of our employees of the

Trust are reminded of their data security responsibilities through education, at induction and through mandatory training requirements. More than 4,000 colleagues received mandatory IG training in 2017/18, and regular reminders are shared via internal communications. Near misses and lessons learned are used to inform the training programme, ensuring that the programme remains dynamic and reflects current and meaningful issues to facilitate greater employee engagement and ownership of IG processes.

We have fully implemented all IG Toolkit requirements set out within the Caldicott recommendations report, and maintained a satisfactory 'green' rating, with 93% compliance for the 2017/18 submission.

Learning achieved from IG-related incidents is disseminated to staff via a variety of methods. These include additional training and support offered to staff members, together with circulating regular IG updates and information about pertinent issues to staff via the weekly bulletin.

Reports are shared at appropriate divisional and corporate meetings, and colleagues are notified about updates to policies and guidelines via the staff bulletin as soon as they are published on the intranet.

As part of ensuring compliance with the information governance agenda, we have reviewed the Terms of Reference for the IG Committee. This group has a more strategic focus to ensure effective policies, processes and management arrangements are in place covering all aspects of information governance, including:

- Information security
- Data quality
- Digital continuity
- Records management
- Information disclosure
- Information sharing
- Legal and regulatory compliance

This strategically focused group is supported by the IG Working Group, which identifies learning from incidents and develops the actions required to address these, ensuring prevention of any future recurrence. The group also reviews national guidance to inform both strategy and policy development together with implementation plans and processes.

Serious Incidents Requiring Investigation (SIRI)

There has been one information governance level 2 SIRI reported to the information commissioner's office (ICO) during 2017/18. The nature of the incident was regarding disclosing information to the wrong patient during an appointment. The incident was fully investigated and the lessons learned implemented. The final report was forwarded to the ICO who have now closed the incident with no action taken.

Information Sharing

The Information Governance department is actively involved in developing meaningful partnership working with neighbouring healthcare providers. This helps to ensure the sharing of patient data is protected in line with national guidance in a seamless, robust and effective way across partner organisations.

The following projects are examples of partnership working where information governance considerations have played a key role:

East Midlands Radiology Consortium (EMRAD)

We remain one of the members of the EMRAD consortium chosen by NHS England, to develop new arrangements between hospitals for sharing staff, services, resources and appropriate and relevant information to help improve the quality of care provided to patients. EMRAD ensures delivery of care for patients regardless of their location within the East Midlands. Consortium members now have access to shared regional imaging of patient records.

Nottinghamshire County Council

We are currently working on a project with Nottinghamshire County Council (NCC) to provide a more enhanced service for information on patient's admitted by us who are in receipt of social care services. The information shared will establish if there are any existing care packages in place and potentially postpone these services until the patient is discharged from hospital. In turn we will provide social care services with expected discharge dates to ensure care packages are reinstated in a timely manner.

The objective of the project is to promote timely patient care through the transfer of information from us to NCC community services.

Musculoskeletal (MSK)

Three organisations are working collaboratively to enhance the MSK service. This service supports patients with MSK conditions – problems with muscles, bones and joints. Information sharing between us, Nottinghamshire Healthcare Foundation Trust, and Nottingham University Hospitals, provides the MSK Together Service with timely accurate data to enhance patient care from acute hospitals to community services and vice versa.

Freedom of Information

We received 490 Freedom of Information requests in 2017/18 with the majority of the requests being from citizens, companies, journalists and MP's The themes requested tend to reflect current news items and are sent to all Trusts across the country. Over the last 12 months the three main trends have been cyber security in the aftermath of the ransomware attack, fire safety and combustibility of the cladding on NHS buildings as a result of the Grenfell Tower disaster and sexual harassment in the workplace as a result of the Harvey Weinsten scandal.

General Data Protection Regulation (GDPR)

The GDPR is European Union (EU) legislation that will become applicable to the UK from May 25th 2018 and will take precedent over the current Data Protection Act 1998. The regulation intends to strengthen and unify data protection for all individuals within the EU. We have implemented a GDPR compliance group which meets monthly with appropriate leads from across the organisation to understand and implement the guidance issued by the Information Commissioners Office with regard to the implications of the GDPR legislation.

We are currently in the process of implementing the new controls to ensure compliance. These include:

- Appointment of a Data Protection Officer (DPO)
- Demonstrating that we comply with the new law (the concept of 'accountability')

- Ensuring we have security breach notifications in place
- Removing charges, in most cases, for providing copies of records to patients or staff who request them
- Keeping records of processing activities
- Ensuring Data Protection Impact Assessment's required for high risk processing are conducted
- Implementing specific requirements for transparency and fair processing
- Tightening rules where consent is the basis for processing

We have developed a plan to ensure all actions are completed in time for the deadline. The group reports to the Audit and Assurance Committee via the regular Information Governance updates.

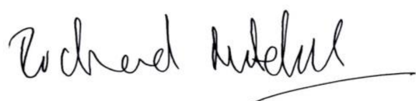
Cyber Security

We adopted the Nottinghamshire Health Informatics Service Cyber Security Strategy in October 2017. The strategy focuses on the 10 steps defined by the National Cyber Security Centre with a strong focus on Cyber Hygiene. Although it is not possible to completely eradicate Cyber Security threats and risks clearly defined processes and procedures which are consistently followed and embedded across the organisation significantly mitigates against the risks posed. We are a member of the Cyber Security Assurance Programme Board which oversees the implementation of the Strategy including external penetration testing, external audits and the production of Cyber Hygiene and Compliance reports. Cyber Security is reported through the Risk Committee via the Nottinghamshire Health Care Informatics reporting process. We also alerted colleagues to potential cyber security risks through the internal bulletin.

Ransomware attack

In May 2017 the NHS including ourselves were alerted to a possible cyber-attack. We took immediate action closing down the network and isolating the data centre and back-up centre. These actions minimised the risk of the virus spreading. We implemented our 'Zero day' process and the security vendors worked with us to identify and quarantine the infection.
One of the key initiatives within health and social care is the timely sharing of clinical information to support patient (or citizen care). This introduces a requirement to link together the health and social care community across Nottinghamshire. In order to achieve this there needs to be the appropriate security. When the risk of the possible cyber-attack was known and the risk of infection was identified, all organisations shut down the links they had between each other.

A controlled and risk adverse approach was established to ensure services could be brought back on line in the most secure and managed way, each stage involving a risk assessment of the next stage. Areas were brought back into live operation based on the risk and patient safety aspect to ensure minimum disruption to patient services within the organisation. By taking these precautionary measures our systems were not directly infected.



Richard Mitchell
Chief Executive

29 May 2018

Annual Quality Report 2017/18

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 Quality Report presents a balanced picture of our performance over the period covered from April 2017 to 31 March 2018 and indicates that there are appropriate controls in place. These controls include:

- Corporate level leadership for the quality account is assigned to the Chief Nurse
- Quality governance and quality and performance reports are included in our performance management framework
- Internal audits of some of our indicators have tested how the indicators included in the Quality Report are derived, from source to reporting, including validation checks
- Key individuals involved in producing the report are recruited on the basis that they have the appropriate skills
- knowledge to deliver their responsibilities

The Quality Report is included within the Annual Report and Accounts and describes how we have engaged with a wide range of stakeholders in our activity to improve the quality of care provided. The same assurance processes are utilised for other aspects of performance.

The Advancing Quality Programme will remain the vehicle to drive the Quality Priorities. The Programme will be closely monitored, updated and amended as required throughout the year with regular progress reports through the Advancing Quality Programme Board, the Trust Quality Committee and Board of Directors as part of the routine cycle of business.

We have used the following intelligence sources to identify and agree the Quality Priorities for 2018/19:

- Stakeholder and regulator reports and recommendations
- Clinical Commissioning Group (CCG) feedback and observations following their quality visits
- Commissioning for Quality and Innovation (CQUIN) priorities
- National inpatient and outpatient surveys
- Feedback from our Board of Directors and Council of Governors
- Emergent themes and trends arising from complaints, serious incidents and inquests
- Feedback from senior leadership assurance visits and ward accreditation programme
- Nursing and midwifery assurance framework and nursing metrics
- Quality and safety reports
- Internal and external reviews
- National policy
- Feedback and observations from Healthwatch through joint partnership working
- Feedback from Stakeholders, partners, regulators, patients and staff in the development of our Advancing Quality Programme

The indicators within the Quality Reports are shared with each of the Trust's five Clinical Divisions and through to the Board of Directors. Specific indicators within the report are monitored and reported via the Trust performance and governance framework namely the:

- Monthly divisional performance management meetings
- Patient Safety and Quality Group
- Quality Committee

We assure the quality and accuracy of our elective waiting time data through the following measures:

- Weekly PTL meetings for RTT and Cancer including;
    - A review of current position at reporting specialty level and action plans to address failing services
    - Patient level review of long waits
    - Monitoring of operational reports that impact on elective care data e.g. outpatient referral and waiting list management reports
    - Access to live self-service RTT PTL
- Elective Care Training programme for administrative staff involved in the management and validation of elective care pathways .
- RTT and Data Quality educator with remit to improve data accuracy of reported information through various mediums.
- Clear lines of responsibility for the management of patient pathways including the Central Booking Team, Operational Managers, waiting list staff, Cancer Tracking Team, Operational Outpatient Teams, Patient Pathway Coordinators, Data Quality Validation Staff.
- Chief Operating Officer nominated and responsible for the sign-off of RTT and cancer returns.

We acknowledge that there are risks to the quality and accuracy of this data and have the following mitigating actions in place:

- Trust wide Data Quality Strategy which sets out the organisational expectations for all colleagues relating to internally and externally reported data. The Strategy defines both ours strengths and known weaknesses and plans for improvement.
- Data Quality Oversight Group provides updates to the Board regarding known data quality issues to ensure both visibility of issues and assurance.
- Data quality dashboard with KPIs that reflect known risks to the accuracy of our data for example unreconciled outpatient attendances, mismatched RTT information in our PAS (e.g. incompatible codes) etc.
- Internal audit programmes designed to highlight and assure the quality of our elective care data with feedback mechanisms to address themes and inform training requirements.
- External audit review and testing of reported data.
- Validation Team who validate and correct data on a daily basis to ensure accuracy of reported data.

We have developed a robust governance and performance framework that is now well established throughout the organisation. This ensures that risks to the safety and quality of patient care, in addition to financial stability are identified and well managed resulting in the maintenance of clinical sustainability and financial viability.

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 who 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 and Assurance Committee, Finance Committee and Quality Committee and plan to address any weaknesses and ensure that continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control was monitored by the Board and its committees. The chairs of these committees play a key role in assuring me of the performance, quality and financial position of the Trust, which in turn supports the management of risks across the organisation.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through their internal audit work. The Head of Internal Audit has provided me with a significant opinion for 2017/18. This reflects the improvements made by the organisation in both embedding risk management and implementing and sustaining a robust Board Assurance Framework assurance process through the Board Risk Committee, which is chaired by me as the Chief Executive.

The structure of the Board of Directors meetings during the year allowed sufficient time to ensure that matters regarding performance, quality and finance could be managed effectively by the Board.

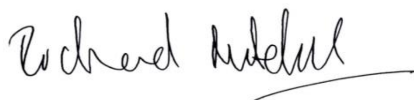
Managers and executive directors provide me with assurance through regular board and management reports, all of which evidence areas of effective internal control and risk management. The Audit and Assurance Committee and the Risk Committee ensure effective operation of risk management and focus on the establishment and maintenance of controls designed to give assurance that assets are safeguarded, waste and inefficiency are avoided, reliable information is produced and that value for money is sought continuously.

My review for 2017/18 is also informed by:

- Regular executive reporting to Board and escalation processes through the Board Committees
- Assessment of financial reports submitted to NHS Improvement
- Patient surveys
- Staff surveys

Conclusion

There are no other significant internal control issues I wish to report. I am satisfied the organisation has a sound system of internal control supported by a robust governance structure. All internal control issues raised during the year have been, or are being addressed through appropriate action plans and escalation processes.



Richard Mitchell
Chief Executive Officer
Signed……………….. 29 May 2018

The Quality Account

Introduction to the Quality Account

Quality accounts are annual reports to the public from providers of NHS healthcare regarding the quality of services that they provide and deliver. The primary purpose of this report is to enable the Board and leaders of our Trust to assess quality in its broadest form across all of the healthcare services we offer. It allows us to demonstrate a shared commitment to continuous, evidence-based quality improvements and for the organisation to openly share its commitment and progress with the communities it serves.

The Quality Report incorporates a review of the activities and achievements in improving the quality of our care during 2017/18, and states and explains our quality priorities for 2018/19.

The retrospective elements of this report pertain to the activities undertaken by the Trust during the financial year of 2017/18 and incorporate all of the mandatory reporting requirements set out by NHS Improvement, referenced within the following documents:

- NHS Foundation Trust Annual Reporting Manual
- Detailed Requirements for Quality Reports 2017/18
- Data Dictionary

Part 1 - Statement of the Quality Account from Richard Mitchell Chief Executive

I joined Sherwood Forest Hospitals as Chief Executive in July 2017 and I have thoroughly enjoyed my first year here.

We are currently waiting for the findings of our CQC inspection which took place in April 2018, but irrespective of the formal result, I believe we had a good year. I think our services today are better than they were 12 months ago, and will be better again in another year's time. Thank you to the staff and volunteers who individually and collectively played a key role in providing safe patient care over the last 12 months.

We know engaged, well supported staff deliver safe care and we are evidence of that, and our staff engagement results last year were some of the best in the NHS. October 2017 was the first time that we offered all staff the opportunity to complete the anonymous national NHS staff survey, and 57% of our staff responded, which was the eighth highest in the NHS.

An impressive 78% of our staff said they would recommend Sherwood as a place for friends and family to receive treatment and 70% said they would recommend Sherwood as a place to work. These are good results. In March 2018 we ran our quarterly staff survey and our scores improved to 90% and 77% respectively. These are very good results.

Our staff provide safe, personalised care to our patients and many quality, safety and patient experience indicators improved last year. We are fortunate to work in buildings which are very clean and, in general, across our three hospital sites are modern and spacious.

Working closely with partners in health and social care, we have again bettered our financial control total, delivered our cost improvement plan, and driven a reduction in our agency spend. The £12 million reduction in agency usage, whilst delivering safe care, is particularly important because fewer agency staff and more permanent staff means greater continuity of care for patients – "our staff caring for our patients". All of this is impressive at a time when the NHS and social care has never been under so much pressure.

Whilst patients on cancer pathways and diagnostic pathways continue to receive timely care at Sherwood, the last year has been difficult for providing timely care consistently on the emergency care and elective (planned) care pathways.

We understand the reasons for this and it is not because of a lack of effort. Many hospitals have struggled for years to deliver timely care on the emergency care pathway and culturally have come to accept this. We do not want to be one of those Trusts and I do not believe we are one of those Trusts. Timeliness of care is an important indicator of the overall quality of care that a patient receives, and improving emergency care and elective care is a priority for us in 2018. It will not be easy, but it is possible.

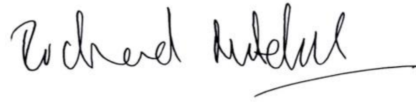
As well as improving care to emergency and elective patients, I hope we can make our staffs' working life calmer this year. This is not an aspirational pledge nor does it detract from the requirements to make difficult decisions, that not everyone will like nor support all of the time, but I am committed to supporting all ideas that make life at Sherwood better for patients and staff.

I worry about the pressure staff have been under, in particularly but not exclusively this winter, and I do not feel good about the length of time some patients have waited for their treatment or admission. I am aware of the

impact this has on patient and staff lives and we will make further improvements at Sherwood over the next 12 months.

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

Signed: Date: 29th May 2018



Richard Mitchell,

Chief Executive

Part 2 – Priorities for Improvement and Statements of Assurance from the Board

2.1.1 Providing high quality, safe care

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) is committed to providing safe, high quality care to all patients and service users. Our focus on continuous improvement will be driven by the Quality Priorities identified within the Quality Strategy 2018-2021.

The Advancing Quality Programme will remain the vehicle to drive the Quality Priorities. The Programme will be monitored, updated and amended throughout the year. Regular progress reports will be submitted to the Advancing Quality Programme Board, the Trust Quality Committee and Board of Directors as part of the routine cycle of business.

The following sources have been used to identify and agree on the Quality Priorities for 2018/19:

- Stakeholder and regulator reports and recommendations
- Clinical Commissioning Group (CCG) feedback and observations following their quality visits
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- Quality and safety reports
- Internal and external reviews
- National policy
- Feedback and observations from Healthwatch through joint partnership working
- Feedback from Stakeholders, partners, regulators, patients and staff in the development of our Advancing Quality Programme

The Trust has developed a robust governance and performance framework that is now well established throughout the organisation. This ensures that risks to the safety and quality of patient care, in addition to financial stability are identified and well managed resulting in clinical sustainability and financial viability are maintained.

The achievement of each Quality Priority will be measured through a range of performance indicators contained within each campaign. Progress will be underpinned by the Trust assurance processes with the formal monitoring and measurement reported through a range of committees and groups that in turn report through the Quality Committee to the Board of Directors. An update on progress will also be presented to the Council of Governors annually.

2.1.2 Approach to Quality Improvement

The Trusts approach to quality improvement is based on well-defined tools for accelerating improvement that have been widely adopted across the NHS. The following principles guide how care quality is improved at the Trust. Every improvement journey at the Trust begins by asking these important questions:

- What problem are we attempting to solve - what exactly are we trying to achieve?

- What change can we make to bring about improvement?
- How will we know that making a change delivers an improvement?

These questions ensure that there are clear aims, measures, specific interventions and how changes will be tested in the clinical setting. All improvement requires making changes, but not all changes result in improvement. Changes that do not result in improvement are helpful as they can help the Trust to learn and adapt. By implementing changes, succeeding and failing as the Trust moves forward, we will identify sustainable change that is most likely to lead to improvement.

2.1.3 Quality Priorities 2018-2021

Since 2015, the Trust has built on the successes of its improvement journey and will continue to progress this work through our Quality Strategy. By 2021 we aspire to be rated as outstanding by the Care Quality Commission (CQC). The Trusts ambition to provide outstanding care that is sustainable, high value, high-quality and delivered in partnership with health and social care providers across Nottinghamshire is reflected in our Quality Priorities.

To advance quality and develop our teams to lead, learn, and continuously improve the Trust has invested in service improvement expertise and positioned itself as a system leader for quality.

The driving force behind the Trusts new approach to quality is partnership: (i) united by shared quality goals - a partnership which brings about much closer integration across the health system to deliver safer and more sustainable clinical services; (ii) a partnership with patients, which seeks to put them more in control of their own care – promoting self-management and informed decision making; and (iii) through the Trusts workforce strategy - *Maximising our Potential* – a partnership with staff that fosters an open, inquisitive, responsive and learning culture.

This represents an opportunity to deliver care that is not just good, but the best care that can be provided. The Trust believes that we can demonstrate outstanding care and be one of the best providers of healthcare in the country. This Quality Strategy provides the road map to get there. The Quality Strategy is comprised of four improvement campaigns:

2.2 Our Quality Campaigns

The Trust recognises that it is important to include the voices and views of the public in its plans. However it also acknowledges that there is more work it can do to make it easier for the public to engage.

As a result it has produced a Public Involvement and Engagement Plan, to run from 2017-2021 the aim of which is to ensure the public have the opportunities to inform (and become informed), be involved in and influence the Trust's plans and services. It has two key objectives:

- There are regular opportunities for the public to be involved and influence plans.
- There are regular channels that inform the public and information aimed at the public has been reviewed by the public.

As a result of this a Forum for Public Involvement was established, holding its first meeting in November 2017. Foundation Trust members and members of the public were invited to participate which resulted in an interested group of 46.

As this group develops and matures it will be in a position to support a wide range of Trust activities from key Governance meetings to the identification of future improvement opportunities.

It is expected that members of the Forum for Public Involvement will support delivery of work streams within the Quality Strategy. The Trust recognises that it is important to include the voices and views of the public in its plans. However it also acknowledges that there is more work it can do to make it easier for the public to engage.

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It is expected that members of the Forum for Public Involvement will support delivery of work streams within the Quality Strategy.

2.2.1 Campaign One: Positive Patient Experience

Changing behaviours and the way care is delivered to impact positively on how care is experienced by those who use and depend upon the services we provide. The Trust aims to:

- Move beyond a paternalistic approach to a model of care that is patient centered and progressing towards models of care that are developed in partnership with patients and service users.
- Consistently achieve and maintain service user recommendation ratings at or above 98%.
  In 2018/19 success will be measured as follows:

Focus on explaining care in an understandable way	Maintain at least 90% or more patients satisfied their care was explained in an understandable way
Engage and involve people in planning and delivering their care	Achieve at least 85% or more patients reporting they were involved in planning their care
To enable service users to be active participants in the Trust Governance groups	Patients and service users will be active members of the Trust key governance groups of Patient, Safety Quality Group and the Quality Committee

2.2.2 Campaign Two: Care is safer: - Focusing on frailty and learning disability we will adapt to meet the healthcare needs of an increasingly elderly patient population and by delivering 'better basics', reduce exposure to harm or complications of care. We aim to: (i) have the lowest number of serious incidents of any East Midlands NHS acute care provider. (ii) Achieve 12 consecutive months or more without a Never Event. We will measure our success in 2018/19 as follows:

Achieve high reliability of risk assessment and effective care planning for patients at risk of falls	92% or more compliance with implementation of falls care plans for at risk patients
Achieve high reliability of risk assessment and effective care planning for patients at risk of hospital acquired pressure ulcers	92% or more compliance with implementation of pressure sore prevention plans for at risk patients
Focus on safety culture in operating theatres and other areas where interventional procedures are undertaken	100% compliance with WHO Safety Checks Every query raised before or during a procedure results in a 'stop moment'

2.2.3 Campaign three: Care is clinically effective - Patient care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence. We aim to: (i) Benchmark in the top quartile for lowest Length of Stay. (ii) Benchmark in the top quartile for lowest rate of readmissions within 28-days of discharge for the same HRG. We will measure our success in 2018/19 as follows:

Reduce harm for those using our services who have a learning disability	Reduce by 10% (based on 2016/17 data) number of harmful incidents involving patients with a learning disability
Focus on preferred venue at the end of life	Maintain at least 85% or more alignment with patient's preferred discharge venue at the end of their life
Ensure all patients have a timely review from a Senior Clinician following admission	>95% of patients are reviewed by a Consultant within 14 hours of hospital admission

2.2.4 Campaign Four: We stand out - Being a leader and striving for excellence on our journey to outstanding. We aim to: (i) be rated outstanding by the Care Quality Commission. (ii) Keep patients with long term conditions well, as independent as possible and avoid foreseeable crisis points which often result in hospital admission. We will measure our success in 2018/19 as follows:

Focus on the specific staff satisfaction questions from the Annual National Staff Satisfaction Survey	KF1: Staff recommendation of the organisation as a place to work is >3.95 KF2: Staff satisfaction with the quality of their work and care they are able to deliver is >4.5
Promote an open and learning culture	To perform in the top 25% of Trusts for levels of incident reporting and near misses
Get to the learning faster; response to serious incidents	>75% of incidents are scoped within 72 hours or sooner of incident occurring

2.2.5 A review of Quality Priorities during 2017/18

The following section provides an overview of the Trust's quality priority performance during 2017/18.Three key quality priorities were selected together with a further nine quality priorities which were sub-divided into the following three domains: Improving patient safety, effectiveness of clinical care and patient experience.

The three key quality priorities selected for 2017/18 were:

1. Providing safe services outside core hours.
2. Recognise and respond effectively to deteriorating patients.
3. To improve the safe use of medicines.

Our Additional Quality Priorities for 2017/18 were:

	2017/18 Additional Quality Priorities
IMPROVING THE SAFETY OF OUR PATIENTS	Patient Safety Culture Programme
	Reduce harm from falls
	To reduce the number of infections
IMPROVING THE EFFECTIVENESS OF CLINICAL CARE	Improve the quality of our discharge
	Improve our care and learning from mortality review
	To improve the care of patients coming to the end of their life
IMPROVING PATIENT EXPEREINCE	Improve the experience of care for dementia patients and their carers
	Using feedback from patients and their carers
	Safeguarding vulnerable people

The above information has been formally reported and presented to a number of key committees, groups and forums within the organisation including the Board of Directors, Council of Governors, Quality Committee and Patient Safety and Quality Committee. The focus of some of the quality priorities for 2017/18 changed from 2016/17. This was due to a change in the areas where the Trust sought to improve quality. These were chosen following consultation with patients, staff and stakeholders and reflected the focus of quality improvement work for the Trust.

2.2.6 Review of Key Quality Priorities

The following sections describe our 2017/18 Quality Priorities in detail and the progress to date.

	Key Quality Priority description	Outcome
Key Quality priority 1	Providing safe services outside core hours.	1. Provide a clinically driven and patient focused Hospital Out of Hours Service that uses both a multi-professional and multispecialty approach to delivering care at night and out of hours. 2. Implementing Nerve Centre as the Trust-wide system that will further enhance care and minimise risk associated with sudden and unexpected clinical deterioration. 3. To standardise how the hospital is managed between 8pm and 8am. 4. To provide an electronic mechanism of facilitating

<table>
<tr><td></td><td></td><td>comprehensive clinical handover (medical and nursing) to ensure that the right action is taken at the right time to optimise care.</td></tr>
<tr><td colspan="3">Key Quality Priority 1 - Progress:

Key priority 1 is identified within the Trust Advancing Quality Programme (AQP) – Programme 5 - ‘Hospital 24’. The Programme aims to reduce variation in outcomes (mortality, patient experience, length of stay and readmission rates) for patients admitted to hospital as an emergency.

The Hospital Out of Hours (HOOH) team is now fully established and providing cover between 8pm and 8am 7 days per week. Further work is underway to extend the cover to provide a ‘twilight’ shift commencing at 5pm, however this will necessitate additional resource and a supporting Business case has been developed to identify the funding stream. A medical lead to support the ongoing clinical development of the team has been identified and is working closely with team members to facilitate the delivery of safe, high quality care at night and out of normal working hours.

The implementation of Nervecentre to support the early identification of the acutely unwell patient has been successful. As part of the implementation the Task Manager module has been switched on to enable HOOH to allocate medical tasks. This specifically enables all areas to use an online requesting function and ensures optimum use of clinical resources.

The development of an electronic integrated handover system is the next step in the Nervecentre Implementation Plan. The Trust is exploring successes from other Trusts where exemplar practice has been highlighted to support the necessary changes in behaviour and culture for this significant change in practice.</td></tr>
<tr><th></th><th>Key Quality Priority description</th><th>Outcome</th></tr>
<tr><td>Key Quality priority 2</td><td>Recognise and respond effectively to deteriorating patients.</td><td>1. To ensure that patients are adequately monitored and deterioration is recognised in a timely manner.
2. Any concerns are escalated immediately to those with specialist skills and knowledge and a timely multi-professional response occurs.
3. Appropriate treatment is planned, administered and documented in timely manner.
4. Patient outcomes and defined improvements are made during 2017/18.</td></tr>
<tr><td colspan="3">Key Quality priority 2 - Progress:

The Deteriorating Patient Group (DPG) is now well established within the Trust Governance structure reporting monthly to the Patient Safety Quality Group (PSQG). The DPG Report provides assurance around a number of deteriorating patient-specific metrics including Sepsis, Acute Kidney Injury, Cardiac Arrest, and Critical Care Outreach.

In addition, the implementation of Nervecentre as the Trust-wide system for identifying the deteriorating patient enables clinical staff to access real time information enabling them to respond to and intervene as necessary with sudden and unexpected clinical deterioration.

A monthly dashboard is provided for PSQG as part of the monthly reporting requirements indicating</td></tr>
</table>

performance against a series of key safety and quality indicators. The dashboard identifies those areas of good performance, in particular the training compliance for the acute response teams and the continued excellent performance in Sepsis Mortality. In addition, DPG are able to commission specific work programmes to address areas of concern with the initiation of a comprehensive project in relation to the identification and appropriate intervention for patients presenting with acute kidney injury.

	Key Quality Priority description	Outcome
Key Quality priority 3	To improve the safe use of medicines.	1. Increase the reporting rate for medication related incidents and near misses reported on Datix with an aim to being in the top quartile nationally. 2. To increase the number of patients whose medicines are reconciled within 24 hours of admission to hospital with the aim of achieving the national goal of 95% of all patients having their medicines reconciliation started within 24 hours of admission to the Trust. 3. To ensure a 72 hour review of medications for patients presenting with Acute Kidney Injury, for patients on antibiotics and those with outstanding medicines reconciliation issues.

Key Quality Priority 3 - Progress:

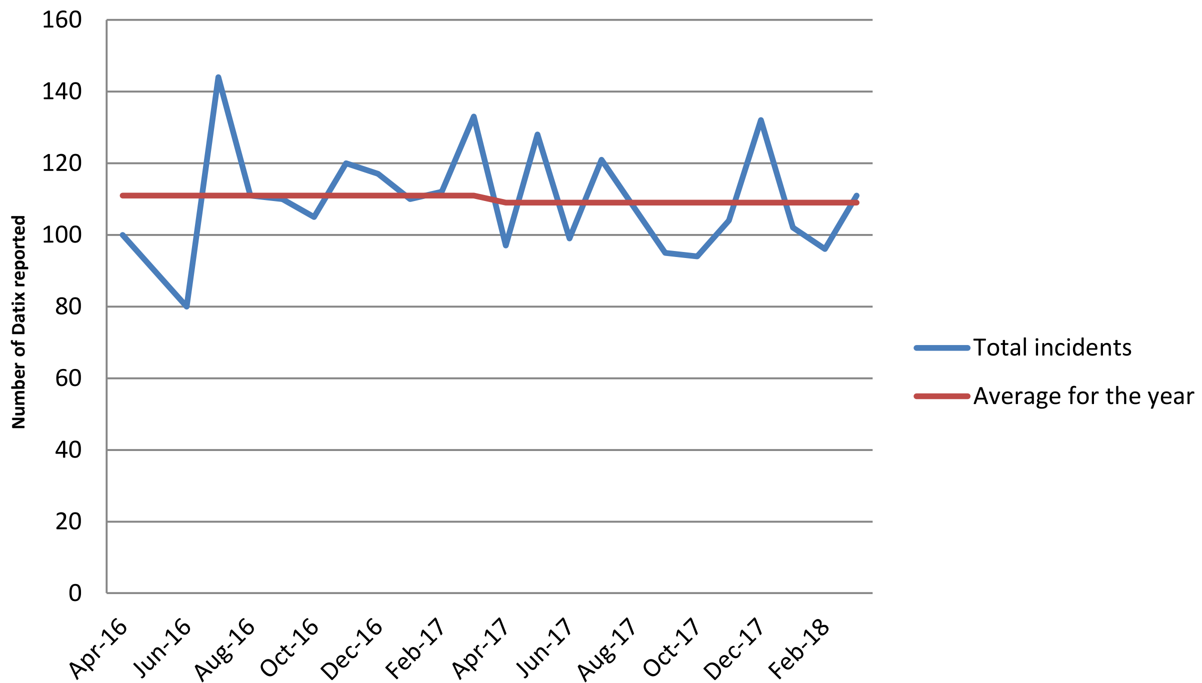
Key priority 3 is identified within the Trust Advancing Quality Programme (AQP) – Programme 4.

1. Increase the reporting rate for medication related incidents and near misses reported on Datix with an aim to being in the top quartile nationally.

The Trust is performing well in terms of medication incident reporting. The latest update of the Medicines Optimization dashboard showed an improvement in reporting rates per 1,000 occupied bed days compared to the previous 6 months. The number of incidents causing patient harm is also below the national average for similar sized organisations. The information can be seen in Table 1 below:
Table 1: Incident reporting rates as published on the Medicines Optimization Dashboard up to March 2017 (no further updates yet available).

Standard	National Rate	SFHFT data
Reporting rate of medication incidents per 1,000 FCE days – as reported on NRLS	4.47 for non-specialist Acute Trusts Medicines Optimisation Dashboard **Oct 16 – Mar 17**	5.66
% medication incidents that are harmful incidents – as reported on NRLS	11.7 % for non-specialist Acute Trusts Medicines Optimisation Dashboard **Oct 16 – Mar 17**	10.3%

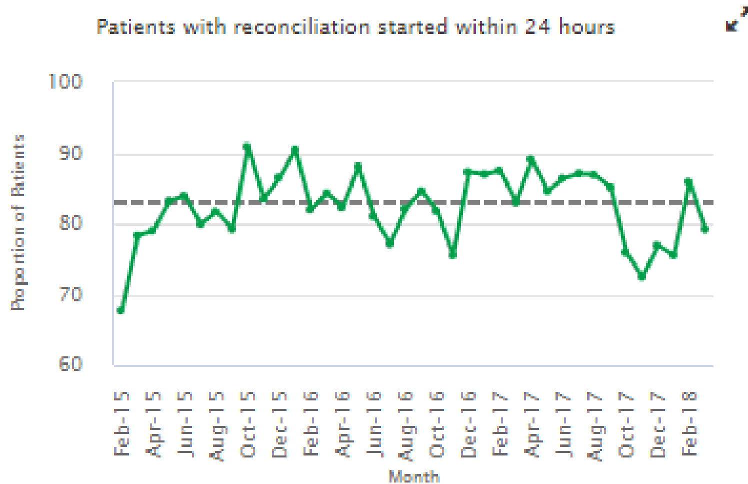
There are no further updates available on the Dashboard at the time of the report and so the number of incidents reported on a monthly basis is tracked as part of the Advancing Quality Programme for 2017/18. Graph 1 shows the medication incident reporting rate for April 2016 – March 2018. There has been a slight decrease in the average number of incidents reported for the year 2017/18 as compared to 2016/2017 and average of 109 per month compare to 111 for the respective periods.



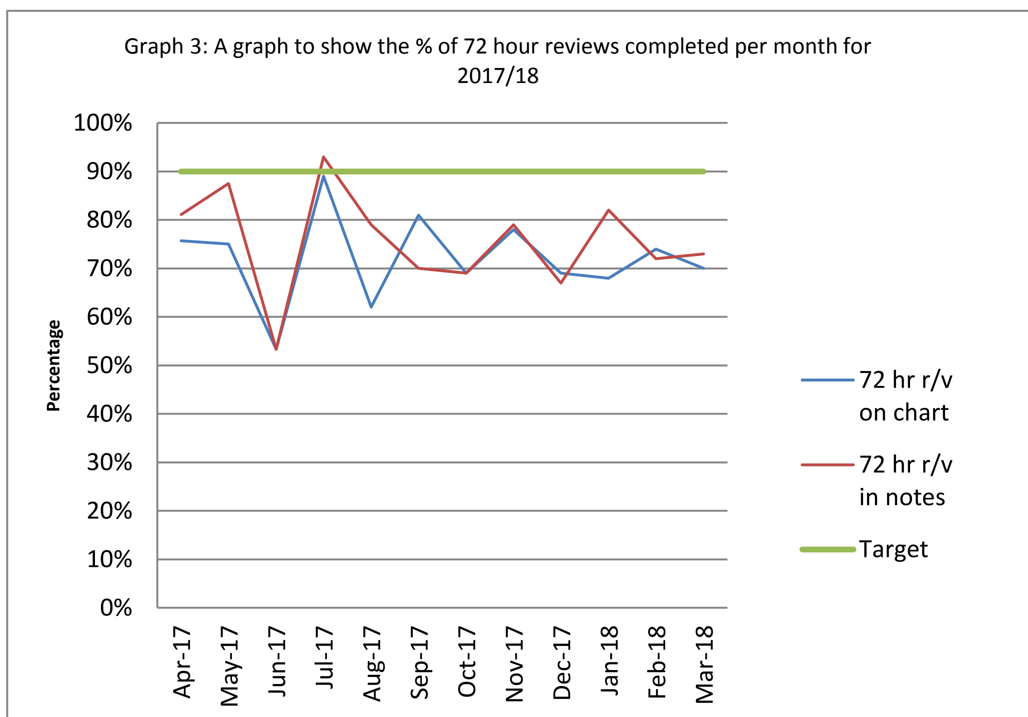
2. To increase the number of patients whose medicines are reconciled within 24 hours of admission to hospital with the aim of achieving the national goal of 95% of all patients having their medicines reconciliation started within 24 hours of admission to the Trust.

The Trust is still not achieving this target. Graph 2, taken from the Medicine Safety Thermometer shows the Trust is currently on average completing 83% medicines reconciliation for all patients admitted within 24 hours. A business case for an increase in pharmacy staffing has been approved to work towards achieving this target and a Pharmacy interface on Nerve Centre, launched towards the end of March 2018 will enable better prioritization of patients to ensure this target is achieved

Graph 2: Percentage number of patients having medicines reconciliation completed within 24 hours of admission.



3.To ensure a 72 hour review of medications for patients presenting with Acute Kidney Injury, for patients on antibiotics and those with outstanding medicines reconciliation issues.
The number of patients receiving a medicines review for Acute Kidney Injury is not currently logged by the Pharmacy team. The introduction of the pharmaceutical profile will enable data to be collected on the number of medicines reconciliations reviews 72 hour after admission. The introduction of Nerve Centre will also allow better tracking of this target. This was made available at the end of March 2018 and so no data is available for this report.
The 72 hour review of patients on antimicrobial therapy is currently a mandatory Trust-wide audit and is undertaken by all specialties with a minimum of 5 sets of notes audited each month. The 90% target has not been achieved for the documentation of this review. Graph 3 shows the percentage of reviews documented in the notes and on the medication chart each month for 2017/18.



2.3 Statement of Assurance from the Board

During 2017/18 Sherwood Forest Hospitals NHS Foundation Trust provided 59 relevant health services.

The Sherwood Forest Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 59 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 81.96 % of the total income generated from the provision of relevant health services by Sherwood Forest Hospitals NHS Foundation Trust for 2017/18.Each year we look after over 52,247 inpatients, 440,480 outpatients, and 122,480 attendances to our emergency department and over 3,400 women who choose to give birth at King's Mill Hospital. We employ 4,831 staff, including 173 consultants, working in hospital facilities that are some of the best in the country.

Our overriding focus is to ensure that quality is at the heart of everything that we do and as we strive for continuous improvement and safe, personalised care we are dedicated to achieving outstanding outcomes and care. In order to ensure that quality is a high priority we formally report on our progress against our quality priorities through our committee structure to the Board of Directors.

Further assurance and triangulation is sought and received via our assurance programmes for example our leadership visibility visits through the Board of Directors, our ward accreditation programme the quality visits undertaken jointly with our Clinical Commissioning Group colleagues.

2.4 Participation in Clinical Audits

Clinical Audit Submission to Quality Accounts 2017/18

Clinical audit is a nationally recognised quality improvement process that seeks to improve patient care and outcomes through the systemic review of care against a range of nationally agreed standards. This approach enables healthcare providers to evidence where services are doing well and identify areas where improvements need to take place to improve outcomes for patients.

Participation in Clinical Audit

During 2017/18, 57 national clinical audits and 3 national confidential enquiries covered relevant health services that Sherwood Forest Hospitals NHS Foundation Trust provides.

During that period the Sherwood Forest Hospitals NHS Foundation Trust participated in 51 of 57 (89%) of national clinical audits and 100% of 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 Sherwood Forest Hospitals Foundation Trust was eligible to participate in during 2017/18 are as follows:

- Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
- Adult Bronchiectasis Audit
- BAUS Urology Audits - Nephrectomy audit
- Bowel Cancer (NBOCAP)
- Bronchoscopy
- Cardiac Rhythm Management (CRM)

- Case Mix Programme (CMP)
- Diabetes (Paediatric) (NPDA)
- Elective Surgery (National PROMs Programme)
- Endocrine and Thyroid National Audit
- Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient falls
- Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database
- Fractured Neck of Femur (care in emergency departments)
- Learning Disability Mortality Review Programme (LeDeR)
- Maternal, Newborn and Infant Clinical Outcome Review Programme - Confidential enquiry into serious maternal morbidity
- Maternal, Newborn and Infant Clinical Outcome Review Programme - Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity
- Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)
- Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance
- Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)
- Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance
- Myocardial Ischaemia National Audit Project (MINAP)
- National Audit of Cardiac Rehabilitation
- National Audit of Dementia
- National Audit of Intermediate Care (NAIC)
- National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
- National Cardiac Arrest Audit (NCAA)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
- National Comparative Audit of Blood Transfusion programme - 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)
- National Diabetes Audit - Adults - National Diabetes Foot Care Audit
- National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia) -reporting data on services in England and Wales
- National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit
- National Emergency Laparotomy Audit (NELA)
- National Heart Failure Audit
- National Joint Registry (NJR) - Hip replacement
- National Joint Registry (NJR) - Knee replacement
- National Prostate Cancer Audit
- Oesophago-gastric Cancer (NAOGC)
- Paediatric Bronchiectasis
- Pain in Children (care in emergency departments)
- Procedural Sedation in Adults (care in emergency departments)
- Sentinel Stroke National Audit programme (SSNAP)
- Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
- Society for Acute Medicine's Benchmarking Audit (SAMBA)
- UK Cystic Fibrosis Registry - Paediatric
- UK Cystic Fibrosis Registry - Adult

- UK Parkinson's Audit

National Clinical Outcome Review Projects 2017/18

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals NHS Foundation Trust participated in during 2017/18 are as follows:

Study Title	Participation	Project Status	%
Pulmonary Embolism	Yes	Cases submitted	100%
Diabetes – Peri-Operative Care	Yes	Cases submitted	100%
Acute Heart Failure	Yes	Cases submitted	100%

Outcomes and Learning from Clinical Audits Undertaken During 2017/18

The number of clinical audits both national and local which formed part of the 2017/18 Audit Plan are as follows:

Total Number of Audits of the 2017/18 Plan: **248**
Number of Local / Other Audits: **194**
Number of National Audits, Inc NCEPOD: **54**
Number of Audits completed: **127**

Sixty seven local audits were either discontinued by the Speciality Audit Lead or removed by the Governance Support Unit due to a lack of audit activity of the last 12 months. This list of discontinued audits was distributed to the Divisional Teams to advise if they wish to have the audit reinstated.

The reports of all previous national and local clinical audits were reviewed by the provider in 2017/18 and Sherwood Forest Hospitals Foundation Trust has taken the following actions to improve the quality of healthcare provided. Examples of some the clinical audits undertaken during 2017/18 are indicated within the audits below. The reports of all local clinical audits were reviewed by the provider in 2017/18 and Sherwood Forest Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided below:

The Sentinel Stroke National Audit Programme (SSNAP)

The audit reviews the care provided to patients on a Stroke pathway, the noted successes were;

- The Trust has achieved an overall 'A' rating for the care it provides patients on a Stroke pathway.
- Joint best centre in the East Midlands and 2nd highest scoring Trust nationally.
- Speech and Language assessments have seen an increase in grading over the last 12 months, up from a 'D' rating to 'B'. The vision is to see this increased from a 'B' to an 'A' rating.
- Case ascertainment level is at 100% meaning we are submitting all available patients to the audit ensuring we are being open and honest about the care we are providing.

BAUS Urology Audits - Nephrectomy Audit

This audit collects data on all patients who undergo this procedure. Case ascertainment was recorded at 100% with all 75 patients undergoing this procedure being submitted. The noted successes were;

- We are excellent for our average length of hospital stay for this procedure. Nationally the average is 4 days with our average being 2.3 days.
- A review of Instrumentation used to carry out this procedure has led to savings of £450.00 per case. This means a total saving of over £33000.
- The average operation time for this procedure within the trust is 115 minutes. This is 35 minutes below the UK average of 150 minutes and 185 minutes below the world average of 300mins.

National Pregnancy in Diabetes Audit

This audit continuously measures the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes. The audit highlighted areas for development as follows:

- Women could be better educated around pregnancy prior to entering the care of the Trust.
- Pregnancies where first contact with antenatal diabetes team at <10 weeks' gestation 20% below the national average.
- Pregnancies where mother had third trimester HbA1c <48 mmol/mol, were 10% below the National Average.

As a result of this audit the following actions have been put in place:

- Increased awareness in primary and secondary care to ensure patients are aware of the risks associated with diabetes in pregnancy. This is being done both by engaging the GP community to ensure that the importance of this message is delivered when expectant mothers first engage the healthcare service and by discussing this with relevant staff within the Trust at weekly/monthly meetings and monitoring this.

Orthotic Footwear Audit

An Orthotic re-audit into patient satisfaction with the Orthotic Department and their footwear provided by the Department. The 2004 audit showed patients did not wear the footwear provided; where the 2015 audit however showed positive results of patient satisfaction. Despite a poor uptake of the audit of only 17 questionnaires being completed, results were positive. 100% satisfaction was reported for given choice of footwear styles, colour and fastenings; this showed improvement from the 2015/6 audit. Overall feedback from patients was that the service was good and information given was of a good standard, and was given the opportunity to ask questions at any point. It was also highlighted that the majority of patients felt waiting times were good for their footwear, there was also an improvement in results where patients knew how to order items if they needed. 94% of patients know how to reorder items. Conversely 30% of patients are waiting more than 3 months for their footwear. 24% patients said they were not told how long it would take to expect their footwear. Results indicate that patients are satisfied with the service; felt communicated with and are showing to wear the footwear provided by the department, which showed improvement from the 2 prior audits.

National Audit of Cardiac Rehabilitation

This audit collects data to support improvement of cardiovascular prevention and rehabilitation services in terms of access, equity in provision, quality and clinical outcomes. The noted successes were:

- A 4.3% reduction in the number of patients with a Body Mass Index over 30.
- More patients were able to exercise for at least 150 minutes per week which showed an increase of 45% before and after a cardiac event.

- A 4% reduction in patients suffering from anxiety and depression having used the Cardiac Rehabilitation service offered by the Trust

Audit of gynaecology new admission clerking's and initial patient management plans

The purpose of this audit was to examine how we can improve the quality of gynaecology admission clerking in line with NICE guidelines. The particular focus of this audit was to look at the variability between different individuals clerking; this was done by constructing and introducing a gynaecology specific clerking proforma.

- The introduction of a clerking proforma showed an increase in the percentage of criteria that was met.
- Significant improvements were noted with compliance to NICE guidelines, in three areas in particular; patients eating status, differentials/impressions and observation frequency.
- Feedback from staff was positive, as they felt it was useful to have all the information in one place and offered reminders of what questions they needed to ask; specifically useful for rotating SHO's and Junior Doctors.
- The audit showed that the introduction of the gynaecology clerking proforma improved the standard quality and reliability.

National Clinical Audit of Patient Blood Management (PBM) in Scheduled Surgery

This audit looks at areas of improvement in pre-operative, intra-operative and post-operative patient blood management practice. Results indicated the findings from King's Mill were similar to the National findings and often better. The noted successes were:

- At Kings Mill Hospital, of those patients having elective surgery, 73% received appropriate pre-operative anaemia management before surgery, as opposed to the 50% national average. This was also an improvement from the Trust's previous result of 44% in 2015.
- On occasions in the post-operative period at least one transfusion was prescribed by clinical staff was 100% at Kings Mill, as opposed to 74% nationally.
- Nationally 84% of patients who had major blood loss surgery received their post-operative transfusion after clinical staff attempting at least one appropriate PBM measure. In comparison at Kings Mill this was 91%, which again was an increase from 2015's result of 85%.
- Finally, the National Audit showed that King's Mill contributed to 11 cases to the Audit of Patient Blood Management in Adults, this was 100% of the sample size required.

Looking Back in 2017/18

There was a restructure of the Clinical Audit Team which has enabled the Trust to develop our knowledge and understanding around the Clinical Audit activity across the Trust.

Owing to the additional resources within the team we have been able to gain a better understanding of our participation in National Audits; this has given the Trust the opportunity to gain better assurance but also to understand any areas of concern sooner in terms of participation and non-compliance.

The Trust has seen an increase in the number of audits which have been completed (52 in 2016/17 vs 123 in 2017/18) owing to the recruitment of a dedicated resource to assist and monitor the quality improvements and outcomes in the patients' experience.

We have been able to further embed our use of the electronic audit system which is now used for all clinical audits.

We have been able to provide all Divisions on a monthly basis a detailed breakdown of their national clinical audit, local clinical audit and NCEPOD participation. This data has improved year-on-year and has enabled Specialties and Divisions to react promptly should any areas require intervention.

The Audit Team have been able to provide each Division with a year end report detailing all of the outcomes from their audits for 2017/18. The Divisions should be able to use this report for learning and development.

Looking Forward to 2018/19

A significant number of audits have been discussed within Specialty and Divisional Governance meetings which has enabled various staff groups to get a better understanding of some of the outcomes and challenges faced as a result of the audit.

Clinical Audit will be re-launched in 2018/19 with a series of events / posters / communication to re-invigorate awareness and participation in Clinical Audit.

An audit day will be planned for early in the year to showcase our achievements, create better understanding and to include a clinical audit competition.

We will support the Divisions to ensure that all national clinical audit and NCEPOD findings are thoroughly evaluated and appropriate actins are documented and undertaken in a timely manner.

The Patient Safety and Quality Board and the Clinical Audit and Effectiveness Group will receive information on published reports and presentations from local and national clinical audits.

We will establish a standard process for reviewing all audits ensuring that all activity is reviewed, disseminated, action planned and celebrated.

A review will be undertaken into the new GDPR guidelines and how that might affect implied consent in relation to clinical audit.

The Trust will represent the East Midlands NHS organisations at the National Quality Improvement and Clinical Audit Network (NQICAN).

National Clinical Audits 2017/18

The national clinical audits and national confidential enquires that Sherwood Forest Hospitals 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 is enquiry.

National Clinical Audit & Enquiry Project Name	Included in NHSE Quality Account List (2017/18)	Part of NCAPOP commissioned by HQIP (Y/N)	%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	100%
Adult Bronchiectasis Audit	N	N	No adults meeting criteria for inclusion
BAUS Urology Audits - Nephrectomy audit	Y	N	100%
Bowel Cancer (NBOCAP)	Y	Y	100%
Bronchoscopy	N	N	100%
Cardiac Rhythm Management (CRM)	Y	Y	100%
Case Mix Programme (CMP)	Y	N	100%
Diabetes (Paediatric) (NPDA)	Y	Y	100%
Elective Surgery (National PROMs Programme)	Y	N	100%
Endocrine and Thyroid National Audit	Y	N	100%
Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient falls	Y	Y	100%
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Y	Y	100%
Fractured Neck of Femur (care in emergency departments)	Y	N	100%
Learning Disability Mortality Review Programme (LeDeR)	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Confidential enquiry into serious maternal morbidity	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	Y	Y	100%
Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	100%
National Audit of Cardiac Rehabilitation	N	N	100%
National Audit of Dementia	Y	Y	100%
National Audit of Intermediate Care (NAIC)	Y	N	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	100%

National Cardiac Arrest Audit (NCAA)	Y	N	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Y	Y	100%
National Comparative Audit of Blood Transfusion programme - 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Y	N	100%
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	Y	Y	100%
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia) -reporting data on services in England and Wales	Y	Y	100%
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	Y	Y	100%
National Emergency Laparotomy Audit (NELA)	Y	Y	100%
National Heart Failure Audit	Y	Y	100%
National Joint Registry (NJR) - Hip replacement	Y	Y	100%
National Joint Registry (NJR) - Knee replacement	Y	Y	100%
National Prostate Cancer Audit	Y	Y	100%
Oesophago-gastric Cancer (NAOGC)	Y	Y	100%
Paediatric Bronchiectasis	N	N	No Children meeting criteria for inclusion
Pain in Children (care in emergency departments)	Y	N	100%
Procedural Sedation in Adults (care in emergency departments)	Y	N	100%
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y	N	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	N	N	100%
UK Cystic Fibrosis Registry - Paediatric	Y	N	100%
UK Cystic Fibrosis Registry - Adult	Y	N	100%
UK Parkinson's Audit	Y	N	100%

There are 6 audits where participation has not been fully achieved and the reasons for this are detailed below.

1. Inflammatory Bowel Disease (IBD) programme - Whilst a new data platform has been secured, we are now waiting for this to be implemented. This means the Trust has been inputting data manually and not able to input a complete data set. Approximately 50% of the data has been inputted.

2. National Ophthalmology Audit - Whilst the Trust is inputting some data we have not been able to input a complete data set for pre-operative assessments as a change is needed in how this data is currently captured. Approximately 50% of the data has been inputted.

3. Major Trauma Audit - Whilst the Trust is inputting some data we have not been able to input a complete data set within the 40 day lock down target. 80% of the data has been inputted.

4. National Lung Cancer Audit - A new data platform is required to allow us to input a full data set. Funding for this has been secured but is yet to be implemented. There was one element of the audit which was not able to be completed; as a result we were able to submit approximately 90% to the audit.

5. National (Core) Diabetes Audit - The data platform changed for this audit and approval for this change has not yet been given. There was an option to submit the data manually which was not utilised.

6. National Comparative Audit of Blood Transfusion - Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients This is was a re-audit following on from the original in 2016 and the service has decided not to participate.

2.5 Participation in Clinical Research and Innovation

The number of patients receiving relevant health services provided or sub-contracted by Sherwood Forest Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by the Research Ethics Committee was 1658.

The Trust is actively involved in clinical research and has a dedicated Research and Innovation team that is responsible for increasing opportunities to expand the research portfolio. The recruitment of patients to participate in research is mainly through studies adopted from the National Institute for Health Research (NIHR) portfolio. Also, the Trust is involved in a small number of non-adopted studies which are typically undertaken for educational purposes.

In 2017/18 the Trust significantly increased its research recruitment performance. In total 1658 participants were recruited with 1625 participants taking part in National Institute for Health Research studies. These figures demonstrate a 70% increase on the 2016/17 recruitment figures and are significantly above the target recruitment of 1200 participants. In December 2017, the Trust introduced a stretched target of 1500 which has also been exceeded.

In 2018/19 the Trust aims to increase the number of patients who have access to research studies as part of their care pathway with an initial target of 1400 patients. In addition to targeting high recruiting National Institute for Health Research (NIHR) portfolio studies, the Trust also expects to increase commercial research activity and secure the setup of between 8-10 industry-sponsored studies.

The Trust is committed to expanding research activities and facilities and has developed strong associations with other Universities NHS Trusts. To expand the types of research studies available to the local population, the Trust has developed collaborative relationships with Nottingham University Hospitals NHS Trust and Nottingham Biomedical Research Centre. At the centre of this collaboration is the development of a dedicated Clinical Research Facility. This would allow the expansion of clinical trials access for patients in the region and enable the uptake of more complex trials, particularly early phase and pharmaceutical.

At a local level, the Trusts Research and Innovation team are working closely with Nursing and Allied Health Professional teams to begin to embed clinical research into frontline care. A joint initiative has commenced which supports research secondments and dedicated research time within new posts, as part of a Research Academy. Also, the Nursing and Midwifery strategy has a research element built into a specific KPI.

The Trust has an external reporting responsibility to the Department of Health via the Clinical Trials Platform. This national KPI for NHS Trusts; “Performance and Initiation in Clinical Research” Q3 report has been received March 2018 with the organisation joint first position in league 5 with 100% of studies meeting the 70 days metric for setting up and recruiting the first patient into a study. Research and Innovation have a presence at Trust board and a performance update is provided quarterly on research and Innovation to the Trusts Patient

Safety and Quality Group and the Clinical Risk and Audit Committee. In addition, the Research Governance committee meets quarterly to oversee and monitor activity.

2.6 Commissioning for Quality and Innovations (CQUIN) Indicators

The Commissioning for Quality and Innovation Scheme (CQUIN) is offered by NHS commissioners to providers of healthcare services commissioned under an NHS contract, to reward excellence by linking a proportion of the provider's income to the achievement of local and national improvement goals.

A proportion of Sherwood Forest Hospitals NHS Foundation Trust income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Sherwood Forest Hospitals 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 electronically at http://www.sfh-tr.nhs.uk/index.php/board-of-directors/board-of-directors-meeting-papers-2017

During 2017/18 the Trust engaged in all eligible national CQUINS and specifically identified specialised CQUINS and has received positive endorsement for all work undertaken by our commissioners (Clinical Commissioning Group and NHS England).

The following section provides an overview of the 2017/18 CQUIN predicted year end position.
A – Achieved
PA – Partially Achieved

Summary of Acute Schemes for 2017/18

CQUIN scheme	Indicator name	Description	Q1	Q2	Q3	Q4
National	Improvement of health and wellbeing of NHS staff	Achieving a 5% point improvement in 2 of the 3 NHS annual staff survey questions on health and wellbeing, MSK and stress. The 2 questions did not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question.	A	A	A	A
National	Healthy food for NHS staff, visitors and patients	Providers were expected to build on the 2016/17 CQUIN by: • Firstly, maintaining the 4 changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19 • Secondly, introducing the following 3 new changes to food & drink provision: Year 1 (2017/18)	A	A	A	A

		a.) 70% of drinks lines stocked must be sugar free (less than 5g of sugar per 100ml). b.) 60% of confectionery & sweets do not exceed 250 kcal. c.) At least 60% of pre-packed sandwiches & other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving & do not exceed 5g saturated fat per 100g.				
National	Improving the uptake of flu vaccinations for front line staff within providers	Achieving an uptake of flu vaccinations by frontline clinical staff (permanent staff & those on fixed contracts) of 70% by 28.02.18.	A	A	A	A
National	Timely identification of sepsis in emergency departments and acute inpatients settings	The % of patients who met the criteria for sepsis screening and were screened for sepsis. The indicator applies to adults & child patients arriving in hospital as emergency admissions & to all patients on acute inpatient wards.	A	A	A	A
National	Timely treatment for sepsis in emergency departments and acute inpatients settings	The % of patients who were found to have sepsis in sample 2a (above) & received IV antibiotics within 1 hour. The indicator applies to adults & child patients arriving in hospital as emergency admissions & to all patients on acute inpatient wards.	A	A	A	A
National	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	% of antibiotic prescriptions documented & reviewed by a competent clinician within 72 hours.	A	A	A	A

Summary of Acute Schemes for 2017/18

National	Reduction in antibiotic consumption per 1,000 admissions	There are 3 parts to this indicator. 1. Total antibiotic usage (for both inpatients and outpatients) per 1,000 admissions (33%) 2. Total usage (for both inpatients and outpatients) of carbapenem per 1,000 admissions (33%) 3. Total usage (for both inpatients and outpatients) of piperacillin-tazobactam per 1,000 admissions (33%)	A	A	A	PA
National	Improving services for people with mental health needs who present to A&E	Successful achievement necessitates partnership working & joint governance between CCGs, acute providers, mental health providers & other key local partners. In Year 1, the Trust is required to reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, & establish improved services to ensure this reduction is sustainable.	A	PA	A	PA
National	Offering advice and Guidance	The scheme requires providers to set up & operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	A	A	A	A
National	NHS e-Referrals	This indicator relates to GP referrals to consultant-led 1st outpatient services only & the availability of services & appointments on the NHS e-Referral Service. All providers to publish ALL such services & make ALL of their First Outpatient Appointment slots available on NHS e-Referral Service (e-RS) by 31.03.18.	A	A	A	PA
National	Supporting proactive and safe discharge - Acute providers - Acute Trusts –	Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories	A	A	A	A

Summary of Acute Schemes for 2017/18

	Mapping					
National	Supporting proactive and safe discharge - Acute providers - Acute Trusts – Emergency Care data set	Type 1 or 2 ED providers to have demonstrable & credible planning by the end of Q1, in order to commence timely submission of the Emergency care data set data from 01.10.17.	A	A	PA	A
National	Supporting proactive and safe discharge - Acute providers - Acute Trusts – Discharge to the Usual Place of Residence	Increasing the proportion of patients admitted via non-elective routes discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 & Q4 2016/17).	A	A	A	PA

During 2017/18 the Trust received payment of circa £5 million (2.5% of eligible clinical contract income) from its commissioners for the CQUIN goals agreed during that reporting period. The available CQUIN was reduced from 2.5% to 0.7% as part of the Alliance Working and this represents full achievement of the 0.7% of eligible clinical contract income during 2016/17. This is in comparison to £1.4m received in 2016/17 when available CQUIN was 0.7% as part of Alliance Working.

2.7 Registration with the Care Quality Commission (CQC)

Sherwood Forest Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration is “registered”. Sherwood Forest Hospitals NHS Foundation Trust currently has no restrictions on registration. The Trust has four locations registered:

- King’s Mill Hospital
- Newark Hospital
- Mansfield Community Hospital
- Ashfield Health Village

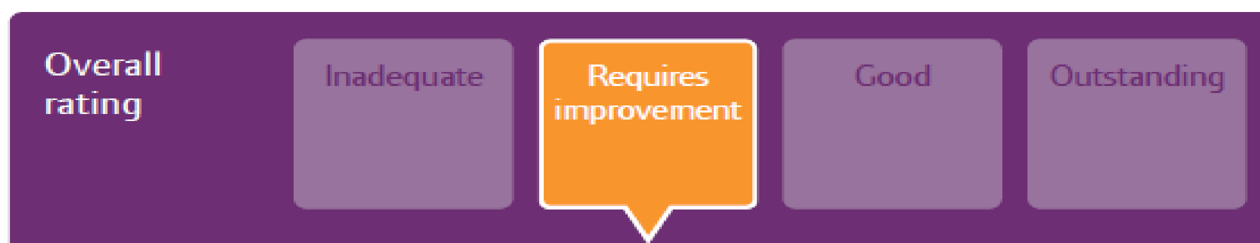
The Care Quality Commission has not taken enforcement action against Sherwood Forest Hospitals NHS Foundation Trust during 2017/18.

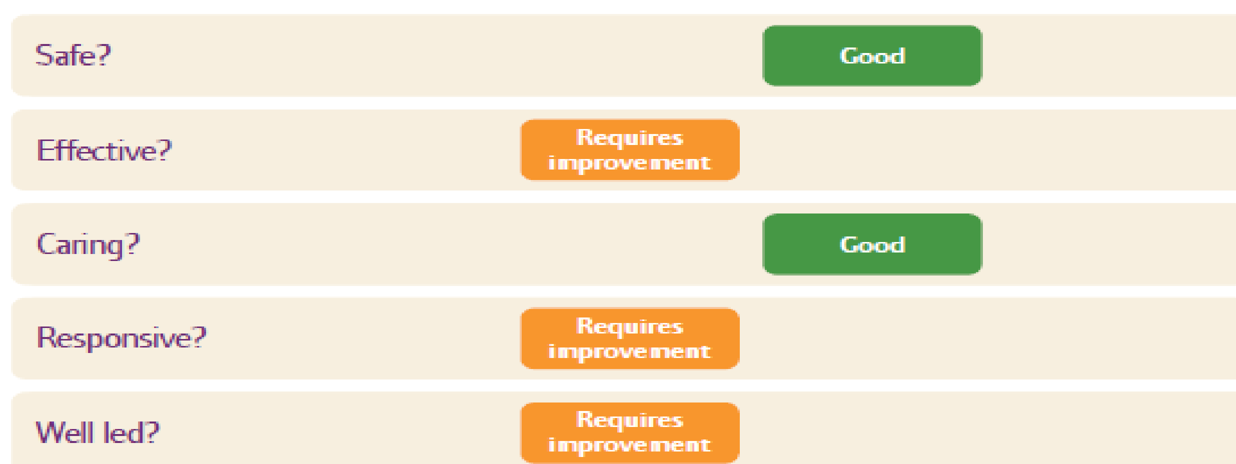
Sherwood Forest Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC carried out a focused unannounced inspection in July 2016 where they paid particular attention to those areas that had been deemed inadequate in 2015. Significant progress in the care delivered to our patients in all areas inspected was noted and this was reflected in the Report published in 9th November 2016.

The report can be found here: https://www.cqc.org.uk/provider/RK5

The improvements made resulted in a re-rating in those areas resulting in an overall rating as “Requires Improvement’ and no areas of service deemed to be inadequate.





The Trust is due to undergo an inspection in April 2018. This inspection will be conducted under the new methodology introduced by CQC following completion of the Comprehensive Inspection Programme 2014-17. The Inspection will comprise of an announced core service inspection over a four-day period in April followed by a three-day review of the well-led domain in May. A final report will be issued in summer 2018. The Trust is dedicated to providing outstanding care to patients, families and communities. To achieve this ambition on a consistent basis the Trust is committed to mobilising and retaining opportunities for learning and improvement.

Information on Secondary Uses service for inclusion in Hospital Episode Statistics

Sherwood Forest Hospitals 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:
99.8 %for admitted patient care;
99.9 %for outpatient care; and
98.8 %for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care; and
99.7% for accident and emergency care.

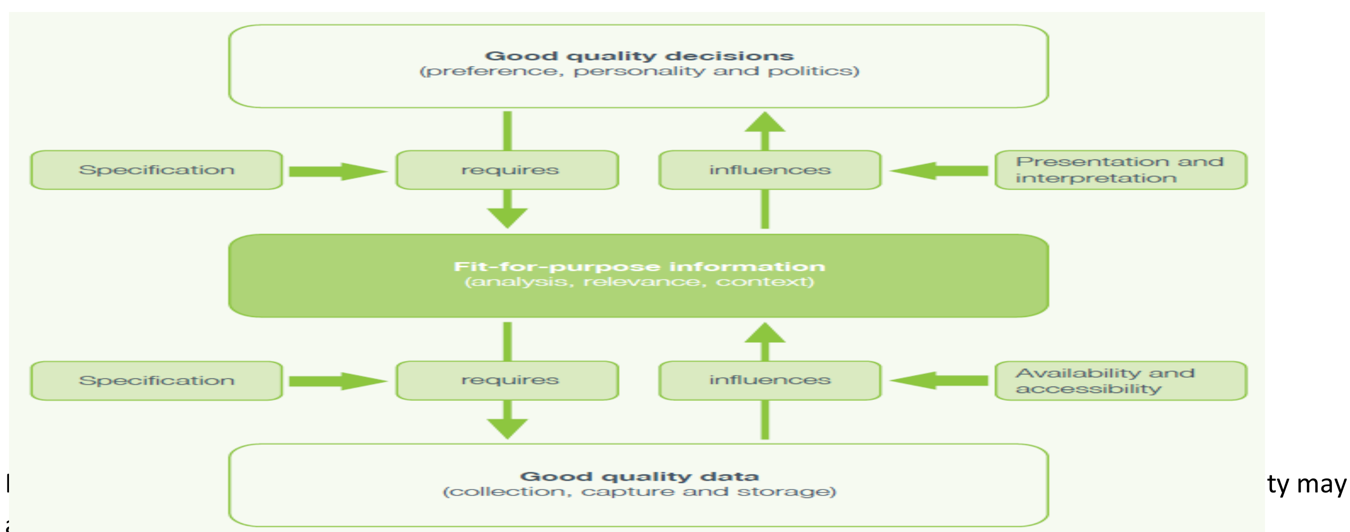
2.8 Data Quality 2017/18

A national core set of quality indicators was jointly proposed by the Department of Health and Monitor for inclusion in Trust's Quality Reports from 2012/13. The data source for all indicators is NHS Digital. The Trust's performance for the applicable quality performance indicators are shown in Appendix 2 for the latest time periods available. Effective decision making by clinical, operational and managerial staff is dependent on the timely availability of accurate and high quality information. As such, patient care can be affected positively and negatively by the quality of data.

High quality data collection is fundamental and non-negotiable enabling the delivery of the high level service demanded by the Trust for its service users.

Review of the Trusts Data Quality Strategy for 2018-2020

The Data Quality Strategy describes the Trust's approach to optimising data quality, to enhance and improve our decision making and services to patients. The following diagram (taken from 'Figures you can trust: A briefing on data quality in the NHS'[2]) illustrates the relationship between information and decision making:



Data Quality must be embedded into values, cultures, and ethos of the Organisation such that 'right first time' is the only accepted outcome. Staff understand the value of capturing high quality data in real time to improve patient care.

Review of the Trusts Data Quality Oversight Group

The Data Quality Oversight Group acts as a point of escalation for emerging data quality concerns and oversees the management and resolution of existing data quality issues. The group prioritises issue investigation and resolution based on risk and available resources, mobilising relevant teams as required. The group ensures that

[2] Audit Commission (2009). Available at: http://.nationalarchives.gov.uk/20150423154441/http://archive.audit-commission.gov.uk/auditcommission/aboutus/publications/pages/national-reports-and-studies-archive.aspx.html

issues are dealt with in a timely manner, ensuring that the appropriate manager or team takes ownership of issues and their resolutions, the overarching aim being to improve the quality, accuracy and timeliness of data capture, reporting and use within the Trust.

In addition the Trust has:

- Reviewed and updated the senior accountability/strategic responsibility for data quality
- Reviewed and updated the operational and management arrangements for data quality

The trust will be taking the following actions to improve data quality:

- Provide consistent feedback to the Board to highlight issues identified through the Data Quality Oversight Group.
- Review current Data Quality risks, outcomes and any lessons learnt from addressing these issues.
- To inform further training requirements.

Data Quality Training

The Trust continue to review all system based and operational Data Quality training materials (including NHIS), and Standard Operating Procedures to ensure that they are fit for purpose (in terms of data collection, recording, analysis and reporting adherence to Data Dictionary Standard Requirements).

Medway Training delivered by the NHIS trainers is a pre requisite to obtaining access to the Trusts Patient Administration System.

The Trust continues to deliver a comprehensive training plan for both Data Quality Training and RTT training accessible through the Training and Development Web page, Medway and Data Quality Webpages.

The Data Quality Team deliver a new starter package including; DQ Generic Training, RTT Generic Training, Role Based Data Quality and RTT Training for all administrative staff and clinical staff where appropriate.

Further ongoing review of Standard Operating Procedures, Medway process guides and role based user guides. Acknowledgement that this is a continuous process in the light of system upgrades.

Data Quality Improvement KPI's

The Trust has further developed the Sherwood Forest Hospitals Data Quality Analytical Dashboard to include coverage of data collection in the following areas:

- Outpatient Referral Management
- Outpatient Activity
- Inpatient Activity
- Elective Waiting List Management
- Referral to Treatment (RTT)
- Maternity
- Medway Patient Administration System (PAS) Maintenance Generic DQ

This will enable the team to proactively identify areas of potential data quality improvement or issues that need to be addressed.

Data Quality Analytical Dashboard

Refreshed	13/03/2018 07:14

Referrals	KPI Type	06/03/2018 Tuesday	07/03/2018 Wednesday
Total Daily Referrals	Information	408	353
Daily Choose and Book Referrals	Information	199	200
Daily Choose and Book 2 Week Wait Referrals	Information	58	51
Daily Non Choose and Book Referrals	Information	193	143
Daily Non Choose and Book 2 Week Wait Referrals	Information	0	2
Daily Consultant to Consultant Referrals	Information	52	41
Daily Consultant to Consultant 2WW Referrals	Information	0	0
Daily Consultant Referrals to AHP	Information	50	20
Daily Non Choose and Book Referral After The Day Received	Action	0	0
Daily Referrals - No Pathway	Action	1	2
Duplicate Referrals	Action	0	0
Total Open Referrals	Information	299721	299624
Total Open Choose and Book Referrals	Information	131422	131336
Total Open Non Choose and Book Referrals	Information	241759	241697
Total Open 2 Week Wait Referrals	Information	20291	20277
Total Open 2 Week Wait Referral 1 Week Old Plus Without Appointment	Action	1	1
Total Open Referrals - No Appointment	Action	8541	8565
Total Open Referrals - No Appointment After DNA	Action	7397	7341
Daily Referrals Created and Closed Same Day	Action	58	34
Total Open Referrals - Not Attended, no Partial Booking and no Waiting List Date	Action	2297	2232
Total Open Referrals Created and Closed Same Day, Not Attended, No Waiting List DTA	Action	3	2
Total CAB 2WW Referral Without a Corresponding Referral, 8 Days and Over	Action	20	20
Total CAS Transfer from Other Provider	Action	2613	2613
Total Same Consultant This Provider	Action	3618	3626
Total OP Referral to John Eastwood Hospital	Information	217	218
Daily OP Referral to John Eastwood Hospital	Information	0	0

Development of a Data Quality Internal Audit Programme

The Data Quality team have an agreed schedule of targeted audits that are undertaken throughout the year to systematically check for data quality issues across the Trust, through sampling of records and providing appropriate feedback at Divisional and Governance meetings and the Data Quality Oversight Group. The Data Quality team have undertaken ad hoc audits in response to suspected Data Quality weaknesses and observational audits in response to emerging themes and issues. The Data Quality team utilise the Meridian Audit Tool as endorsed by the Trust Audit Department to design and facilitate the on-going audit plan.

Data Quality Team Audit Programme for 2018/19

MAY - 18	JUNE - 18	JULY - 18	AUG - 18	SEPT - 18	OCT - 18	NOV - 18	DEC - 18
RTT Clinical Pathway Audit Review	RTT Clinical Pathway Audit Review	RTT Clinical Pathway Audit Review	RTT Clinical Pathway Audit Review	RTT Clinical Pathway Audit Review	RTT Clinical Pathway Audit Review	RTT Clinical Pathway Audit Review	RTT Clinical Pathway Audit Review
Monthly RTT Clock Stops Audit	Monthly RTT Clock Stops Audit	Monthly RTT Clock Stops Audit	Monthly RTT Clock Stops Audit	Monthly RTT Clock Stops Audit	Monthly RTT Clock Stops Audit	Monthly RTT Clock Stops Audit	Monthly RTT Clock Stops Audit
	SFHFT Internal OPA Audit		SFHFT Internal OPA Audit		SFHFT Internal OPA Audit		SFHFT Internal OPA Audit
OPD Process Audit	OPD Process Audit	OPD Process Audit	OPD Process Audit	OPD Process Audit	OPD Process Audit	OPD Process Audit	OPD Process Audit
SFHFT Internal APC Audit		SFHFT Internal APC Audit		SFHFT Internal APC Audit		SFHFT Internal APC Audit	
Inpatient Ward Data Quality Spot Check	Inpatient Ward Data Quality Spot Check	Inpatient Ward Data Quality Spot Check	Inpatient Ward Data Quality Spot Check	Inpatient Ward Data Quality Spot Check	Inpatient Ward Data Quality Spot Check	Inpatient Ward Data Quality Spot Check	Inpatient Ward Data Quality Spot Check
	Audit Programme Urgent and Emergency Care			Audit Programme Urgent and Emergency Care			

Development of robust communication channels to inform good data quality practices

Good communication is an important factor in the effective implementation of any Data Quality Strategy. It is vital that all key data quality information (e.g. guidelines, policies, procedures, plans and training material) is communicated clearly, effectively and in a timely manner to all staff in the Trust.
The Data Quality Team led and coordinated communication through the following channels:

- Trust articles and bulletins;
- Dedicated Data Quality web page (on the Medway front screen e.g. contains Standard Operating Procedures [SOPs]; Q&A section; policies and procedures etc.

- All training sessions (e.g. System specific training [coordinated by NHIS]; Data Quality Team; and Information Governance Team)
- E-learning tools;
- Awareness sessions;
- Progress reports to the Board and Audit Committee
- Dedicated Data Quality and Clinical Coding support provided to all Divisions (and Service Lines as appropriate).

The trust will be taking the following actions to improve data quality:

- To continue to keep the Trust informed of emerging data quality issues through our regular communication channels.
- To maintain the process of continuous evaluation of documentation designed to support system users to maintain data quality standards e.g. Standard Operating Procedures.
- Where system upgrades take place documentation is amended in response and appropriate user awareness sessions are delivered.

SFH Data Quality Position April 2018

The following table demonstrates the current known strengths and weaknesses in relation to Data Quality and the evidence that supports this view:

	Description	Evidence
Strength	Completeness and validity of core data items (including NHS number, date of birth, gender, postcode, specialty and consultant)	Data Quality Maturity Index (DQMI)[3] – this currently demonstrates strong performance
	Referral To Treatment Waiting Times	Significant Assurance is provided of the progress made by the Trust to improve the functionality of the Medway PAS, and the efforts made to improve patient tracking and validation.
	Completeness and compliance with data standards across a number of key fields in the various commissioning data sets (CDS)	SUS Data Quality Dashboards (DQDs) – they currently demonstrate performance above the national average
	Accuracy of reported waiting times in relation to 62 day cancer standard	Internal audit rating of 'significant assurance'
	Governance and Leadership Policies and procedures Systems and processes People and Skills	Internal audit rating of 'significant assurance' Overall the Trust has a strong baseline for supporting the quality of data, with plans in place for further strengthening going forward
Weakness	Accurate and real-time data capture issues in ED / on SystmOne	Internal audit rating of 'limited assurance' in relation to ED 4 hour standard indicator. Following this report the data capture

[3] The DQMI is a quarterly publication that provides timely and transparent information on data quality for a defined set of metrics and comparisons with peers / other local Trusts.

		process in ED have been revised to ensure electronic recording of time stamps.
	Accurate and real-time data capture issues on wards and for patients transitioning to wards	Internal reporting and auditing
	Historic referral management issues	Backlog of open referrals and historic 'on hold' lists
	Process for assuring and signing off data reported externally	Inconsistent approach for reporting data externally
	Referral To Treatment Waiting Times	Limited Assurance is provided over the accuracy of clock start and stop times and the quality of evidence found within case notes. Following this report all recommendations have been undertaken and are now complete.

These work streams are described below:

- Accurate and real-time data capture issues in ED / on SystmOne Accurate and real-time data capture issues on wards and for patients transitioning to wards. Work stream established with the objective: To address process and system issues in ED that currently result in information not being recorded in real-time, with discrepancies existing between paper and electronic records

- Historic referral management issues – Internal DQ Team established to validate and cleanse the data to establish true position of open patient episodes within the Trust Patient Administration System.

- Work stream established with the objective: To address process issues resulting in potential failures to manage patients' care pathway following outpatient attendance and compound referral management issues

- Process for assuring and signing off data reported externally - Work stream established with the objective: To ensure processes are in place to provide the Trust with assurance that internally and externally reported data has received the required validation and sign off.

- Work stream established: To ensure that all 'live' patient management reports are owned and managed appropriately, supported by robust and embedded processes to ensure patient care is delivered at the appropriate time and to prevent delays potentially caused by process failure.

- Referral To Treatment Waiting Times – Validation pilot in place to assess the extent of lack of accuracy of clock start and stop times and the quality of evidence found within case notes. This will inform themes and subsequent educational requirements.

2.9 Information Governance Assessment Report

The Sherwood Forest Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 82% and was graded as 'green satisfactory.'

Information Governance Aims for 2017/18

The Trust aimed to maintain the scoring for the 2017/18 submission, version 14.1 of the IG Toolkit and has worked on strengthening the existing information in place for these standards.

Performance against this Target

The final submission score as of 31st March 2018 for 2017/18 version 14.1 was 93% and was graded 'green satisfactory.' The Trust performed above the anticipated target score of 82 % 'green satisfactory' achieving an improvement of 11%.

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 14.1 (2017-2018)	Published	0	0	9	36	45	93%	Satisfactory	n/a	n/a

How Was This Achieved

The improvement in the submission score relates to participating in internal and external audits (performed by 360 Assurance) and working with the Information Commissioners Office. These mechanisms assisted the Trust to identify weakness, strengthen and action current controls.

In 2017, the Department of Health published "Your Data: Better Security Better Choice, Better Care" and introduced ten new data security standards which the Trust is continuing to implement. These standards have strengthened and maintained existing standards and assisted the Trust to achieve level 3's in areas which were previously level 2's.

Monitoring and Reporting for Sustained Improvement

All actions taken from internal and external audits and the 10 data security standards have been amalgamated into one improvement plan. Progress is reported and monitored at the Information Governance Committee and the Audit and Assurance Committee.

Serious Incidents Requiring Investigation

In 2017/18, the Trust had one information governance level 2 serious incident. The incident was related to the disclosure of information to the wrong patient during an appointment. The incident was thoroughly investigated, and lessons learned identified and implemented. The final report was forwarded to the Information Commissioners Office who subsequently closed the incident with no further action required.

2.10 Clinical Coding Audit

Sherwood Forest Hospitals was not subject to the Payment by Results Clinical coding audit during 2017/18 by the Audit Commission.

The Trust has a dedicated team of qualified and trainee clinical coders that are responsible for coding approximately 90,000 inpatient activity for 2017/18. Coded activity data is submitted to Secondary User Services (SUS) which is used to support commissioning, healthcare development and improving NHS resourcing efficiency.

Sherwood Forest Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust has appointed a team member with specific job role of RTT and Data Quality Educator whose remit is to improve the coverage of training throughout the Trust. This role also involves the development of bespoke training materials aimed at differing staff groups and using different delivery mediums to attract staff who may be unable to attend face to face sessions. The aim is to ensure that Data Quality training is mandated for all staff involved in patient care either direct or indirectly.
- Monitor levels of data quality.
- Identify improvements or deterioration in data quality.
- Identify areas for validation.
- Correct inaccurate or incomplete data.
- Identify training needs.
- Process map information flows to ensure continuous improvements.
- Facilitate ad-hoc audits as required to identify issues and assess progress.
- Expand the current audit programme to include other data quality metrics.
- Continue to proactively react to emerging themes and allow for ad hoc audits in response to suspected Data Quality weaknesses.
- A Data Quality Improvement programme has been established to address weaknesses in relation to data quality. Several work streams have been put in place to monitor and drive forward the required improvements and report progress via a work stream highlight report into the Data Quality Oversight Group on a monthly basis. Each work-stream has an objective described and reports required actions, key milestones and risks to the delivery of the programme of work.

The Data Quality Oversight Group will lead the development of this work and corporate ownership will be gained through data quality governance structure.

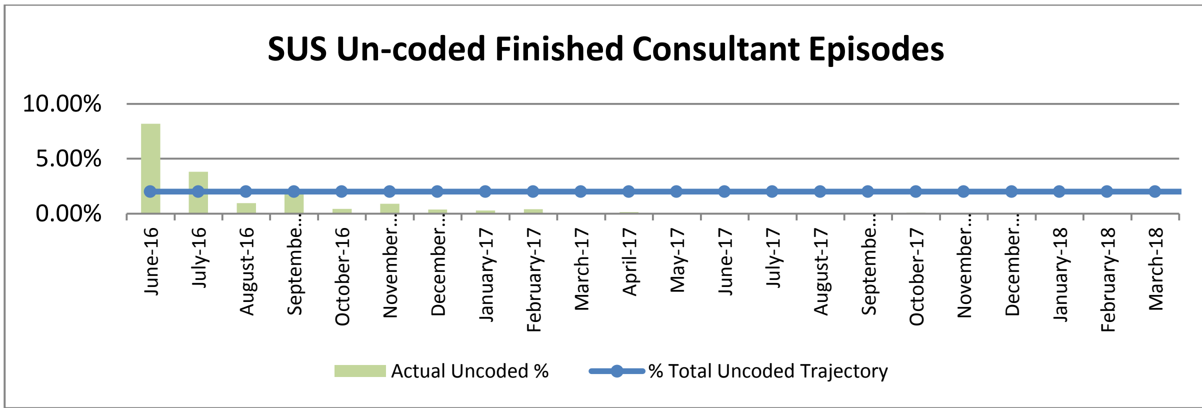
Clinical Coding Aims for 2017/18

- Deadline and Targets: Achieve 100% coding target by the 5th working day after the month end.
- Audits: Improving coding accuracy by conducting monthly audits of coded data before the final submission.
- Recruitment and Training: Recruit and train trainee clinical coders.
- Coding Awareness
- Clinical Engagement

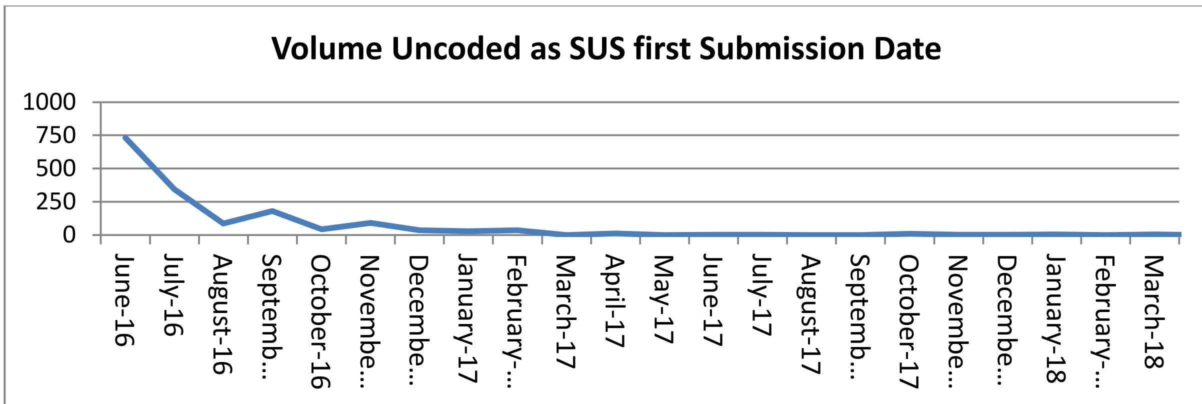
Performance against this Target

The Trust has consistently achieved 100% coding targets by the 5th working day after the month end. The average percentage of finished consultant episodes coded at first submission has increased from 97.2% in 2016/2017 to 99.9% in 2017/2018.

FCE Month	1st SUS Submission date	Total Number of Episodes	Volume Uncoded as SUS first Submission Date Actual & Trajectory	Actual Uncoded %	% Total Uncoded Trajectory	% Coded at 1st Submission
April-16	20/05/2016	8866	702	7.92%	2.0%	92.1%
May-16	20/06/2016	8789	747	8.50%	2.0%	91.5%
June-16	20/07/2016	8960	733	8.18%	2.0%	91.8%
July-16	18/08/2016	9012	344	3.82%	2.0%	96.2%
August-16	20/09/2016	8897	85	0.96%	2.0%	99.0%
September-16	20/10/2016	9063	180	1.99%	2.0%	98.0%
October-16	18/11/2016	9404	42	0.45%	2.0%	99.6%
November-16	16/12/2016	9882	90	0.91%	2.0%	99.1%
December-16	20/01/2017	8972	35	0.39%	2.0%	99.6%
January-17	20/02/2017	9559	29	0.30%	2.0%	99.7%
February-17	20/03/2017	8721	36	0.41%	2.0%	99.6%
March-17	24/04/2017	10049	0	0.00%	2.0%	100.0%
April-17	19/05/2017	8644	12	0.14%	2.0%	99.9%
May-17	19/06/2017	9307	0	0.00%	2.0%	100.0%
June-17	19/07/2017	8898	1	0.01%	2.0%	100.0%
July-17	17/08/2017	9024	1	0.01%	2.0%	100.0%
August-17	19/09/2017	9082	0	0.00%	2.0%	100.0%
September-17	18/10/2017	8859	0	0.00%	2.0%	100.0%
October-17	17/11/2017	9297	8	0.09%	2.0%	99.9%
November-17	15/12/2017	9315	1	0.01%	2.0%	100.0%
December-17	17/01/2018	8447	1	0.01%	2.0%	100.0%
January-18	19/02/2018	9003	3	0.03%	2.0%	100.0%
February-18	16/03/2018	7899	0	0.00%	2.0%	100.0%
March-18	19/04/2018	8840	3	0.03%	2.0%	100.0%



Notes:
The table above provides an indication of the volume of un-coded episodes for discharged hospital spells within each month. The 1st Submission date and % un-coded will aid users on what period to select for Mortality reports to ensure a more robust picture. All discharges are coded for the Post PbR Reconciliation deadlines and a refreshed SUS submission sent



Audits

The Trust has a coding quality assurance programme that automatically assesses clinical coding prior to monthly submission of activity data. This is supplemented by targeted audits to improve quality of the coded data conducted by Clinical Classifications Service Approved Auditor.

1. SAVINGS & INVESTMENTS PROFILE													
2016 / 2017 Gross Savings or Income (£'000)													
Area:	**A**	**M**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Coding Rules	0	0	(£7.5)	£38.1	£33.3	£9.7	£28.4	0	0	0	0	0	£102.00
Co Morb	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**£0**	**£0**	**(£7.5)**	**£38.1**	**£33.3**	**£9.7**	**£28.4**	**£0**	**£0**	**£0**	**£0**	**£0**	**£102.00**
Investments (invoice dated)													
Area:	**A**	**M**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Data	0	0	0	0	0	0	0	0	0	0	0	0	0
Auditors	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net Savings													
Total	**£0**	**£0**	**(£7.5)**	**£38.1**	**£33.3**	**£9.7**	**£28.4**	**£0**	**£0**	**£0**	**£0**	**£0**	**£102.0**

Information Governance Audit

As part of Information Governance Standard 505, the Trust has undertaken an audit of 200 finished consultant episodes (December 2017) to assess the accuracy of clinical coding. The Trust's coding accuracy achieved Information Governance Toolkit (IGT) Level 3 (Good) in three out of four coding indicators set by NHS Digital. The Trust achieved Level 2 (Adequate) for primary diagnosis and is therefore at Level 2 overall. Comparison results from the last financial year shows there is an improvement in coding accuracy of Procedures – both primary & secondary.

	IGT level 3 requirement	**IGT level 2 requirement**	**Trust achievement 2016-17**	**Trust achievement 2017-18**
Primary diagnosis	>=95%	>=90%	93%	93%
Secondary diagnosis	>=90%	>=80%	98.14%	94.85%
Primary procedure	>=95%	>=90%	91.60%	97.96%
Secondary procedures	>=90%	>=80%	92.52%	94.27%

Recruitment and Training

The Trust successfully recruited three trainee clinical coders in October 2017. The trainee coders completed their clinical coding standards course in January 2018 and are currently undergoing training in coding multiple specialities.

Clinical Coding Awareness

Clinical coders conduct the Bitesize Learning events to raise coding awareness to admin and clerical staff. Clinical coders also conduct specialty coding presentations to doctors at Clinical Governance meetings.

Clinical Engagement

Clinical engagement is in place in order to improve the accuracy of coded data. This includes specific coding queries via email, one to one meetings with clinicians, clinician-led teaching sessions and observing procedures.

How Was This Achieved

- Better planning, organisation and target-setting have helped to achieve monthly deadline targets.

- A regular internal programme of clinical coding auditing and training ensures the quality of coded clinical data to satisfy NHS regulatory bodies that the organisation exemplifies best practice and promotes a culture of continuous improvement.

- Raising coding awareness to admin and clerical staff has helped other departments in sending the case notes of discharged patients to the coding office in a timely manner. This enables the department to code more quickly.

- Raising coding awareness to clinical staff has led to more easily-available information in medical notes. This allows coders to code more quickly and accurately. Engagement with clinical staff has allowed quicker resolution of coding queries, leading to greater coding accuracy.

Monitoring and reporting for sustained improvement

- All coding staff have access to the uncoded report which helps them to monitor and plan their daily workload.
- The department has two lead clinical coders who are responsible for the organisation and planning of workloads to ensure monthly deadlines are achieved 100%. They also liaise with Trust wards and departments to put processes in place for faster delivery of notes to the coding department.
- Individual audit feedback is given in a timely manner to ensure high individual coder accuracy. Training sessions are put in place if necessary.

Sherwood Forest Hospitals will be taking the following actions to improve data quality:

- Ensure that both Operational staff and Clinical staff are made aware of the importance of data quality and validation of their data. This will be achieved through addressing training and educational needs, awareness sessions and regular communication.
- Improve engagement between clinical and administrative staff.
- Consider all challenges to the accuracy of our data and where necessary update processes to reflect these constraints.

- Praise excellent performance and highlight good practice and share amongst other staff.
- Seek to understand where data accuracy is under achieving and will engage with administrative staff to improve.
- Develop local performance reporting tools that demonstrate, following audit, the accuracy of our data.
- Empower line managers of administrative staff to engage with data accuracy and quality.
- Provide accurate complete and timely information to support commissioning.
- Ensure that data items are valid and adhere to data standards set out in the NHS Data Dictionary and any locally developed standards are consistent with the NHS Data Dictionary.

2.11 Improving Care and Learning from Mortality Review

The National Guidance on 'Learning from Deaths' sets out the Trusts new responsibilities which came into effect on 1 April 2017. The guidance provides a framework to ensure Trusts give sufficient priority to learning from deaths so that valuable opportunities for improvements are not missed. It points out the importance of engaging in an appropriate and supportive way with bereaved families recognising their insights as a vital source of learning.

In 2017/18 the Trust continued to improve the care delivered to patients by ensuring widespread learning from the review of patients who die while inpatients in the hospital. The process for conducting a mortality review is structured on the Royal College of Physician's Structured Judgement Review (SJR). This approach is widely used across Acute Trusts, and our clinical teams are becoming more proficient with its use. The benefits of conducting a review using a consistent, validated methodology ensures that care is recorded in the same way whether it is good or bad. This generates concise statements (both positive and negative) and yields a rich store of information to identify areas of excellent practice and areas in need of improvement.

The benefits of conducting a review using a consistent, validated methodology ensures that care is recorded in the same way whether it is good or bad. This will generate concise statements (both positive and negative), yielding a rich store of information to identify areas where there is excellent practice but also identify those areas for further improvements.

The Trust has provided a report each quarter to the Board of Directors through 2017/18 indicating performance against a defined data set and has demonstrated achievement of the review of >90% of all deaths by 31 March 2018. The data set used by the Trust is set out below:

- Total number of deaths – including the number receiving the initial review via the electronic Mortality Review Tool (MRT).
- Number of deaths scoring <3 on the Avoidability Assessment following a Structured Judgement Review (SJR).
- Themes and issues identified through review and investigation.
- Changes that have been made as a consequence of this process.

During 2017/18 1,555 of Sherwood Forest Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 355 deaths in the first quarter;
- 348 deaths in the second quarter;

- 375 deaths in the third quarter;
- 472 deaths in the fourth quarter.

By 31st March 2018, 1198 (77.04%) mortality reviews and 21 avoidability assessment investigations have been carried out in relation to 1555 of deaths included above. During the first year of the implementation of the National Guidance the Trust has focussed on ensuring maximum uptake of the electronic Mortality Review Tool (Phase 1) to ensure that all deaths receive a first review with a view to achieving the >90% deaths reviewed standard. The second focus has been the completion of the Avoidability Assessment (Phase 3) where possible avoidable factors in the care delivered had been identified and the subsequent presentation to the Trust Mortality Surveillance Group. Through 2018/19 we will focus on the learning from the Case Record Review (Phase 2) of the overall Structured Judgement Review process thus we are unable to quantify the number of deaths, which following the initial review required a phase 2 case record review during this reporting period.

The Royal College of Physicians Structured Judgement Review methodology (SJR) relies upon trained reviewers looking at the medical record in a critical manner and commenting on specific phases of clinical care.

The SJR, for use in relation to adult inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the Trust.

The detail captured can identify both poor practice and good practice of individual clinicians. When multiple reviews are undertaken within a clinical area or across the hospital, a thematic analysis can be performed that may highlight process or systemic issues.

21, representing 1.35% 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;
9 representing 3.4% for the first quarter
5 representing 1.7% for the second quarter
5 representing 2.3% for the third quarter
2 representing 0.42% for the fourth quarter

These numbers have been estimated using the Royal College of Physicians structured judgement review methodology as described above.

In 21 of cases a death was subjected to both a case record review and an investigation.

Achievement of the >90% review of all deaths standard has been particularly challenging through Q3 and Q4 due to the significant operational pressures experienced across the Trust. Some specialties have seen a significant increase in the number of deaths during the winter period – i.e. Geriatrics and Respiratory in particular. An audit of deaths where a mortality review has not taken place has been conducted to identify missed learning opportunities and ensure those cases that trigger the requirement for a second stage (SJR) review are identified to the relevant clinical team. This audit process will be implemented on a quarterly basis in 2018/19.

Learning from deaths is not seen in isolation of other learning opportunities but is an integral part of service and the wider Trust Governance Framework. Key issues identified as part of the Mortality Review process are collated with themes and trends from other intelligence sources to aid the prioritisation of immediate and future improvement requirements.

Through 2017/18 the key learning identified is set out in Table 2:

Learning themes identified from Trust Mortality Review 2017/18

Theme	Action
The availability of notes at the time of review to support a robust, comprehensive review of care delivered.	The initial Mortality Review is commenced at the point of death certification to enable optimum information to be gained from the medical notes prior to transfer to the coding department or the coroner.
Education requirement for Junior Doctors re accurate identification of cause of death.	Junior doctors are supported by the Bereavement Centre and the Trust Mortality Lead Consultant. Education sessions are in place.
The standard of handover/clerking documentation to ensure decisions, diagnosis and treatment options are captured to facilitate effective and safe decision-making.	Clerking documentation has been standardised across the Trust. Handover is included within the next phase of the implementation of Nervecentre – the electronic system for supporting clinical teams in the management of patient care.
Delays and complexity in having timely access to resus equipment had been a theme over time for paediatrics.	Paediatric and Newborn Resuscitation Trollies have been designed and rolled out in conjunction with the launch of a revised Resus Drug Chart.
Complex multi-specialty cases.	Reviewing a multi-specialty, multi-disciplinary case through the Structured Judgement Review process identified the complexities and learning opportunities, however also the challenges of bringing teams together. A Rapid Review structure has been implemented to ensure early identification of issues in order to develop an appropriate investigation plan.
Inappropriate attendance at the Emergency Department.	Mortality Reviews of deaths within the Emergency Department has identified the lack of availability of advanced care planning for Emergency Department staff and Ambulance Crews. This work is being included within the wider system improvement work around attendance avoidance and support in community settings.
Ceilings of Care	A failure or reluctance to have timely discussions

	around ceilings of care is a theme across a number of reviews. The implementation of the ResPECT Tool will support the required improvements.
Responding to the Deteriorating Patient	Failure to respond to an escalating NEWS score, early review by a senior doctor and acting on deteriorating blood results has been a feature in Mortality Reviews. The Trust has established a Deteriorating Patient Group who monitor key safety and quality metrics in relation to the acutely unwell patient. This group is held to account through the Trust Governance Structure to ensure appropriate actions are taken and improvements made where necessary.

Table 2

The review of deaths in a planned and structured manner has resulted in a significant improvement in the way clinical teams view the care they have delivered to patients in the weeks or days prior to their death. This has resulted in a much wider understanding of the value in learning opportunities an effective review offers.

A high number of clinicians across the Trust have been formally trained in the use of the Structured Judgement Review approach through 2017/18 and this is now the recognised method of mortality review for all specialties.

Teams have reported positively on the SJR experience, particularly in the increased involvement of multi-disciplinary colleagues. The Trust has moved from a mortality review system that was medically led to a system that encourages a multi-disciplinary and where necessary a multi-specialty approach to determine the safety and quality of care delivered, promoting a whole team solution to any learning opportunities.

The Trust recognises that learning from the care given to patients in their final days is about understanding what effective, sustainable improvements are needed but also where we provide excellent care and how we share good practice across the organisation. It is important to recognise that improving mortality will improve that standard of care for all patients.

The information reported below is new legislation and therefore has to be included but there are no numbers available for this reporting period.

0 case record review and 0 investigations completed after 31st March 2017 which related to deaths which took place before the start of the reporting period.

0 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.

0 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

2.12 Reporting Against Core Indicators

Since 2012/13, NHS Foundation Trust have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. Details relating to the progress against some of these indicators are included in this section.

2.12.1 Summary Hospital Level Mortality Indicator (SHMI) Banding

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

The table below illustrates the Trusts SHMI banding as being consistently recorded as a two, which indicates 'as expected' level of mortality.

Year	SFH SHMI Value	SFH SHMI Banding	National Average	Highest Performer	Lowest Performer	SHMI banding - Worst	SHMI banding - Best
Oct-15 – Sep 16	95.15	2	100.34	68.97	116.39	1	3
Oct-16 - Sep-17	101.62	2	100.50	72.70	124.73	1	3

The Sherwood Forest Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services by working with our partner organisations to ensure that our SHMI banding is within the expected (2 "level of mortality").

The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI). The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between trusts in the way that palliative care codes are used. Using the same spell level data as the SHMI, this indicator presents crude percentage rates of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level.

Percentage of Patient Deaths (coded as palliative care)

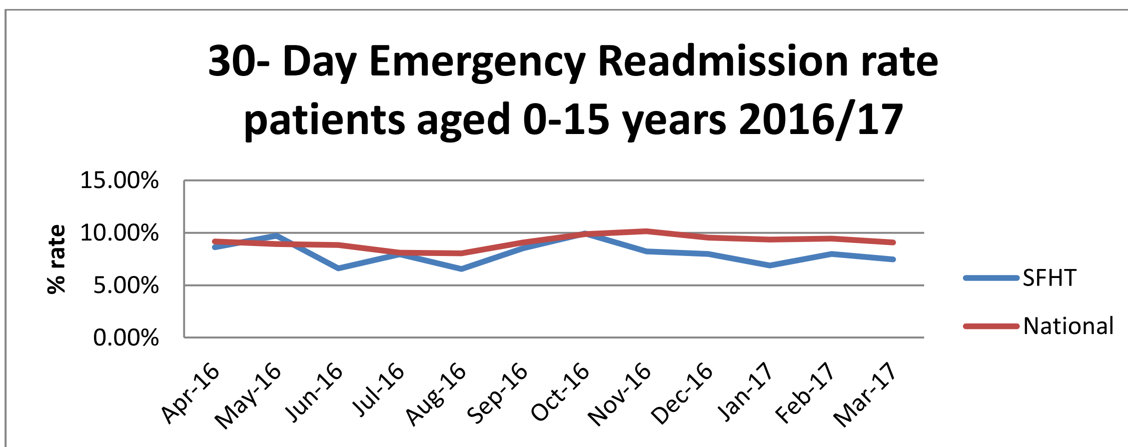
Year	% of	National Average	Highest Performer	Lowest Performer
Oct-16 - Sep-17	15.0%	31.2%	59.5%	11.5%

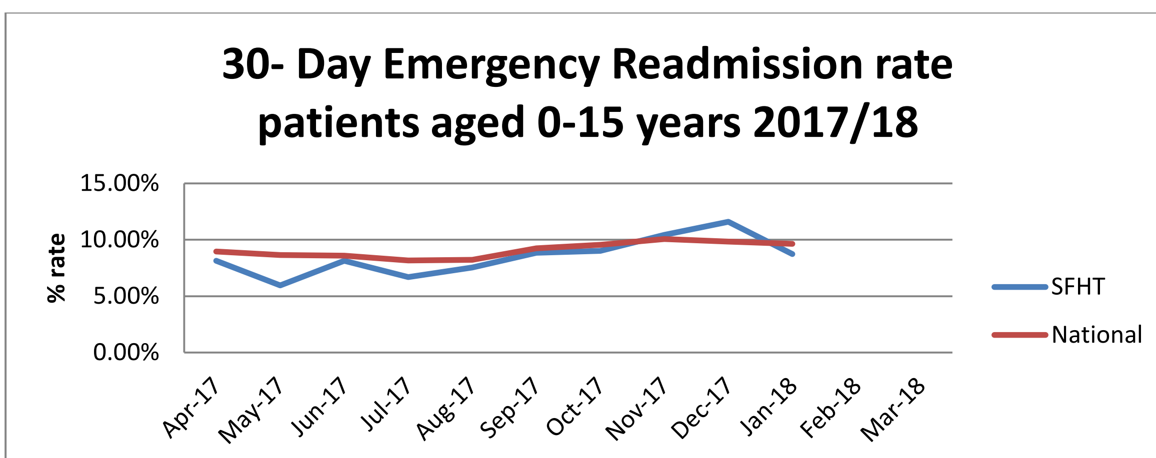
The Sherwood Forest NHS Foundation Trust intends to take the following actions to improve this percentage score and so the quality of its services, by capturing this within our quality improvement works.

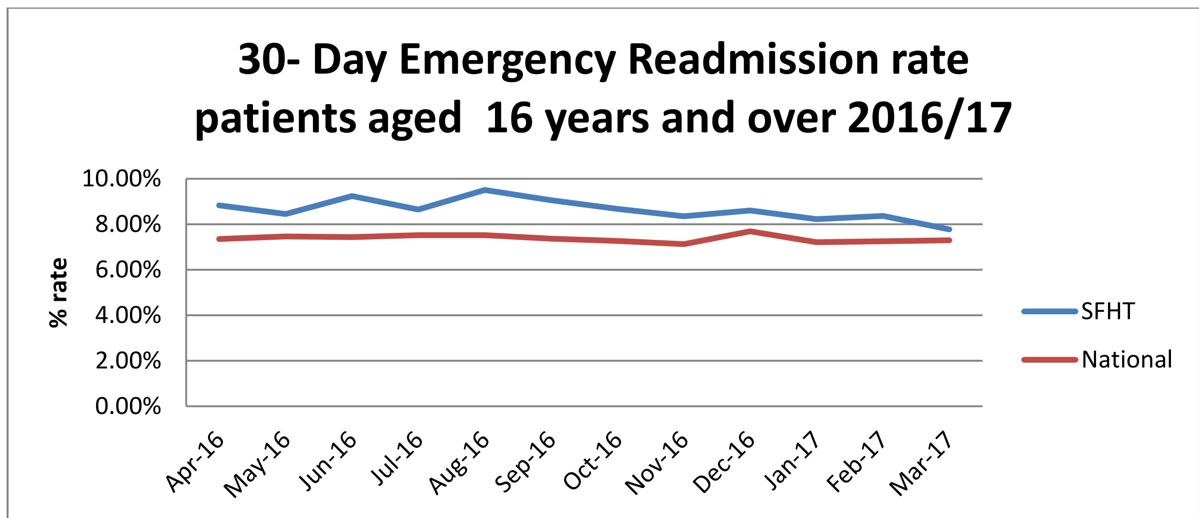
2.12.2 Percentage of patients readmitted to hospital within 28 Days

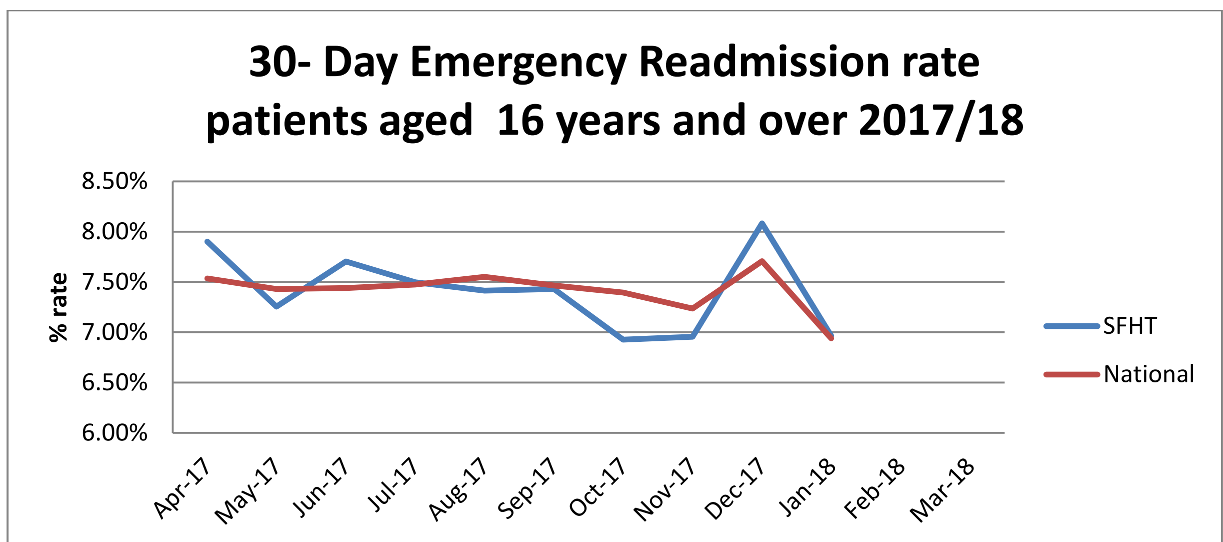
The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; That the information is made available to the Trust through Healthcare Evaluation Data (HED) . The national picture compares values of approximately 325 organisations contained within the HED software The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during 2017/18:

- Aged 0 to 15 is 8.43%
- Aged 16 or over is 7.43%









The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages, and so the quality of its services by:

- Safe, timely discharge planning together with appropriate support after discharge. The Trust maintains good operational working relationships with Community and Social Care providers, both of whom who are well engaged with the Trust discharge planning arrangements, so that patients are supported through the discharge process.

During 2017/18 an internal audit was undertaken to assess the effectiveness of the arrangements that the Trust has in place to monitor and report on readmission levels. Following this audit the Trust reports monthly on readmission rates and this is monitored monthly through the divisional performance review meetings, with escalation to Trust Board of Directors on an exception basis.

2.13 Patient Reported Outcome Measures (PROM's)

The Sherwood Forest Hospital NHS Foundation Trust considers that this data is as described for the following reasons. Graph 1 below shows the how the Trust compares to the England average for measuring generic health

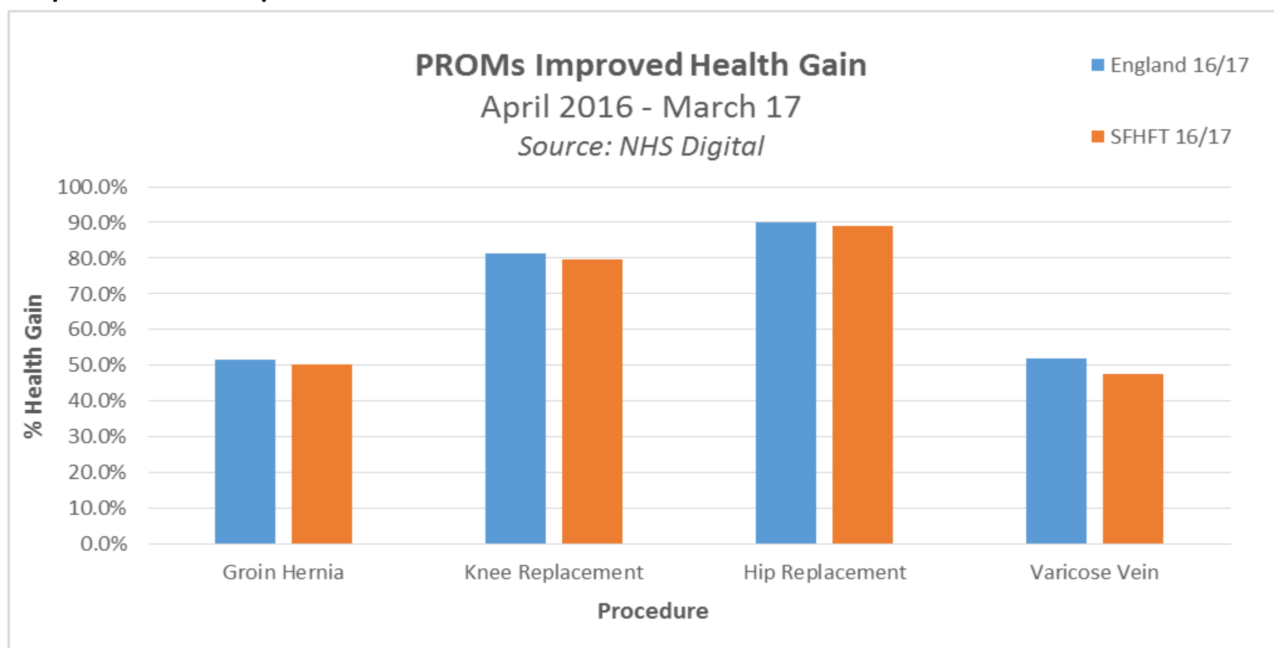
status. This is one of the most commonly used generic health status measurement, and has high levels of validity and reliability reported in various health conditions.

The national average data is included in the graphs below for the reporting period. Data is not available to compare with other NHS Trusts with the highest and lowest percentages for the reporting period. The Sherwood Forest Hospitals NHS Foundation Trust considers this data is as described for the following reason; that it is made available to the Trust through NHS Digital

PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery. This provides an indication of the outcomes or quality of care delivered to NHS patients and has been collected by all providers of NHS-funded care since April 2009.

PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Finalised data for varicose vein and groin hernia procedures for 2016/17 has now been published and finalised data for 2017/18 is due to be published at the end of May 2018 and is therefore unavailable at the time of reporting.

Graph 1 – PROMs Improved Health Gains

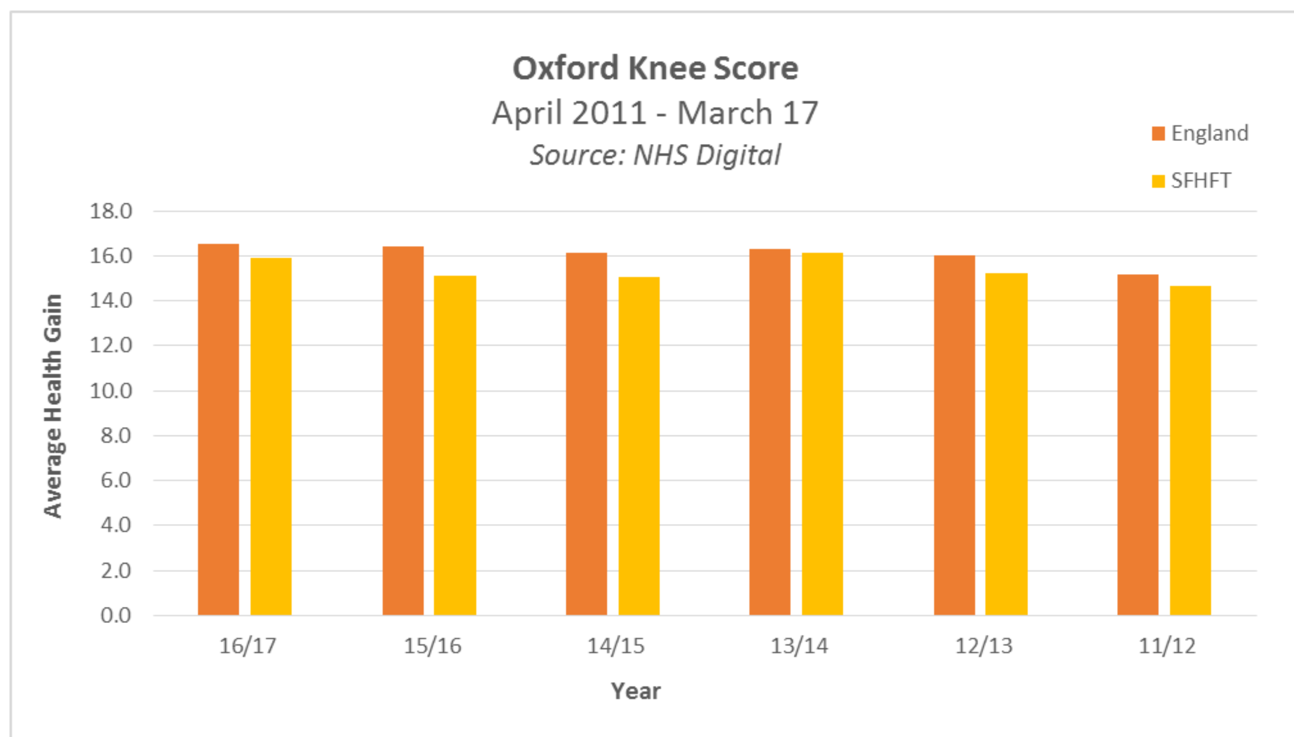


The Sherwood Forest Hospital NHS Foundation Trust has in 2017/18 taken the following actions to improve the Oxford Knee scores as these were below the National average and so the quality of its services by implementing the following:

- All hip and knee replacement patients attend pre-operative hip and knee school, to be given information regarding their procedure as well as the opportunity to practice exercises and use of aids with expert support. The school also allows patients to be assessed for their OT needs and requirements.
- Audit of all patients reporting deterioration, with a specific focus placed on reviewing patients having Hip replacements with either a negative or no health gain identified from Oxford Hip Score.

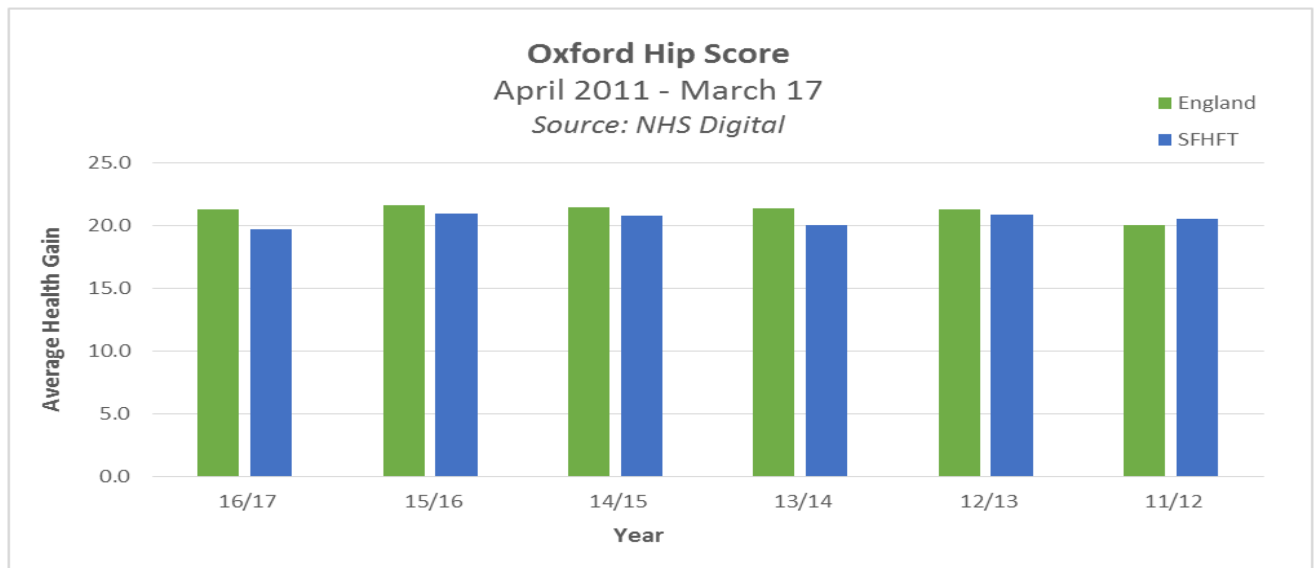
The data from March 2017 to present is not available for reporting during this time period. As a result of the above, while the national average Oxford Knee score across England has remained fairly static, the Trusts health gain increased and is now within acceptable range of the England average as shown in Graph 2.

Graph 2 – Oxford Knee Score – April 2011 – March 2017

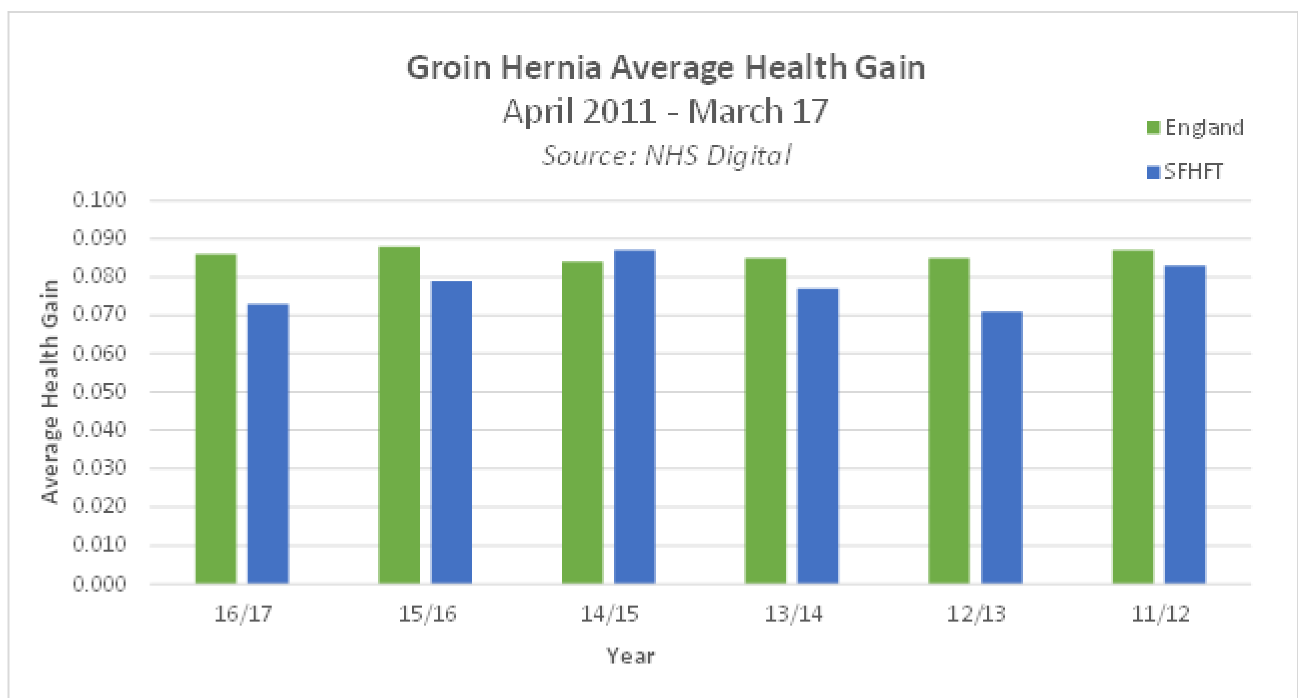


In response to the latest Oxford Hip scores shown in graph 3, further work and audits will be undertaken to ascertain how the Trust can improve the scores to above the national average. A key action for the next period is to implement a telephone clinic to enable a specialist nurse to support the patient in completing their post-operative questionnaire and compare their pre-operative questionnaire scores. At present, patients do not have their pre-operative questionnaire scores in order to compare and support their completion.

Graph 3- Oxford Hip score April 2011 – March 2017

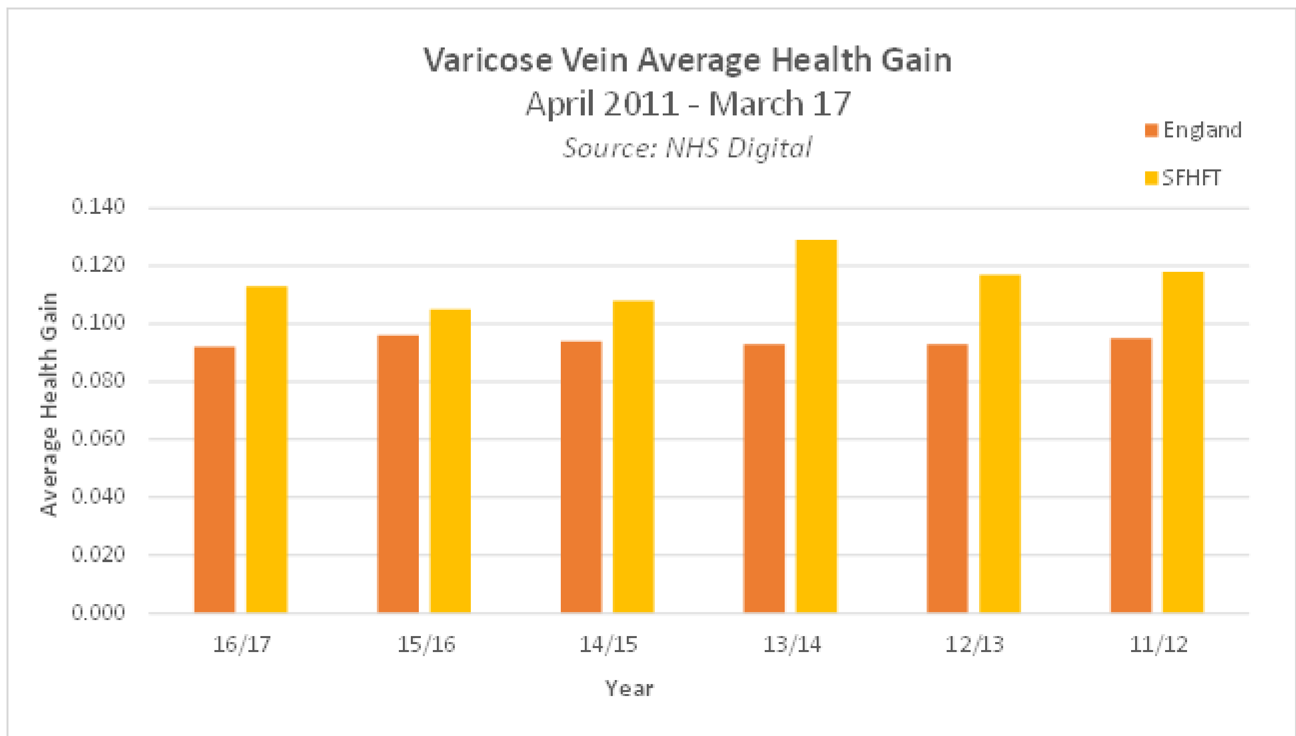


Graph 4 – Groin Hernia Score – April 2011 – March 2017



Trust performance has been below average for the last two years, an improvement plan is being developed to focus on addressing this for 2018/19.

Graph 5 – Varicose Vein score – April 2011 – March 2017



Trust performance has consistently been above average for England for the last 6 years and it is anticipated that this will be maintained during 2018/19..

2.14 Trust Responsiveness to the Personal Needs of Patients

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust is committed to resolving any complaints or concerns at the earliest opportunity and this is often achieved through the patient, relative or carer discussing their concerns directly with the Patient Experience Team (PET).

The PET provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the department/ward directly, or where they have done so but their concern remains unresolved. The PET aim to resolve any concerns that are raised with them quickly and informally with the cooperation of the department/ward involved in the care and treatment provided to the patient. Should the patient or carer feel that their concern should be formally investigated they are able to make a formal complaint. The Trust operates a centralised complaints service, which ensures that a patient centred approach is taken to the management of complaints and that all complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt, or where necessary an agreed timescale dependent upon the complexity of the complaint.

During 2017/18 the Trust received 259 complaints. In the same reporting period we responded to 94.3% within the recommended 25 days. It is recognised that some complaints are complex and as such a timeframe to respond will be agreed with the complainant on a case-by-case basis.

Responsiveness to personal needs of patients is reported through the national inpatient survey data. The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason: the survey was undertaken by Quality Health for Sherwood Forest Hospitals NHS Foundation Trust using the methodology determined by the survey co-ordinating centre for the overall national inpatient survey programme. The report for the 2017 inpatient survey is unavailable until 13th June 2018.

The table below shows the average scores and compares the scores with the lowest and highest performing Trust for a selection of patient experience responses from the survey.

Question	Score 2016	No of respondents	Lowest Score Trust	Highest Score Trust	RAG rating
Patients were not bother by noise at night from other patients	71.4%	489	49.5%	77.3%	
Doctors did not talk in front of patients as if they weren't there	86.7%	483	82.2%	92.3%	
Patients got enough help from staff to eat their meals	70.4%	121	64.3%	90.1%	
Carers were given all the information they needed to help care for the patient	56.5%	341	52.1%	71.2%	
Patients were told who to contact if they were worried about their condition after they left hospital	75.8%	432	68.3%	90.9%	
Patients were given clear written information about their medicine	84.6%	344	69.9%	84.6%	

The Sherwood Forest Hospitals NHS Foundation Trust has taken the following actions to improve these scores, and so the quality of its services by: analysing PET data to identify any themes from incidents, claims and coroner inquests, centralise and review the storage and retention of patient information and accessibility, revision of discharge information for patients and families, Introduction of Carers Charter to enable a smooth

transition within our services and improve discharge experience. Mechanisms to ensure lessons are learnt include:

- Quarterly reporting to the Patient Safety and Quality Group
- Monthly Divisional Governance meetings where attendance by the Divisional Patient Experience Leads ensures feedback in the form of patient stories
- Datix dashboards provide real-time feedback ion complaint, concerns and compliments to divisions and specialities
- Representation on End of Life and Dementia Groups to highlight any themes and share complaint case outcomes

Mechanisms to share intelligence include the bespoke Datix Dashboards available to all wards, specialties and divisions, quarterly CLIP report to the Patient Safety and Quality Group which is combined with incidents and claims data.

Complaint cases are presented by the Divisional Patient Experience Leads at divisional governance meetings, which facilitates a multi-disciplinary conversation about how we could have improved the experience and implement the improvements identified as a result of our findings.

Monitoring and reporting for sustained improvement

In order to continue to understand how patient experience and maintaining high standards, we continue to strive to provide feedback received from complaints, concerns, compliments, Friends and Family Test and more recently the introduction of Care Opinion.

Complaints, concerns and compliments will continue to be triangulated with incidents, legal claims and Coroners' Inquests to identify themes and trends. The learning from complaints is managed by action plans that are tracked with divisions to ensure learning is embedded and evidenced.

The complaints and concerns policy is currently under review as part of the 3 yearly revision, PET are working in partnership with divisions to further embed the complaints processes and procedures within divisions including enhanced training for the Heads of Nursing and investigators to ensure all responsible staff are competent to undertake and complete investigations.

PET staff will continue to provide training at induction and leadership events to raise awareness of the importance of supportive and effective complaint management across the Trust.

During 2018/19 plans to launch Datix to its full functionality led by the Datix Manager and Head of Patient Experience will provided a fully automated complaint audit trail and avoid duplication. This will deliver a more sophisticated reporting in relation to monitoring complaint investigation timescales.

All patient experience data will continue to be reported monthly and quarterly to the various groups within the governance structure, which will identify how well we are doing against the standard operating frameworks targets and understand our patients, relatives and carers experiences when using our services.

2.15 Staff Friends and Family Responses and Recommendation Rates

National NHS Staff Survey – 2017

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust participates in the national NHS Staff Survey on an annual basis. The most recent survey was undertaken from the beginning of September and until early December 2017. The Trust elected to survey all staff and over 2,500 responded giving a response rate of 57%. This was the highest in the East Midlands and joint 7th in England for acute NHS Trusts, where the average was 44%. The 57% response rate compares well

with the 41% Trust response rate in 2016, which was based on a random sample percentage of staff being offered the opportunity to respond.

Survey response rate

Year	Ranking compared to other acute trusts in England	Response rate		Trust improvement or deterioration on previous year
		SFH	(all Trusts in England)	
2016	Below Average	41%	44%	-4%
2017	Highest 20% - 4th in East Midlands Joint 7th in England	57%	44%	+16%

The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by implementing the actions outlined below:

Areas identified for action following the 2016 staff survey

The 2017 NHS Staff survey responses were largely an improvement on the previous year. This had been influenced by some of the initiatives that the Trust undertook in response to the 2016 NHS staff survey finding. The 2016 results were initially reported to the Trusts Organisational Development and Workforce Committee and divisional action plans were developed together with key strands being linked into the Trusts Workforce Strategy: Maximising our Potential. Many of the actions during 2017 focused on the following areas:

- **Staff engagement**
  This continued to be a high priority with activities set out in the Organisational Development and Engagement Plan element of the Workforce Strategy, supported by the Trusts Communications Strategy. A formal launch event for Maximising our Potential was held at both the Kings Mill Hospital Site and at Newark, with all staff invited to attend.
- Regular staff briefing events took place throughout the year. There was emphasis on ensuring staff received regular and honest information about the Trust's performance, the CQC rating, quality and improvement activities and celebrating achievements.
- Senior leaders continued their commitment to engagement. A blended approach to this was encouraged through CEO and executive open briefing and drop-in sessions held at each hospital site, executive attendance at board rounds on wards and Trust Board member workplace visits designed to increase visibility. Later on in 2017/2018 "15 steps" visits were introduced for executives, senior clinical leader and governors.
- The Trust launched a reformatted Staff Brief and Staff Bulletin, introduced a weekly CEO all staff email briefing and increased the social media presence of the Executive Team.
- The Trust launched its new Vision and strategic priorities in spring 2017. This was underpinned by work which refreshed the Trust CARE values, which set the professional and behavioural expectations for all staff. This was delivered to workplaces during 2017/18 enabling staff to explore how they live the CARE Values in their daily work and pledging what they will enhance or do differently to contribute to the Trusts improvement journey.

These initiatives continue to provide staff with an opportunity to see, hear from and question senior leaders, with Divisional representation on the Staff Communications and Engagement Forum continuing to prove beneficial by providing a facility through which to monitor staff engagement, 'test the temperature' and explore new initiatives.

Staff well-being and safety activities

These are set out in the Staff Health, Safety and Wellbeing Plan of Maximising our Potential and included embedding as business as usual the CQUIN Staff Health & Wellbeing work undertaken the previous year.

The link between engaged, well-motivated, happy and healthy staff and the delivery of high quality patient care is well documented and pivotal to our engagement philosophy in the Trust. The 'Happy, Healthy, Here' initiative designed to achieve the CQUIN Staff Health and Wellbeing targets for 2017-18 included an in-house fast-track staff physiotherapy service and health and wellbeing drop-in sessions.

The national 'Time to talk' initiative was introduced to support the mental health and wellbeing of staff, with events held to raise awareness and training provided for Time to Talk Champions.

Creating and maintaining a safe environment is important in the Trust and therefore ensuring that all staff attend high quality mandatory training that reflects best practice is a priority. For all of 2017/18, the compliance rates for attendance on this training continually exceeded the 90% target.
All staff are encouraged to raise concerns through appropriate mechanisms and to have a culture where they are confident that they will be listened to and have their concern considered. This is achieved by adopting an open door policy with senior leaders being accessible to hear concerns and ideas and promoting a no blame culture.

The Trust initially appointed two Freedom to Speak Up Guardians, increasing this capacity in 2017/18 with the appointment of two more guardians and one Champion. Their role and contact details continue to be widely publicised through Staff Brief, the Orientation Day, Staff Bulletins, posters, pop up banners and drop-in sessions. Where staff raised concerns the Trust ensures that these are addressed appropriately and that feedback is provided to the person raising the concern. The concerns raised are monitored for themes and trends, periodically reported to the Executive Team and the Trust Board and triangulated with KPIs, findings from pulse surveys and feedback from leavers.

Valuing staff

These initiatives were set out in the Recruitment, Reward and Retention Plan of Maximising our Potential and the Trust Communication Strategy. The Trust reviewed how it engaged with potential recruits and refreshed its recruitment branding, microsites and its presence on social media. Alternative approaches to selection including assessment centres and values based recruitment have offered personalised approaches to the selection and appointment of future staff.

In addition, the Trust engages with new starters prior to them commencing employment through its Welcome Assure Reassure Meet (WARM) principals. This means that staff feel welcome and valued from the start of their employment journey at Sherwood.

Retention initiatives were introduced designed to promote the key benefits available to Trust staff, together with further investment in the Occupational Health Department, particularly to create targeted wellbeing at work activities which draw on the benefits of early intervention.

Developing Trust Leaders and Staff

The Leadership, Talent Management and Succession Plan and the Trusts Training, Learning and Development Plan set out initiatives for improving the development of Trust leaders and staff. A formal leadership talent mapping and succession planning system was created and piloted which documents and supports the readiness of existing senior leaders for progression. It also identifies areas of risk. This will be integrated into the Trusts appraisal process next year, when the process is revised to include talent conversations for staff at all levels. This follows on from the work in 2017/18 which introduced a management appraisal for those who are in formal medical leadership roles.

In 2017/18 the Trust refreshed its leadership development programmes and introduced a leadership framework. The Trusts facilitators have been instrumental in the delivery of the first Mary Seacole Leadership Development programme for the wider health and social care system, through effective cross-organisational partnership working. The Trust introduced an interactive networking Managers Induction Programme for new people managers and leaders in order to ensure a seamless transition into their leadership role with the Trust. In total, over 400 Trust leaders accessed a range of leadership and management courses throughout 2017/2018.

Summary of performance for 2017 NHS staff survey

Much of the work undertaken during the first half of 2017/18 will have had a positive impact on the 2017 NHS Staff Survey. However, in keeping with all other NHS Trusts in the country, Sherwood Forest continued to operate against a backdrop of significant financial pressures and continued high demand on services. Positively, despite these pressures the Trust has made significant and sustained improvement.

The survey is comprised of different sections, or 'key findings', which pursue a specific line of questioning, for example, Job Satisfaction, Patient Experience and Care. Our results improved in 3 key findings with no change in 28 key findings, with a deterioration in only 1 key finding.

The following tables show how the findings for our Trust compare with the national average for similar Trusts in England, demonstrating at a high level the overall improvement achieved particularly over the last three years.

Summary of all key findings for 2014, 2015, 2016 and 2017

	2014 (29)	2015 (32)	2016 (32)	2017 (32)
Best 20%	1	2	8	8
Better than the average	5	3	8	10
Average	4	9	6	9

Worse than the average	11	6	7	2
Worst 20%	8	12	3	3

Overall indicator of staff engagement

Very positively, the overall indicator of staff engagement for the Trust was 3.87, which was well above average when compared to trusts of a similar type. This was a further increase on the previous year's score of 3.85, when the Trust was again above average, demonstrating significant and sustained improvement.

NHS Staff Survey Comparison for Overall Staff Engagement for 4 years			
Overall Staff Engagement 2014	3.66	Average for acute Trusts in England	3.74
Overall Staff Engagement 2015	3.68	Average for acute Trusts in England	3.79
Overall Staff Engagement 2016	3.86	Average for acute Trusts in England	3.81
Overall Staff Engagement 2017	3.87	Average for acute Trusts in England	3.79

Where staff experience has improved

- KF23. % of staff experiencing physical violence from staff in the last 12 months
- KF10. Support from immediate managers
- KF6. % of staff reporting good communication between senior management and Staff

The work during 2017 to support staff engagement and senior leadership visibility, together with an awareness programme relating to physical violence is likely to have had an impacted here.

In 2016 KF6 was worse than average. However it has moved from 29% in 2016 to 34% in 2017 which is now in the average category for acute Trusts in England.

Where staff experience has deteriorated

- KF28. % of staff witnessing potentially harmful errors, near misses or incidents in the last month.

This is of concern and will be picked up in action plans arising from the survey.

Highest and lowest ranking scores

The rankings show how our 2017 staff survey results compare with other acute Trust in England.

2017 Top 5 ranking scores

- KF2. Staff satisfaction with the quality of work and patient care they are able to deliver. No change. The Trust is in the highest (best) 20% of acute trusts in England. **SFH is 4th nationally and top in the East Midlands.**
- KF9. Effective team working. No change. The Trust is in the highest (best) 20% of acute trusts in England. **SFH is 4th nationally and top in the East Midlands.**
- KF21. % of staff believing that the organisation provides equal opportunities for career progression or promotion. No change. The Trust is in the highest (best) 20% of acute trusts in England. **SFH is 6th nationally and top in the East Midlands.**
- KF11. % of staff appraised in the last year. No change. The Trust is in the highest (best) 20% of acute trusts in England. **SFH is 7th nationally and top in the East Midlands**.
- KF20. % of staff experiencing discrimination at work in the last 12 months. No change. The Trust is in the lowest (best) 20% of acute trusts in England. **SFH is 10th nationally and second in the East Midlands.**

These scores evidence a much more positive culture emerging in the Trust.

2017 Bottom 5 ranking scores

- KF22. % of staff experiencing physical violence from patients, relatives or the public in the last 12 months. No change. The Trust is in the highest (worst) 20% of acute trusts.
- KF24. % of staff/colleagues reporting most recent experience of violence. No change. The Trust is in the lowest (worst) 20% of acute trusts.
- KF18. % of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves. No change. The Trust is in the highest (worst) 20% of acute trusts.
- KF27. % of staff/colleagues reporting most recent experience of harassment, bullying or abuse. No change. The Trust is below (worse than) average for acute trusts.
- KF28. % of staff witnessing potentially harmful errors, near misses or incidents in the last month. Increase (worse than 2016). The Trust is above (worse than) average.

On a positive note, these are the only five scores that were actually worse than average. KF22 and KF18 were also amongst our bottom five scores in 2016. Steps were taken during 2017 to make staff more aware of reporting procedures if they experience physical violence together with general awareness. This appears to have resulted in a positive reduction in the percentage of staff experiencing physical violence from other staff in the last 12 months which is one of our significant areas of improvement. However, it is clear that there is still an issue with staff experiencing physical violence from patient and relatives.

The Trust has a rigorous sickness absence management policy which is actively implemented which may be leading to the high score for KF18. During 2017 the Trust increased its staff wellbeing events and interventions which will continue during 2018.

Staff recommending the Trust as a place to work or receive treatment

This is one of the significant measures which are articulated by the NHS staff survey results. Questions Q21a, Q21c and Q21d feed into KF 1 “Staff recommendation of the organisation as a place to work or receive treatment.”

	2015	2016	2017	*2017 av.
Q21a "Care of patients/service users is my organisation's top priority"	71%	82%	81%	76%
Q21b "My organisation acts on concerns raised by patients/service users"	65%	76%	76%	73%
Q21c "I would recommend my organisation as a place to work"	48%	68%	70%	61%
Q21d "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	57%	74%	78%	71%
KF1 Staff recommendation of the organisation as a place to work or receive treatment*	3.54	3.87	3.93	3.76

** Possible scores range from minimum 1 to maximum 5*

The results of this show a marked improvement in all areas to well above the *national average for acute Trusts in England. Staff recommending the Trust as a place to work is now 9% above this average and staff being happy with the standard of care provided by SFH is 7% above the average. This places SFH in the top 20 acute Trusts in England for this important measure and second in the East Midlands

Staff Friends and Family Test

The Staff Friends and Family Test (FFT) has been in place since April 2014 and was designed as a tool to support local improvement. Results are submitted to NHS England and are published nationally. All staff must have the opportunity to respond at least once in the year. The survey has to be undertaken in quarters one, two and four (there is no requirement for quarter three because the NHS Staff Survey is undertaken at this time).

The Staff FFT asks staff to rate how likely (using a scale between extremely likely and extremely unlikely) they would be to recommend the organisation to family and friends as a place to:

1. Receive care or treatment
2. Work

The following table summarises the FFT results from 2017/18.

	Q1 FFT	Q2 FFT	Q3 Staff Survey	National Average
How likely would you be to recommend this organisation to friends and family if they needed care or treatment?	85.71%	89.69%	78%	71%
How likely would you be to recommend this organisation to friends and family as a place to work?	71.43%	71.82%	70%	61%
Number of respondents	21	291	2,515	

The Q3 NHS Staff Survey questions are slightly different:

1. *"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"*
2. *"I would recommend my organisation as a place to work"*

It is a requirement to provide a free-text follow up question for each of the two areas, to request the main reason for the answer given. This enables staff to provide more detailed feedback should they wish. Although the free-text responses are not submitted to NHS England, our Trust uses this feedback to inform and support improvements to benefit both staff and the patient experience.

Pulse survey

In quarters one and two we asked additional questions in the staff FFT to evaluate staff views to enable us to better understand:

- Q1 – Bullying, harassment, violence and aggression
- Q2 – Health and wellbeing with a particularly focus on mental health

The findings informed aspects of the Trusts action plan in response to the 2016 survey. Additionally the feedback was used alongside the information gained from exit interviews, to monitor progress of our action plans and to inform future initiatives, to improve the experience of staff and patients.

Leaver interviews

Staff leaving the Trusts employment are offered a leaver interview. This can be with their line manager, higher line manager or a trained volunteer. Alternatively, staff can complete a leaver questionnaire, which can be done online or via a paper copy which is then returned to the Human Resources (HR) Team.

This staff feedback is valued and triangulated with Key Performance Indicators as well as results from both the staff survey and the quarterly staff FFT. This helps us to understand the staff experience more effectively. HR Business Partners (HRBP) and Assistant HR Business Partners (AHRBP) utilise this information to identify trends, inform initiatives and support the coaching and mentoring work they undertake with managers.

Where a leaver's feedback raises a concern or identifies an issue, work is undertaken discretely to explore and address the problem. Any significant concerns initiate an investigation.

The number of staff agreeing to give feedback as they leave has decreased and remains low. Following a review of the leaver feedback process and questionnaire, the option for staff to complete a questionnaire on-line was introduced from 1 April 2016. However, this has not increased the number of completed leaver questionnaires. In an attempt to increase the number of staff providing feedback the questionnaire has been revised and staff will now receive an email with a link to the leaver questionnaire inviting them to give feedback. The option for a leaver's interview is still offered. The revised system is due to be launched in April 2018.

Future priorities, targets and monitoring

The 2017 staff results have been communicated to staff in an electronic briefing, supported by further communications, including divisional videos, detailing the actions that will be taken as a result of the staff survey

feedback. There were also a number of individual suggestions for improvement that were captured in the free text that are being explored.

The results were discussed at the Staff Communication and Engagement Forum to obtain their views on priority actions. In addition, the Director of Human Resources and Organisational Development has undertaken four hour long drop-in session across all three sites during March with an open invitation for any staff member to attend and offer further feedback. The quarter four (March) pulse survey, available to all staff also contained a number of follow-up questions.

The Sherwood Forest Hospitals NHS Foundation Trust has taken the following actions to improve the staff who would recommend the Trust to family and friends percentage rate , and so the quality of its services, by : Divisions scrutinising the staff survey results in order to develop their action plans which were shared at the Senior Leadership Team Development day in February. Delivery of those actions plans, which are pertinent to Divisions, will be monitored at the monthly Divisional performance meetings with Executives.

There are also Trust wide initiatives for incorporation into the Workforce Strategy 2018/19 Implementation Plans, which will also be influenced by these results. These will include continuation of engagement activities, a focus on staff health and well-being and diversity and inclusivity. Some of the results will also feature in Trust recruitment campaigns. Additionally the Trust will be working with NHS Elect to develop a new senior leadership development programme, to support our talent management and succession planning approach, which will commence in late 2018.

The improvements in the 2017 staff survey results, especially the positive overall score for staff engagement, are heartening and give the Trust a good platform upon which to both consolidate and build upon to support our journey to outstanding over the coming year.

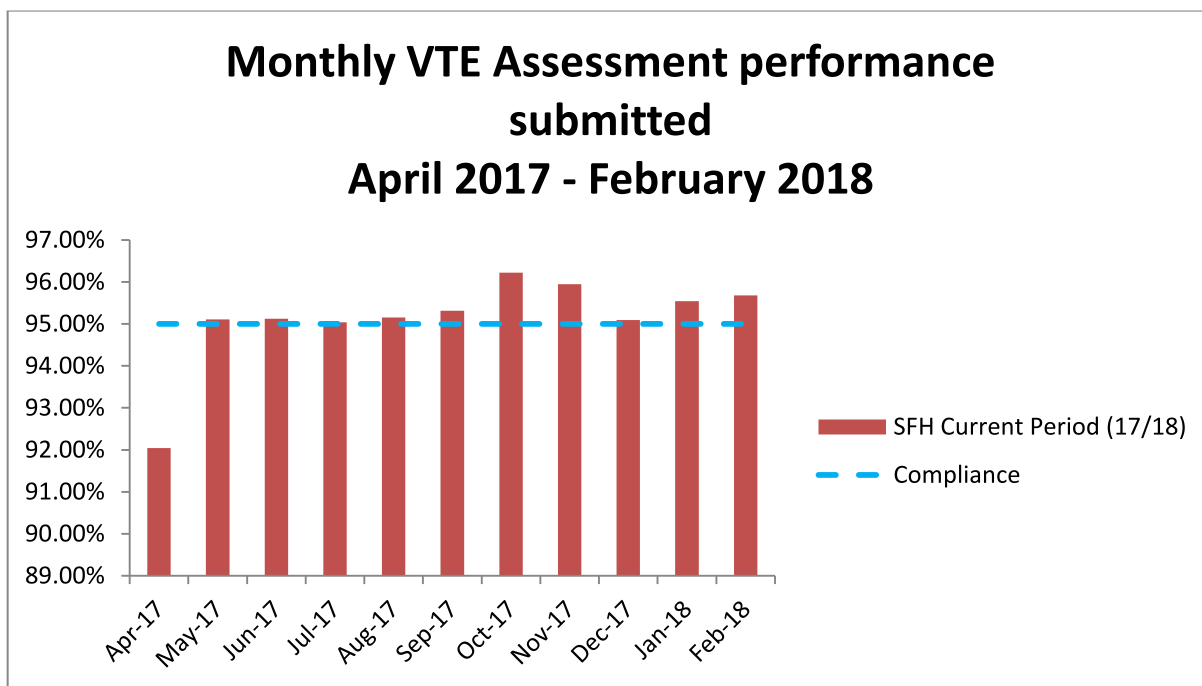
2.16 Venous Thromboembolism

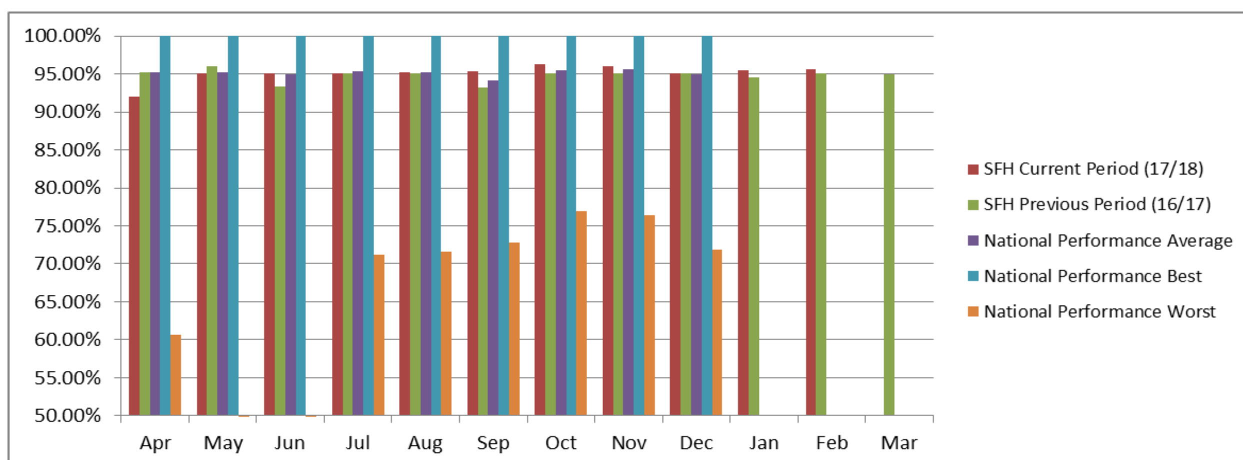
The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. A VTE is a blood clot (thrombus) that forms within a vein that can cause occlusion within the lung (pulmonary embolism) or in the deep leg veins (deep vein thrombus). The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable, hospital acquired venous thromboembolism (VTE) every year. This includes patients admitted to hospital for medical and surgical care. . VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long term morbidities is associated with considerable cost to the health service.

All adult patients should have a VTE risk assessment on admission to hospital using a nationally recognised risk assessment tool. The Trust aims to achieve 95% or above compliance with this standard. During the reporting period April 2017 – February 2018 compliance was met each month apart from April 2017. Compliance was not achieved during April due to the risk assessment not being completed or not found in the medical records. The Trust can report that no Incidents have been raised where a patient was harmed as a result of developing a hospital acquired thrombus (during the reporting period that met the NHS England Serious Incident Framework criteria.

The Sherwood Forest Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by undertaking a monthly review of a random sample of medical notes to ensure that all eligible patients have had appropriate VTE prophylaxis in accordance with Trust guidance. To date this review demonstrates that appropriate VTE prophylaxis is being initiated.

Graph – Monthly VTE assessment rate





2.17.1 Clostridium Difficile Infection

Clostridium Difficile Aims for 2017/18

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. Clostridium Difficile infection is acknowledged as a problem that impacts upon the whole health economy. The partnership working between colleagues from primary care commenced during 2014/15 and has evolved to consider all potential aspects causing infections across the health economy and includes joint working to promote infection prevention messages. The Trust aims for 2017/18 are outlined below:

- Review and identify common themes across organisations within the whole healthcare economy.
- Share relevant learning between the local infection prevention teams.
- Ensure that Trust attributable cases in the reporting period remain below 48.

How Was This Achieved

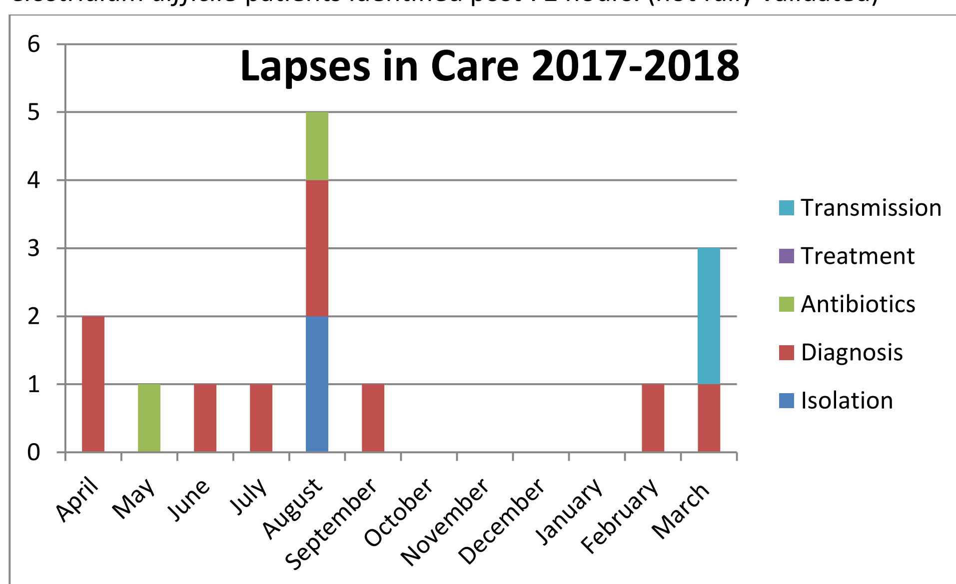
At the end of 2014/2015 the Trust reported 67 cases of *Clostridium difficile*, during, 2017/2018 the numbers of cases identified were 39. In comparison the 2016/2017 this was disappointing; a rise in numbers was identified during Quarter 2 and is displayed in graph 2. A full review of all cases was performed to establish if there were any common themes, at this point no genetic link was established to suggest that there was cross transmission. It was identified that a change in antimicrobial prescribing had occurred due to an international shortage of the antibiotic piperacillin -tazobactam *Clostridium difficile* proliferates where the gut flora is disturbed, certain groups of antibiotics are known to have a greater impact than others. During Quarter 4 three cases were genetically linked suggesting that there has been a direct transmission within the Trust. (there had been high levels of influenza with secondary bacterial infections therefore many more patients guts were susceptible to *Clostridium difficile*,. This issue demonstrates the importance of aggressive monitoring of *Clostridium difficile* and response during times when the Trust has high levels of activity. Patient Management is a core element of improving patient outcomes following a diagnosis of *Clostridium difficile* infection and reducing the risk of onward transmission. Patient care is closely monitored by the infection prevention team.

The Sherwood Forest Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by placing even greater emphasis on Clostridium difficile management and implementing the interventions outlined below:

- All wards are visited a minimum of bi weekly ward to monitor patients and their environment.
- Multidisciplinary ward round including Infection Prevention, microbiology, gastroenterology and antimicrobial pharmacist occurred twice a week.
- Antimicrobial Stewardship rounds including the microbiologist, antimicrobial pharmacist, sepsis nurse and infection prevention nurse are undertaken twice a week.
- Where lapses of care (Graph 8) have been identified, targeted actions in relevant areas have been undertaken.

Graph 8: Lapses in care according to recognised definitions in The Trust recognised that even with a greater emphasis on *Clostridium difficile* management being required and several interventions were implemented:

Clostridium difficile patients identified post 72 hours. (not fully validated)



Education and Training:

- All educational programmes highlighted the importance of preventing primary infections to avoid increased use of unnecessary antibiotics.
- Regular information was provided to all divisional, speciality governance forums.
- Weekly update to nursing teams, identifying key practice points requiring address.

Cleanliness:

The standard of cleaning is fundamental in reducing the risks of transferring Clostridium difficile. This year the IPCT continued to work closely with Medirest, Skanska and commercial companies to improve the consistency of the cleaning processes and ensure that all staff are aware of their responsibilities.

A number of initiatives have been introduced:

- The trial and review of innovative cleaning equipment and processes including ultra violet cleaning.
- Monthly meeting to identify any areas and ensure that the periodic deep clean programme was signposted to 'at risk' areas.

Auditing:

This is an important part of both monitoring existing practice and driving improvements in those areas required. The IPCT performs standardised audits, providing photographic evidence of issues identified; detailed specific immediate feedback and education at time of audit has been provided. In addition Medirest monitor against National Standards for Cleanliness:

- Continued improved compliance with both environmental and equipment cleanliness has been evident.
- Delays in diagnosis continues to be the main reason for lapses in care identified (graph 1) In April 2015, a stool proforma was introduced to direct staff when and when not to send samples, during 2017/2018 the overall rate has averaged at 79%, with areas achieving much higher rates at time.
- All samples that are rejected have been monitored and the teams informed to ensure timely diagnosis and treatment of the patients is not delayed excessively.,

Graph – Cumulative totals of Clostridium Difficile

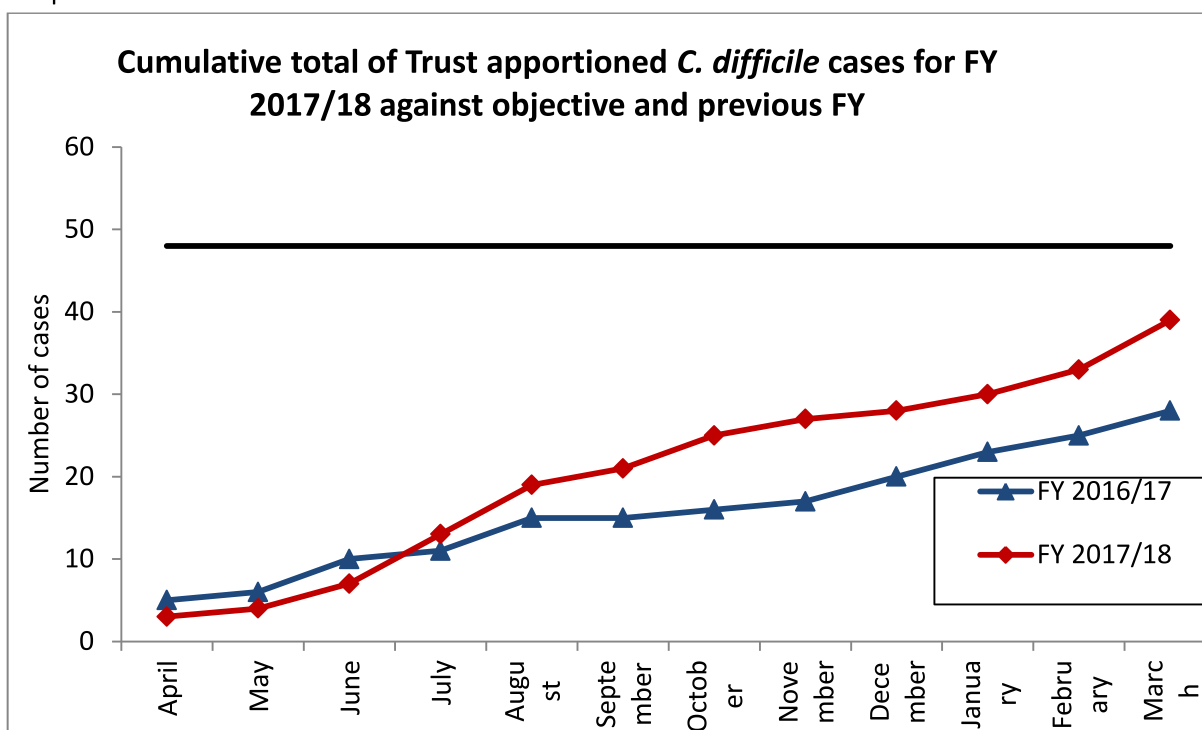


Table 2 C-Difficile Rates per 100,000 bed days

Period	April	May	June	July	August	September	October	November	December	January	February	March
2013/14	9.0	18.4	9.9	9.2	19.0	18.9	22.3	23.6	9.0	8.5	4.7	21.5
2014/15	22.6	26.5	23.7	30.9	22.9	31.5	13.6	32.7	41.6	12.9	28.4	18.1
2015/16	20.4	38.9	20.4	30.8	20.7	5.3	5.2	5.3	5.4	25.4	38.8	15.2
2016/17	26.8	5.6	22.3	5.4	21.7	0.0	5.5	5.4	15.7	14.9	11.4	16.0
2017/18	17.6	5.7	18.8	36.1	36.5	11.8	22.2	11.1	5.4	10.2	17.0	30.9

*The threshold for 2017/18 was 48 cases with a rate of 22.64 per 100,000 bed days.

Monitoring and reporting

All cases of *clostridium difficile* infections within the Trust are reported to Public Health England (PHE) they have undergone a root cause analysis (RCA) to establish the underlying reasons why the patients have succumbed to the infection and whether the infection was avoidable. These have been reported back within both internal corporate and divisional governance structures and externally. Themes have been identified and work undertaken to review and manage those actions both in the immediate and for future planning.

The threshold for 2018/19 has been reduced to 47 cases with a rate of less than 23.7 per 100,000 bed days. This will provide us with an on-going challenge to continue and build on the improvements already achieved. Monitoring will continue through the Infection Prevention and Control Committee.

2.18 Patient Safety Incidents

The Sherwood Forests Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. Sherwood Forests Hospitals NHS Foundation Trust is committed to the reporting and investigation of adverse events and near misses, as it is recognised that this provides the Trust with invaluable opportunities to

learn, improve the quality of services and reduce the risk of those types of event happening again. The process for the management of reported incidents is described within the Trust's Incident Reporting Policy and Procedures.

Any incidents that affect patients are graded according to the Data Quality Standards (September 2009) published by the National Reporting and Learning System (NRLS) and, along with all other types of adverse incidents, are reported and investigated using the Trust's Datix Risk Management System.

All patient safety incidents recorded by the Trust are reported to the NRLS on a regular basis. The NRLS publishes a 6-monthly report which provides information on the quantity and types of reported incidents, comparing the organisation with other non-specialist acute trusts.

Table 3 below shows the comparative level of patient safety incident reporting within Sherwood Forests Hospitals compared with other non-specialist acute providers:

Table 3.- Level of patient safety reporting.

	Sherwood Forest Hospitals			All non-specialist acute providers
Period	Number of incidents uploaded to NRLS from SFH	Number of incidents reported by NRLS	Rate per 1,000 bed days, reported by NRLS	Median average rate per 1,000 bed days
1st Oct 2015 – 31st March 2016	3687	3657	34.63	39.31
1st April – 30th Sept 2016	3397	3339	32.82	40.02
1st Oct 2016 – 31st March 2017	3581	3507	33.51	40.14
1st April – 30th Sept 2017	3277	To date not available.	To date not available.	To date not available.

The data provided by the NRLS shows that the Trust is below the median average of reporters in terms of incidents reported per 1,000 bed days. Where there are discrepancies between the number of incidents recorded by the Trust and the number published by the NRLS these are reported to NHS Improvement.

The Sherwood Forest Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by improving the timeliness of reporting and the quality of the data submitted to the NRLS. As a result of this provisional data from the NRLS shows an 11% decrease in person identifiable information upload breaches and is currently at 2% which is 1% above the best practice standard of 3%.

The median days between all incidents occurring and being reported has also improved and is now at 18 days with all serious incidents being uploaded within 5 working days or less.

From the 1 April 2017 to 31 March 2018 the Trust declared a total of 31 serious incidents in accordance with NHS England's Serious Incident Framework (May 2015). Of the 31 incidents, 2 were deemed to be Never Events. All serious incidents were investigated and action plans developed to mitigation the risk of reoccurrence. Detailed work into the root cause of Incidents has also taken place. The type of Serious Incidents reported has changed which is a positive indicator as learning from the patient safety incidents during 2016/17 has been sustained.

The Trust has continued to invest in all aspects of the Datix system with developments throughout the year, working to enhance the reporting and investigation processes and improve the provision of essential management information at divisional and ward level to support informed, evidence-based decision making and robust accountability. This includes a review of the Datix dashboards; these allow the user to interrogate the incident trend and themes. Implementation of a Trust generic ward, specialty and divisional dashboard has commenced and is currently being piloted on one of the Orthopaedic wards. The Dashboards included a breakdown of the area's incident by severity and also provides trend and theme analysis. This data is available to Ward leaders and Deputies and is designed to improve awareness of incidents in each area. As well as this element of the project a 'Daily Incidents Dashboard' has been created which shows the previous days incidents in their entirety and also provides a breakdown of incidents graded moderate or above. It is expected that all wards will conduct a 'Daily Huddle' with all Staff in order to review the incidents, agree any immediate actions, share learning and ideas for improvement of quality on the wards. It is anticipated that incident and near miss reporting will increase as Staff see how incident reporting can lead to quality improvements for their patients.

The Datix system is also utilised by Patient Experience and Legal Services and these areas have also been further developed with the implementation of the DatixWeb Legal module and the Patient Experience module which this year saw the trust wide role out of the Compliments and Concerns reporting form, this form is now available to all Staff with access to the intranet. Migration onto the web platform has provided a workflow that is currently being tailored to bring the system in line with Trust processes allowing for eventual real time alerts, reminders and Trust wide user access to records and reporting facilities. This also allows triangulation with Incident reporting to further enrich our understanding of adverse events.

Duty of Candour

The Trust has a legal responsibility to formally offer an apology, verbally and in writing, within 10 days of any patient safety incident which is graded moderate, severe or catastrophic. Under the Duty of Candour healthcare professionals must:

- Tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong.
- Apologise to the patient (or, where appropriate, the patient's advocate, carer or family).
- Offer an appropriate remedy or support to put matters right (if possible).
- Explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

This requirement is enshrined within the Trust's Policy for Duty of Candour and embedded within the Datix incident management systems. This enables constant monitoring of Duty of Candour and enables the Trust to demonstrate the Duty is consistently being met.

Sign Up to Safety Campaign

The Trust has been part of the 'Sign Up To Safety campaign since its inception, however the programme formed part of the Trusts previous Quality Improvement Plan which included all our patient safety improvements plans and in particular the Trusts patient safety culture programme. The objective of this programme has been to develop a systematic approach from which to create an open culture where all staff understand the connection between what they do, how that impacts patient safety and in which staff feel empowered to learn and initiate improvements from incidents and near misses. Part 3 of the quality account details the patient safety culture programme which for 2017/18 includes a focus on reinvigorating and updating the 'Sign Up to Safety' Campaign.

2.19 Seven Day hospital Services

The seven day services programme, which is about ensuring that patients receive consistent high quality care every day of the week was rolled out by NHS Improvement in 2016. It is made up of 10 clinical standards, which should be met to provide a good seven day emergency service, four of which are deemed as priority standards. The time from admission to consultant review is one of these priority standards and is more likely to have the biggest impact on reducing patient mortality. The four priority standards are:

- Time to first consultant review.
- Access to diagnostic tests.
- Access to consultant directed interventions.
- Ongoing review by consultant twice daily if high dependency patients, daily for other.

Sherwood Forest Hospitals is one of the best Trusts when it comes to treating patients that are admitted to hospital through the Emergency Department quickly, no matter what day of the week it is. We are in top 25th percentile nationally and the best of the East Midlands Trusts.

The seven day service assessment, which was carried out at Kingsmill Hospital over a three week period, showed that 9 out of 10 emergency patients who were admitted to a ward after being seen in the emergency department were reviewed by a consultant within 14 hours, even over a weekend.

When a patient comes in to the emergency Department at Kingsmill Hospital they are seen by a doctor and either discharged or admitted to a ward within the hospital. If they are admitted, these results show that most patients are then reviewed by a Consultant within 14 hours, meaning that a plan for further investigations or treatment can be put in place quickly, ultimately resulting in less time spent in hospital.

Part 3 - Other information – Additional Quality Priorities

3.1 Safety – Improving the Safety of our patients

Patient Safety Culture Programme Aims for 2017/18

The Patient Safety Culture Programme is key to improving the quality and safety of care and has been identified as a critical quality priority for 2017/18. The Trust plans to build on this work and enhance the overall Patient Safety Culture by:

- Implementing Schwartz Rounding to maximise and facilitate learning opportunities for the wider organisation.
- Reinvigorating and updating the 'Sign Up to Safety' Campaign.
- Introducing Patient Safety Conversations (PSC) to promote an open culture to discuss with staff about how we can make patients safer.

Implementing Schwartz Rounding

Performance against this Target

Schwartz Rounds provide a structured forum where clinical and non-clinical staff come together to discuss the emotional and social aspects of working in healthcare. Schwartz Rounds can help staff feel more supported by allowing them the time and space to reflect on their roles. The Trust successfully applied to the Point of Care Foundation and is now an accredited site for the delivery of Schwartz Rounds. Trained facilitators are required to deliver this internationally recognised staff support programme.

How Was This Achieved

In preparation for implementing Schwartz Rounds, two senior Consultants and a senior Nurse were trained to become Schwartz Round clinical leads and facilitators. This training provided them with the opportunity to share the learning from organisations already running Schwartz Rounds by observing a round in action, speaking with staff and attending a National Point of Care Foundation Schwartz Round conference.

Monitoring and Reporting for Sustained Improvement

A staff steering group has been established to support the ongoing planning and delivery of Schwartz Rounds. The Trust is looking forward to holding its first Schwartz Round in the coming months.

Sign Up To Safety Campaign

Performance against this Target

The Sign up to Safety Campaign is a national movement designed to harness the commitment of staff, and organisations care for patients in the safest way possible and achieve their patient safety aspirations. The Trust has "Signed up to Safety" as part of its continued commitment to improving patient safety. There is no national definitions regarding requiremnts.The set of actions outlined below will be undertaken in response to the five Sign Up To Safety Pledges:

- To put safety first - commit to reduce avoidable harm in the NHS and make public the goals and plans developed locally.
- To continually learn - to make the Trust more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe services are.
- To be honest - be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

- To collaborate - take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
- To support - help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

The Trust has used its Advancing Quality Programme to demonstrate the patient safety areas that we have been focussing on.

How Was This Achieved

At the heart of Sign up to Safety is the philosophy of locally led, self-directed safety improvement. Since its launch, the Patient Safety Culture Programme has worked with staff across wards to better understand what helps and stands in the way of taking change forward, and to capture and share staff feedback on core safety culture values such as team working and working conditions. This was taken forward via an independent Staff Culture survey and followed with staff interviews at ward level. The approach also encouraged improvements championed and led by ward staff. Anonymised feedback and results from the Programme have been shared within Divisions, and with the Executive Directors and Trust Board. It provided invaluable insights on the 'big issues' that impact on staff and has informed how best to engage people in continuing this important conversation. Over the course of the Programme, individual ward projects have been embedded and have resulted in better and safer care for our patients.

Monitoring and Reporting for Sustained Improvement

The focus will now be on consolidating the work undertaken as part of the Patient Safety Culture Programme by developing a locally shaped framework for Quality Improvement. This will ensure that anyone at any level in Trust can feel confident and have the right skills needed to take forward improvement in their area.

Introducing Patient Safety Conversations

Performance against this Target

The Trusts ambition is that all staff are provided with the opportunity to lend their voices to conversations that captures the current patient safety culture in their department. Having a mechanism in place to engage in regular Patient Safety Conversations will help to achieve this by providing an opportunity for staff to talk openly and honestly with each other about anything safety related. The Trust has developed a tiered approach to Patient Safety Conversations so that all staff have the opportunity to access a channel through which they can get involved in a conversation about Patient Safety and working safely.

How was this Achieved

In the past year, the Trust has focused on developing Kitchen Table Safety Conversations (as championed by the National Sign Up to Safety team). These events are hosted informally and flexibly and can focus on specific topics such as Medicines Safety. The Trust started hosting these events in March 2017 and have identified a number of quality improvement opportunities based on staff suggestions. This approach to Kitchen Table Safety Conversations has received recognition in the national Sign Up to Safety Newsletters.

Sign up to SAFETY SignUPdate @SignuptoSafety | www.signuptosafety.nhs.uk

7th June 2017

Twitter pic of the week!

Sherwood Forest Hospitals showing that Kitchen Tables are here to stay!

19th July 2017

Twitter pic of the week

Fab maternity team having great safety conversations around the kitchen table at Sherwood Forest NHS Foundation Trust

Monitoring and Reporting for Sustained Improvement

Throughout 2018 the focus will be on developing the Patient Safety Conversations to ensure that all teams and areas get the opportunity to get involved. Also, the Trust will work to create opportunities to link staff with plans to build quality improvement capability and capacity within the Patient Safety Programme.

3.2 Safety – Reduce Harm from Falls

Falls and falls related injuries are a major cause of disability and the leading cause of mortality in older people in the UK (NICE 2013). Falls are also associated with increased length of stay and may precipitate admission into long-term care. More than 240,000 falls are reported in acute hospitals and mental health trusts in England and Wales each year (NPSA 2010). Inpatient falls are the one of the most commonly reported types of patient safety incident within the Trust. The Trust is committed to reducing the number of patients who suffer a fall or fall-related injury.

Achievements during 2016/17

- Delivered a safety improvement programme utilising best practice from a local and national perspective.
- Worked in collaboration with Alliance partners to reduce harms from falls.
- Reviewed the impact of the redeveloped enhanced patient care tool.

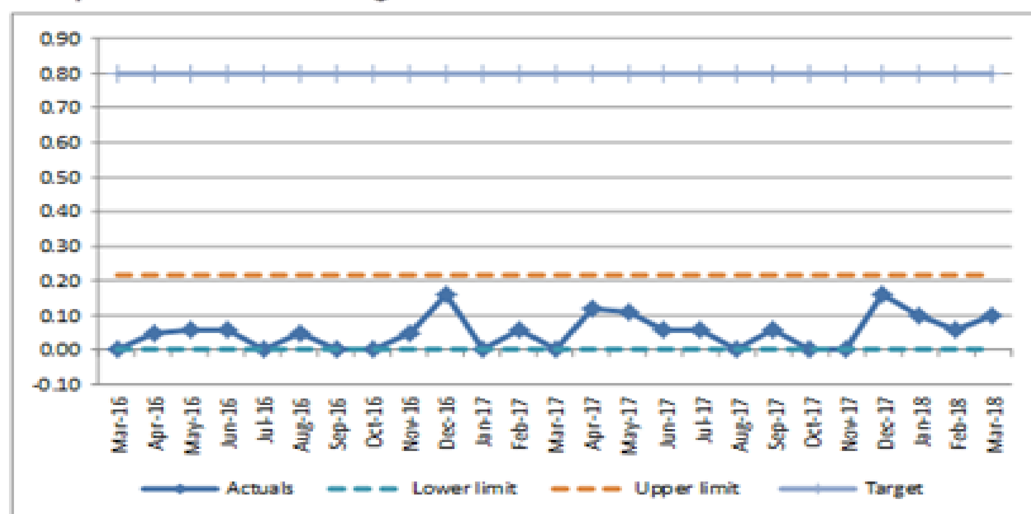
Reducing Harm from Falls Aims for 2017/18

- Further develop and maintain partnership working with the Alliance and Community to provide a consistent approach to education about falls prevention in hospitals. This will also be extended to utilise best practice from neighbouring Trusts.
- Drive improvements with a structured audit process and programme for 2017/18.

- Drive accountability and improvements by setting target reductions across Divisions.
- Continue to progress with evidence based practice and develop safety improvement programmes through learning from best practice and innovations.

Performance against this Target

Graphs 1 and 2 (below) show the percentage of falls calculated by the occupied bed days (OBD) as per the National Audit of Inpatient Falls criteria. Noting the fluctuations with this, the Trust is focused on embedding improvements to see another step change in reducing the number of falls. The current Trust figure for March 2018 low or no harm has shown a slight increase to per 1000 OBDs against the National average of 6.63 and internal target of 5.5.



How was this achieved

1. Alliance and Community partnership working. This will also be extended to utilise best practise from neighbouring Trusts.

In relation to falls the Trust has taken forward the initiatives outlined below:

- Jointly produced a health education video for use in care homes and hospitals to highlight the importance of regular activity. This is also presented at staff teaching forums to enable reinforcement in relation to Red and Green days.
- Worked in collaboration with the Nottingham Fire and Rescue Service Safe and Well visits in relation to falls prevention. Identifying those individuals at the greatest risk of falling and refer them to the appropriate services.
- The Trust contributed to an Exercise and Fall Prevention promotion day in October. Various members of the Better Together Alliance group promoted healthy lifestyle changes in relation to falls prevention.
- Hosting of a multi-disciplinary study day in July 2017 which incorporated guest speakers from both the community and Alliance.

- Consistent approach to recommending use of the Saga Get Up and Go booklet in the hospital and community setting.
- Utilising best practice from other Trusts. Example being how to take forward the RCP Bedside Vision Check assessment.

2. Drive improvements with a structured audit process and programme

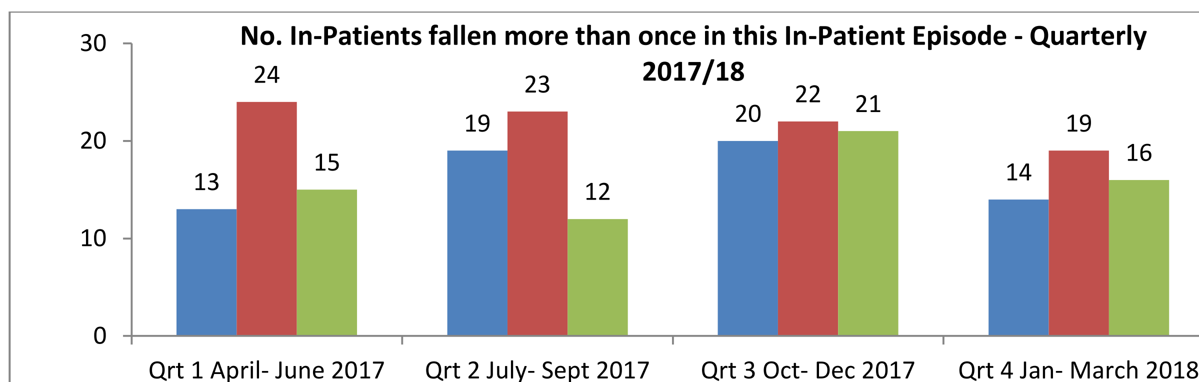
The key recommendations and findings of the 2017 National Audit of Inpatient Falls will form part of the 2018/19 work plan and will be accompanied by a structured in-house audit programme for falls prevention within the Trust. . Falls performance continues to be monitored through monthly ward assurance meetings and ward and department metrics. This allows performance to be discussed and challenged.

Development of a standard operating procedure that will identify what and how falls data is produced within the Trust with the aim of improving reporting and providing a consistent approach.

3. Drive accountability and improvements by setting target reductions by Division.

Membership of the Falls Group and the terms of reference were revisited late in 2017.. Discussions around setting individual targets for divisions are an on-going progress for 2018/19. The Group agreed the Trust target of zero tolerance for patients who fall more than once. The Trust continues to prioritise actions and drive education around preventing repeat falls within the Trust which included a deep dive into all repeated falls within a particular month.

Graph 2 (below) shows the repeat falls from April 2017 on a quarterly basis.



The Falls Lead Nurse issues a monthly report to wards and departments which highlight themes, trends and ward /department specific results. This includes repeat falls and levels of harm. .

4. Continue to progress with evidence based practice and develop safety improvement programmes through learning from best practice and innovations.

Recommendations from NICE guidelines and the Royal College of Physicians (RCP) in relation to falls prevention and education have been adopted within the Trust.

Examples are:

- Redesign of the Nursing Falls Care Plan that incorporates NICE guidelines around multifactorial risk assessments and post fall guidance. The Trust has a Falls Care Plan *and* a Post Falls Care Plan which also allows for specific person centred care documentation.
- Promotion and distribution of the RCP information which also incorporates NICE guidelines to provide relevant written information for patients, families and carer's in relation to falls prevention within

hospitals. The RCP guidelines for recording the measurement of a Lying and Standing blood pressure have also been promoted to ensure best practise.

- The RCP E –Learning programme Falls prevention is now available for trained Nurses and AHPS on the training and development website. The programme has been developed around NICE guidelines and best practise.
- Development of the *Call Don't Fall* signs that many Trusts adopt to remind patients to use the call bell system.
- Promotion and education of the importance of safe footwear for patients.
- Multi-disciplinary work continues around mobility aid provision for patients which will improve 24/7 access to the correct mobility aids.
- Pre and post fall safety huddles have been promoted by the Falls Lead nurse as good practice in conjunction with reinforcing the message that safety and flow must be combined discussions at ward at department board round meetings

Monitoring, measurement and reporting

- During 2017/18 performance has been reported through the Falls Prevention Group.
- The Falls Prevention Group will operationally lead the implementation of the Falls Prevention and Falls Care Strategy 2018/21. Progress will be reported to the Patient Safety and Quality Board chaired by the Medical Director.
- Falls performance is also monitored through monthly ward assurance meetings and performance is published on the ward communication boards.

What do we aim to achieve in 2018/19?

- Continue to reduce the number of inpatient falls and falls with harm against an agreed trajectory to less that the national average and agreed Trust targets. To continue to improve how we learn from falls related incidents by delivery of a safety improvement programme developed through learning from best practice.
- Falls prevention strategies to incorporate the 2017 National Inpatient Falls Audit recommendations.
- Falls prevention improvement to be guided by recommendations within the SFHT 2018/21 Multi-Disciplinary Falls Prevention Strategy to ensure maximum effectiveness.
- To drive improvements with a structured audit process and re-audit progress using the Royal College of Physician's Falls Audit Tool incorporating use of the Meridian tool.

3.3. Safety - To Reduce the Number of Infections

Aims for 2017/18:
To Ensure 90% of all antimicrobials are reviewed with a clear plan documented in the medical notes/medication chart within 72 hours.

- To achieve a 10% reduction of post 48 hour Escherichia coliform (E.coli) bacteraemia associated with urinary tract infection using the 2016/2017 rate as a benchmark. This is in line with NHSI recommendations for 2017/18.

- Reduce the number of surgical site infections in the mandatory orthopaedic fields to within the national benchmark.

Performance against this Target

- **To ensure 90% of all antimicrobials are reviewed with a clear plan documented in the medical notes/medication chart within 72 hours.**

A senior clinical antibiotic review is required to be performed within 72 hours and information is collected on patients that have a confirmed diagnosis of severe sepsis. There is an expectation that 50% of that specific group of patients will be audited, and this has been completed by the sepsis nurse to ensure consistent information. Throughout 2017/2018 over 90% of prescriptions for patients that fall into this group were reviewed by a senior clinician. This information is submitted through Public Health England and is publicly available.

For the remaining group of patients in receipt of antibiotics an audit is completed monthly by the clinical teams, there are two standards relating to ensuring review occurs within 72 hours and is appropriately documented in either the medical notes or the prescription chart. During 2017/2018 the audit results indicate this occurs in approximately 75% of cases. Since December 2017, the antimicrobial stewardship group has implemented twice weekly ward rounds to improve patient treatments and ultimately outcomes. As part of the rounds they have introduced ward based training for prescribers to improve knowledge, compliance and understanding.

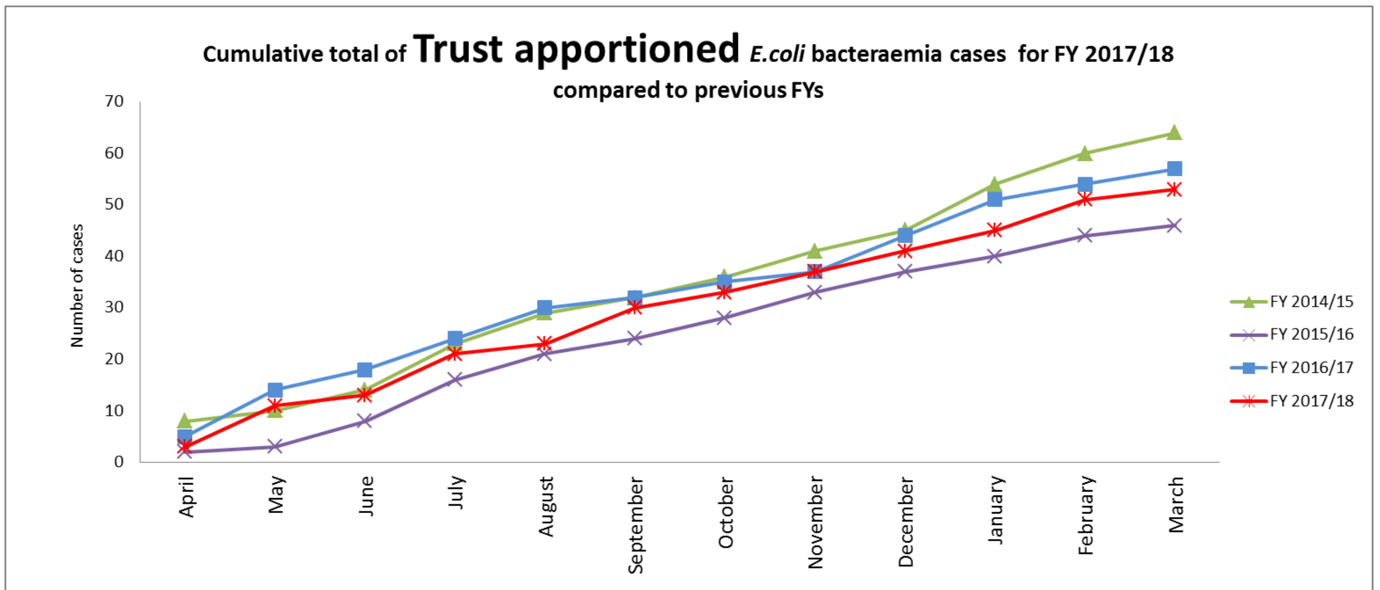
- **10% reduction of post 48 hour Escherichia coliform (E.coli) bacteraemia associated with urinary tract infection using the 2016/2017 rate as a benchmark.**

Nationally there is a focus on the reduction of gram-negative blood stream infections (GNBSI) with an ambition to reduce these by 50% across our CCG's by 2021. The main causative organism is Escherichia coliform (E. coli). Recent data from Public Health England suggest that 83% of E. coli's tested at the Trust are not Trust apportioned, however, 17% are. The primary causative factor remains urine focussed within the community, but within the acute setting, the causes appear to be more varied with the hepatobiliary and gastroenterology route being more frequently implicated.

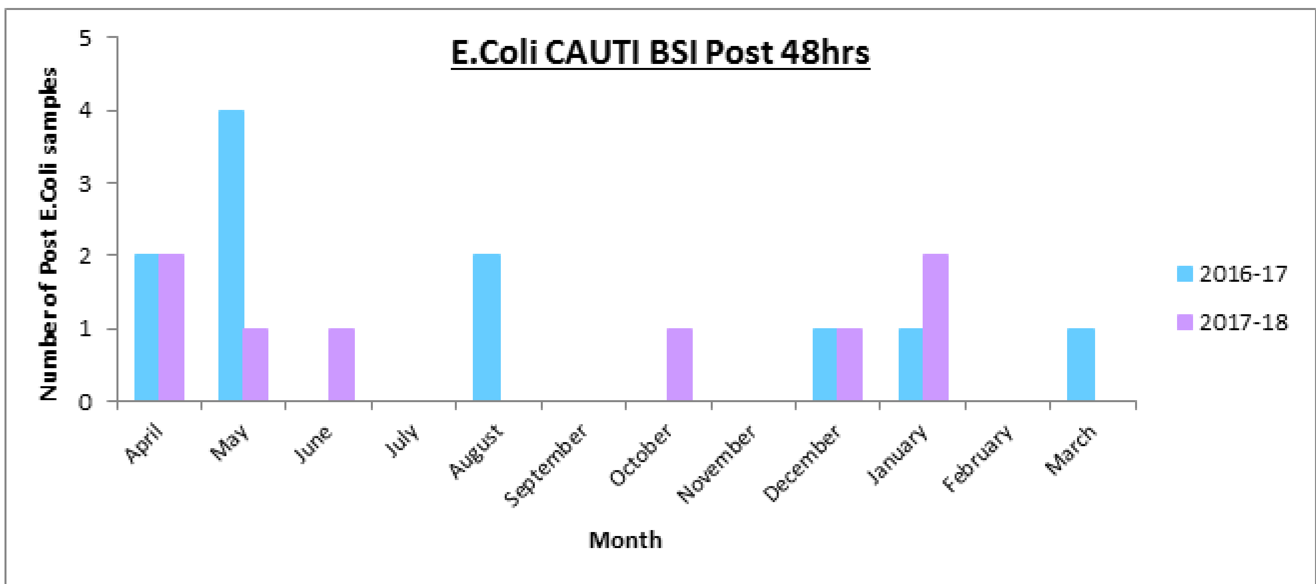
The specific standard required relates to a reduction in E. coli blood stream infections against data from 2016/2017. This information was not gathered formally until December 2016. Therefore, it is necessary to extrapolate the information from a range of sources. Severe infection, possibly resulting in sepsis, cannot be managed without factoring the need for identifying the risk factors that put individual patients most at risk.

Graph 1, provides a comparison with all E. coli blood stream infections identified from 2017/2018 against the results from the preceding three years. In 2016/2017 there has been a reduction of about 9% (not validated) however it is difficult to identify if the data is of any significance at this point, although the trend compared to 2014/2015 shows a degree of sustained reduction. This may in part be due to measures implemented to reduce Catheter-Associated Urinary Tract Infections (CAUTI) using an integrated catheter pack to drive compliance with insertion technique. Also, the implementation of a catheter, passport has enabled improvements in communication between primary and secondary care. Pre-implementation CAUTI prevalence across the Trust identified an infection rate of 13.6% of all patients with a catheter in situ; whereas post implementation that rate has consistently reduced to 2% in March 2018, (graph 3). This improvement has been translated into the numbers of blood stream infections directly attributed to a urinary catheter, (graph 2) which, in 2017/2018 saw a fall for the first time in several years to 8 cases.

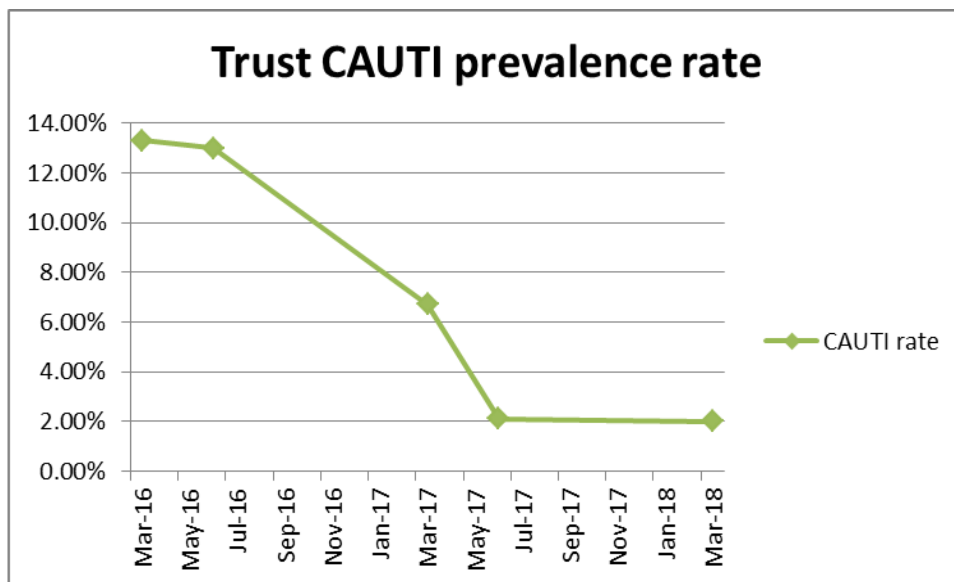
Graph 1



Graph 2



Graph 3



- **Reduce the number of surgical site infections in the mandatory orthopaedic fields to within the national benchmark**.

The report from Public Health England for October - December 2017 (table 1) indicates that for last 4 periods the Trust are no longer outliers against the national benchmark. The table indicates the summary result that suggests in all 3 fields the Trust has a rate lower than the amalgamated average. It should be noted that the rates of elective surgery have slightly reduced over the winter periods whereas as the trauma surgery has continued at the usual level for the year.

Table 2

Surveillance site	% inpatient/readmission infected Sherwood forest		% inpatient/readmission infected All Hospitals
	October – December 2017	Last 4 periods	Last 5 years
Total hip Replacement	0.0	0.3	1.1
Total Knee Replacement	1.1 (1 case)	0.5	1.3
Neck of Femur	0.0	0.3	1.2

Several measures were undertaken to improve practice by reducing traffic within theatres and reinstating the ‘red line’. Also, work has commenced on the use of the surgical site care bundle, and a review of the theatre department has been completed using the ‘One Together’ Assessment tool. This has helped to identify gaps and areas for improvement, including the wider use of masks in ultra clean theatres. To support the surgical care bundle work the Infection Prevention and Surgical teams are working together with a doctoral student from the University of Nottingham to explore the facilitators and challenges to the implementation of care bundles for preventing surgical site infections in hospitals.

In addition, the Root Cause Analysis (RCA) process and subsequent learning have been reinvigorated and learning disseminated through the Trust governance structures and ward-based training. This has demonstrated

significant improvements and highlighted areas where further improvements could be made for example pre-warming of patients on the ward, early admission for patients that exhibit specific risk factors.

3.4 Effectiveness – Improving the Effectiveness of Clinical Care

Improving the Quality of Discharge Aims 2017/2018:

- Ensure that safe discharge processes are identified in relevant patient pathways.
- Undertake a review of all discharges reported to the Trust as 'unsafe' to drive improvements and changes in practice.
- Implement identified innovations and programmes of good practice related to discharge as they are identified through the year.
- In conjunction with the Patient Experience Team, design an evaluation tool to measure the experience and effectiveness of patient discharge.

Performance against this Target

There is no national definition aligned to discharge. During 2017/18 the Trust worked in partnership with local health and social care providers to undertake an integrated discharge review. This aim of this review was to promote safe, timely discharge with the philosophy of 'home first', supporting patients to continue to live independently at home wherever possible.

From engagement events held and through engagement with partners the following good practice has been identified to build into the integrated discharge model:

- Build on existing good practice such as the ASSIST scheme from Mansfield District Housing which supports patients with housing needs.
- Clinical Assessors in the Emergency Department provide a conduit to community services, challenging misconceptions, providing insight and support to prevent avoidable admissions.

A number of complex patient pathways have been reviewed during the year, for example, for non-weight bearing patients, to ensure that alternative, more appropriate care services are available for patients who no longer require an acute hospital bed.

All discharges reported to the Trust as 'unsafe' have been reviewed, in conjunction with the Patient Experience Team, in order to identify improvements that could be made to the Trust discharge planning arrangements.

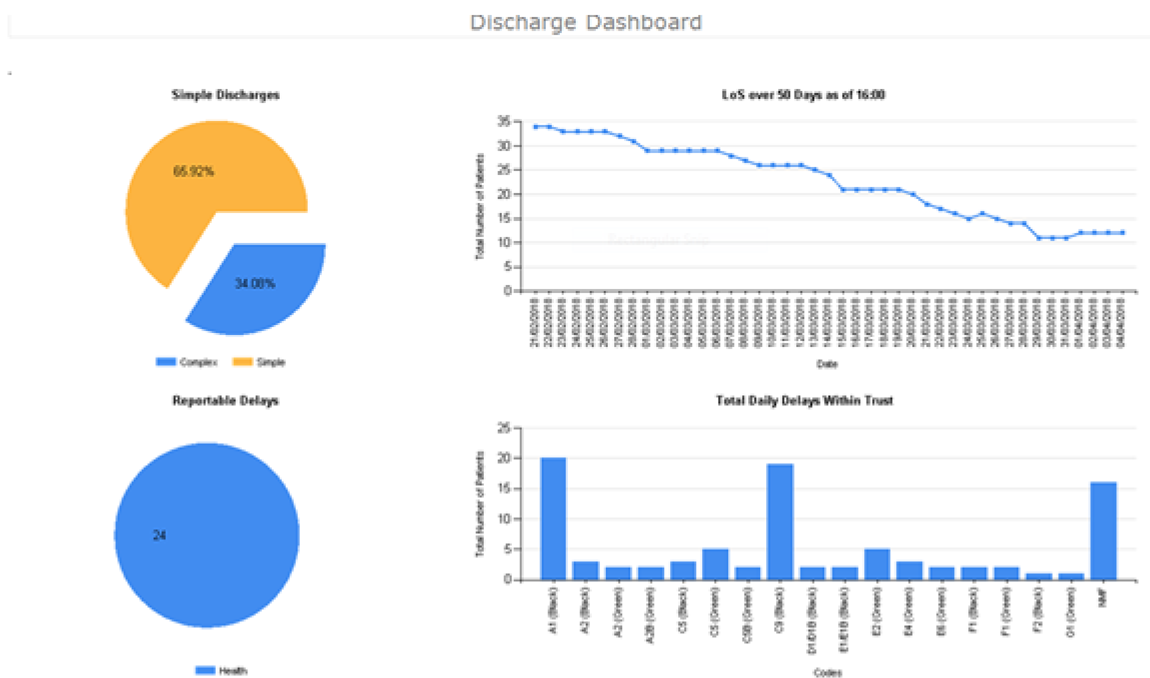
How Was This Achieved

An integrated discharge group was formed during 2017/18, this involved joint working with key partners across the local health and social care community to review discharge arrangements. This has included a review of the processes to streamline and simplify where possible and a review of complex patient pathways.

In addition, the Trust reviewed internal discharge planning processes and these have been revised to incorporate daily oversight of the discharge plans for all patients from admission through to discharge. Colleagues from community nursing teams join this daily review to expedite discharge where possible.

Monitoring and Reporting for Sustained Improvement

The work to improve the quality of patient discharge is one of the key work streams in the Trust's improving access to urgent and emergency care work programme. A discharge dashboard has been developed and this provides the Integrated Discharge Team with real time information on the current discharge status of every inpatient across the Trust, including the identification of simple and complex discharges and delayed transfers of care. An example of this is shown below:



With this monitoring process, the Trust is able to gather accurate real-time information regarding length of stay and any delays. This information is also used to identify gaps in capacity across the local health and social care system.

3.5 Effectiveness – Improve our Care and Learning from Mortality Review

Through 2017/18 the Trust continued to improve the care we deliver to our patients by ensuring widespread learning from the review of care delivered to those patients who die whilst inpatients in the hospital.

The National Guidance on Learning from Deaths setting out the new responsibilities for members of the Trust Board came into effect on 1st April 2017. The Guidance provides a framework to ensure Trusts give sufficient priority to learning from deaths so that valuable opportunities for improvements are not missed. In addition, it points out the importance of engaging in an appropriate and supportive way with bereaved families recognising their insights as a vital source of learning.

The Trust Mortality Surveillance Group (MSG) is well established. Meeting monthly, chaired by the Executive Medical Director, it is the focal point for understanding the safety and quality of care provided to patients in the days leading up to their death and importantly identifying the learning opportunities, ensuring the learning is shared across the wider clinical teams.

The Trust had initiated a comprehensive Mortality Review process in 2016 by standardising the approach to local Mortality Reviews. An electronic screening tool was developed to capture initial data following the death of a patient and this has been subsequently expanded to include triggers to alert clinical teams that a more in-depth review is required. There is an expectation that all deaths are captured on the electronic Mortality Review Tool in the first instance with performance reported by way of a 'heat map' to MSG monthly.

Clinical Teams continue to receive training, encouragement and support to complete a MRT for every patient that passes away whilst under their care in order to identify where a more in-depth review is required. The accurate and timely notification of a death is key to enabling clinicians to commence the initial phases of mortality review.

The Trust adopted the Royal College of Physician's Structured Judgement Review (SJR) methodology as the mandated process for conducting the phases of mortality review if potential lapses in care are identified through completion of the MRT. This methodology has been widely used across a number of Acute Trusts nationally and our clinical teams are becoming more proficient with its use.

The benefits of conducting a review using a consistent, validated methodology ensures that care is recorded in the same way whether it is good or bad. This will hopefully generate concise statements (both positive and negative), yielding a rich store of information to identify areas where there is excellent practice but also identify those areas for further improvements.

The Trust is required to provide a report each quarter to the Board of Directors indicating performance against a defined data set and by 31st March 2018 will be expected to show that we review 90% of all deaths. The data set is set out below:

- Total number of deaths – to include number receiving the initial review via the MRT
- Number of deaths scoring <3 on the Avoidability Assessment following a Structured Judgement Review
- Number of Deaths investigated under the Trust Serious Incident Framework
- Themes and issues identified through review and investigation
- Changes that have been made as a consequence of this process

Learning from deaths are not be seen in isolation of other learning opportunities but are an integral part of service and the wider Trust Governance Framework. Key issues identified as part of the Mortality Review process are collated with themes and trends from other intelligence sources to aid the prioritisation of immediate and future improvement requirements.

The Trust recognises that learning from the care given to patients in their final days is about understanding what effective, sustainable improvements are needed but also where we provide excellent care and how we share good practice across the organisation. It is important to recognise that improving mortality will improve that standard of care for all patients.

3.6 Effectiveness – To improve the experience of patients who are coming to the end of their life

Improving the palliative and end of life care remains a public priority across the country and for our local communities. The Trust is committed to support 'advance care planning' and training staff to listen to patients choices and preference for their treatment or care and help support people who are bereaved. This

commitment is set out in the Trust End of Life Care strategy and builds on the Ambitions for Palliative and End of Life Care national framework (2015-2020).

Aims for 2017/18

The quality of palliative and end of life care for patients and those people important to them remains a quality priority for the Trust and is a focus for improvement. The three priorities identified by the Trust are outlined below:

- Ensuring there is adequate provision of specialist and general palliative care to hospital patients we aim to achieve this through partnership working across the Mid-Nottinghamshire Alliance to review the Contract for Specialist Palliative Care service delivery; End of Life care team workforce plan.

- Delivery of key quality standards to support palliative care of patients in hospital our focus is to complete improvements to the medical guidance and clinical documentation for last days of life care and implement new national ReSPECT tool which replaces Allow Natural Death documents, enhancing treatment and Escalation decisions.

- Focusing on improving the coordination and responsiveness of palliative care wider involvement and support is required in use and roll out of Electronic Palliative Care Co-ordination System (EPaCCS) including to pilot cross boundary working.

Performance against this Target

The Trust continues to be an active partner in the Better and Together Alliance for End of Life Care and this year has seen the development of plans to deliver a new co-ordinated and collaborative End of Life Care Service. This has superseded the cross boundary pilot work the Trust considered for this year. The Trust is a key leader in Nottinghamshire's approach to promoting more standardised services across providers and statutory agencies. This will be part of the proposal to the quality improvement work on behalf of the Clinical Reference Group.

Support for patients with Specialist Palliative Care (SPC) needs continues to be provided by Nottinghamshire Healthcare NHS Trust and John Eastwood Hospice. New governance arrangements have been put in place with a supporting Memorandum of Understanding (MOU) to ensure the continuity of this specialist service. This year we have developed our working practices with the SPC team which has resulted in:

- Closer links to manage day to day service needs
- Proactive involvement in admission areas
- New referral systems through 'call for care'
- Joint development and delivery of education and training programmes

In terms of general palliative and end of life care, there has been a change this year in nursing leadership. This role is now dedicated solely to end of life care as the Trust has also appointed a separate Lead Nurse for Cancer. Unfortunately there has been a reduction in support to the lead nurse role but there is a plan to request support from the alliance as this function and the developments we have agreed are key enablers to the Mid Nottinghamshire strategy and Alliance programme. In addition, we are considering other new ways of developing capacity and capability, as part of the End of Life Care team workforce plan. The Trust currently has a

risk relating to the service arrangements for both the specialist (SPC) and the generalist provision and this risk will be reduced with the implementation of the new service and management for end of life care.

The Last Days of Life (LDoL) medical documentation has been piloted on the respiratory and health care of the elderly wards and has been rolled out across the Trust. This has given further clarity to medical staff to focus on patient priorities, more transparency and accountability on medical decision making. The first round of clinical audit has been performed by junior doctors under supervision and the results are being triangulated with pertinent bereavement surveys. This has been part of a 2 step approach to further improve all LDoL documentation. The plan for next year is to consider combining both existing nursing and medical documentations into a multidisciplinary format.

The Allow Natural Death (AND) policy was updated this year. The Trust intends to implement the new national voluntary ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) tool in 2018-2019 in a coordinated way with other providers. This is a positive development as it further encourages and supports patients and those close to them to be involved in a range of important treatment and care decisions including cardio-pulmonary resuscitation. This tool requires senior clinicians to support this summary plan with more detailed documentation of the assessments and discussions with the patient or if they lack mental capacity their representative.

Allow a Natural Death (figures up to and including month 10, year 2017-18):

Consultant endorsement mean 91%; range 86-95% target >80%
Patient and family involvement mean 90%; range 83-95%
Evidence of MDT involvement mean 53%; range 48-71%

This demonstrates that there is an excellent record of consistent consultant endorsement of this decision with this endorsement being the most important clinical check and balance in the process. It is acknowledged that sometimes immediate decisions must be taken before the consultant can sign the form and in such cases, a decision may have been discussed on the telephone. With the implementation of ReSPECT we aim to improve the quality of discussions and documentation of such decisions.

Implementation of the ReSPECT process has been agreed with the Trust and will form part of the Advancing Quality Programme for 2018-19. There has been consultation and collaboration across Nottinghamshire and the wider East Midlands to achieve a coordinated and consistent approach. Achieving this joint working has required us to reschedule the implementation of the ReSPECT process within the Trust. We are promoting a joined up approach to implementation, including the training of staff, with other specialist groups such as the Resuscitation Group, Deteriorating Patient Group and the Intensive Critical Care Unit.

Improvements to the Bereavement Survey process have been made enabling us to take timely and specific actions. This includes:

- Proactive conversations between Bereavement Centre staff and relatives
- Improving the invitation letter to complete the survey
- Offering the bereaved relatives the opportunity to receive feedback by giving their contact details

Increased administration support at the Bereavement Centre has enabled inputting data into an electronic audit and performance system (Meridian). The End of Life Care Team then:

- analyse the responses
- develop reports for key quality meetings
- give feedback to the individual ward areas
- develop action plans for clinical improvements where necessary

This has been an evolving process which we have tried to appropriately sensitise to the local demographic and has elicited a consistently good response. Further developments in measuring the experience of care is being developed as part of the Mid Nottinghamshire Alliance programme.

With the active planning of the medical lead for End of Life Care, who is also the new Trust lead for Mortality Management, we are evolving a key triangulation process about the quality of treatment and care also through the lens of Mortality Reviews. It is clear through the CQC report and the response of the NHS Quality Board we all must learn from patients' deaths. The electronic system is based on the national programme and uses a structured judgement method. This has changed the type of discussions at morbidity and mortality review meetings.

In order to continually improve experiences at end of life it is crucial that we are able to identify people who are in the last year, months, weeks or days of life. EPaCCS is an enabler of this and we continue to use the existing infrastructure of this system in the Emergency Department (ED) and through the Integrated Discharge Advisory Team (IDAT). We are actively seeking ways of enhancing access to this system in conjunction with the Alliance programme.

The information technology supporting this process is complex and requires strict information governance safeguards for such sensitive information. We have continued our previous CQUIN work with the Emergency Department to develop a manual method of identifying patients that present at the front door with an EPaCCS record using a 'Gold Star' flag.

The Trust has in recent months, implemented NerveCentre as a new clinical digital platform designed to enhance patient safety and information sharing. This includes an End of Life Care model which enables us to track patients across the hospitals. It allows the Trust to identify patient with end of life needs quickly and easily. This helps us direct support and track transfers or discharge.

Monitoring and reporting for sustained improvement

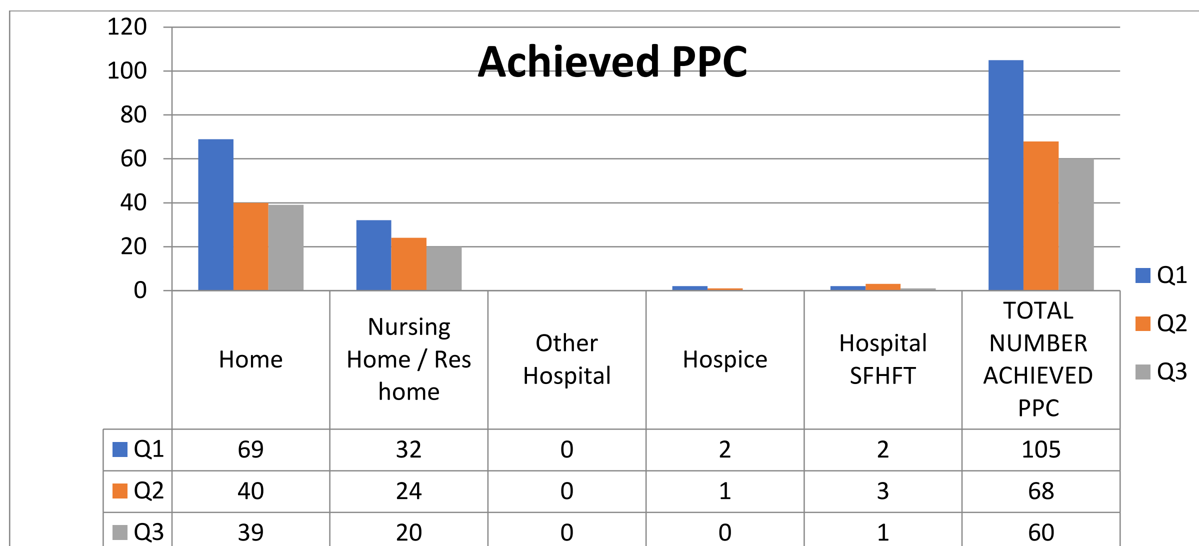
Throughout the year the Trust has continued to monitor the number of hospital deaths. In this last year 1560 died in hospital. This is a higher than expected figure due to a number of factors especially seasonal influenza. The Trust mortality statistics are included in the quality account. Despite this significant increase in severely ill and dying patients we have maintained standards and have continued to promote choice. For patients that are dying and have been referred under Fast Track Continuing Health Care funding we explore and support the achievement of their Preferred Place of Care (PPC). We have worked in collaboration with partners to increase the number of patients who die in their preferred place of care.

The Integrated Discharge Advisory Team facilitate this process and report on their activity **(data is currently only available to the end of quarter 3)**. The summary of Preferred Place of Care is as follows:

- There were a total of **300** patients that were referred to the Integrated Discharge Advisory Team (IDAT) for facilitation of their discharge to PPC
- Out of these **300** patients we achieved PPC for **233 (see graph 1)**

- For **227** patients, PPC was not in hospital and they died in their PPC
- **6** patients chose hospital as their PPC
- Out of the **300** patient's referred **67** did not achieve their preferred place of care because they died before discharge could be effected

Graph 1



	Home	Nursing Home / Res home	Other Hospital	Hospice	Hospital SFHFT	TOTAL NUMBER ACHIEVED PPC
Q1	69	32	0	2	2	105
Q2	40	24	0	1	3	68
Q3	39	20	0	0	1	60

The most common reasons for not achieving an effective discharge to the patients Preferred Place of Care was family choice of appropriate destination or ability to manage at home; patients suddenly deteriorated before discharge was achieved; and patients were unable to be discharged due to care home availability.

To ensure that patients are discharged safely and effectively, underpinned by robust communication with care planning principles in place; We continue to monitor the quality of discharges to ensure that patients are discharged safely and effectively by auditing the following aspects of the discharge process. A fast track patient is described as a patient who has a rapid deteriorating condition, which may be entering a terminal phase. It is important with fast track discharges to ensure that the person who is at the end of their life has all the medication, equipment, people and processes in place to support them and ensure a safe discharge. Table 1 shows achievement of the monitored indicators for people who had fast track discharges during 2017/18.

Table 1 – Indicators in place on fast track discharge

Number (%) of people with this indicator in place on discharge	**Monitored discharge indicator**
229 (99%)	Patients had Anticipatory Medications prescribed
206 (91%)	GPs/Healthcare Professionals were communicated
229 (99%)	Had an Allow Natural Death in place
224 (98%)	Patients were discharged with a care plan in place
170 (75%)	Patients were registered on the GP GSF register/ SystmOne EPaCCs IT system

The standard turnaround time for processing a Fast Track Continuing Care discharge should be no longer than 3 days. For 190 patients, discharge was delayed over 3 days, the common themes were:

- delay due to family/patient choice (41)
- funding for continuing care packages (36)
- weekend/bank holiday (24)
- delays in care packages/night sitters being set up or available (24)
- Care Home assessments being performed (20)
- Family delay (19)
- Equipment (19)
- Delay due to Care Home availability (17)

Where there are factors within our control we have taken actions to support improvement including extra support at weekends. The Trust continues to deliver a structured programme of EOLC education and training and the figures for attendance by non-medical staff from 1st April 2017, up to and including 31st March 2018 are outlined in the Table 2 below:

Table 2

Course Code	Course Title	Method of Learning	Number Of Attendees
-	Mandatory Work Book	E-Learning	2426*
IND 20	Nurse Induction	Classroom	267
IND 21	HCA Induction	Classroom	136
OKS392	End Of Life Care e-ELCA	E-Learning	1
OKS405	End of Life Care (Supporting BTEC module) for HCA's	Classroom	11
OKS376	End of Life Foundation Programme	Classroom	35

*Work Books that include 'End of Life' are for the following groups of staff:

- Chaplaincy
- HCA/ANP's
- HCS (Paeds/NICU)
- Housekeepers
- Midwifery
- Qualified Therapists
- RN/ODP
- RN (NICU/Paeds)
- Therapy Assistants

In terms of the Mandatory Work Book figures, the total number of attendees includes Bank Staff and 'others' who have chosen to complete it. From a true Mandatory Training point of view, 2212 staff were required to complete it and a total of 2005 (91%) achieved this. Staff that did not complete (445) includes those on maternity or long term sick leave.

There have been bi-monthly EOLC Champions meetings throughout the year with a core group of Registered Nurses, HCA's and AHP's attending. This is an educational, sharing and supportive forum focused on enabling frontline staff to deliver outstanding EOLC. Activity this year has included:

- The development and piloting of Care after Death competency training
- Creation of Allied Health Professionals newsletter
- Consultation on policies & procedures
- Updates from Specialist Palliative Care and IDAT
- Introducing the concept of QELCA (Quality End of Life Care for All) – a new initiative to support the increase in capability and capacity of frontline staff in EOLC

We have participated in the CP2 and 3 Medical Student Training and collaborated in Foundation and Core Medical doctors training with the Specialist Palliative Care Team.

Aims for 2018/19

The quality of palliative and end of life care for patients and those people important to them remains a quality priority for the Trust and we will focus on:

- Implementation of ReSPECT
- Collaboration in the new End of Life Care Service as part of the Better & Together Alliance
- Addition of EOLC measures as part of the Ward Accreditation
- QELCA project
- Collaborative Education & Training programme across the Alliance in line with new national frameworks
- Participation in national audit – NACEL
- Roadshows – 'Talking Point'

3.7 Patient Experience – Improving Patient Experience - Improve the Experience of Care for Dementia Patients and their Carers

Care for patients with dementia is part of the Trust's core business. Approximately two thirds of in-patient beds are occupied by people aged over 65 years and up to 40% of these individuals will have dementia and/or delirium. The guiding principle for the Trust is to deliver safe, high quality, compassionate, person-centred care for people with known or suspected dementia or delirium and their carers.

Aims for 2017/18:

- To increase the number of staff undertaking Tier 2 dementia training
- To continue to make adjustments that make the care environment more dementia-friendly
- To grow the Dementia Champions network that was re-launched in December 2016
- Implement and embed the principles of John's Campaign

- Enhance our Place audit scores for dementia environment.

Performance against this Target

A Dementia Strategy has been developed and was presented to the Quality Committee on March 21st 2018 for ratification. A range of training is available and numbers completing in 2017/2018 are shown in the table below:

Training Opportunity	Stakeholders captured
Orientation – Dementia Awareness (Tier 1)	713
Contemporary Issues (Tier 2)	122
Mandatory training	2791

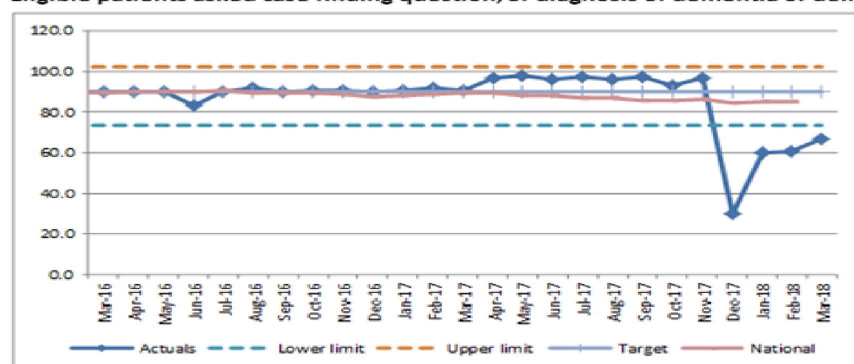
Creation of a dementia-friendly care environment continues to progress. Our 2017 PLACE audit scores showed that we were higher than the East Midlands average for providing a dementia-friendly care environment. The Bluebell Room in the Emergency Department opened in early 2018 to provide a quieter environment for patients with dementia to be treated in. Sconce ward at Newark Hospital is being developed to provide a dementia-friendly environment and this will help to increase our PLACE audit scores further.

The Dementia Champions network meets quarterly and there are currently 50 people identified as Dementia Champions across the Trust. Information about the champions is included in all training to encourage more staff to join the network.

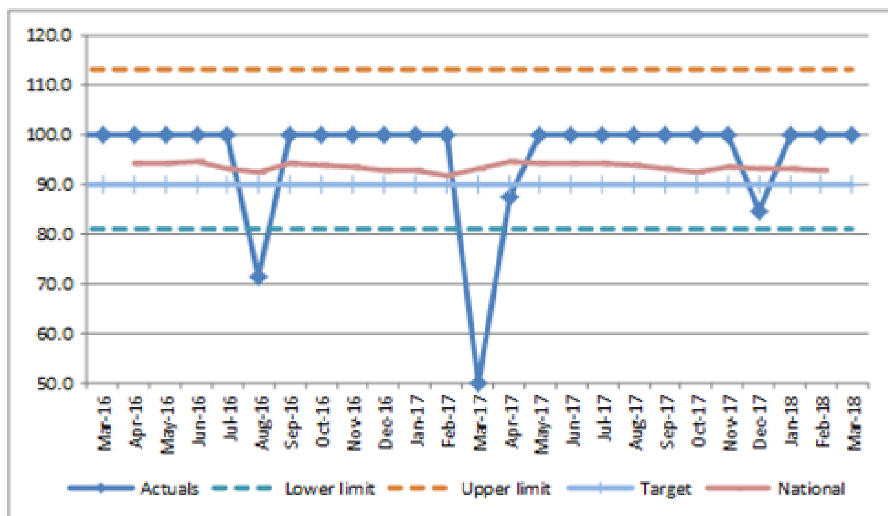
The Trust has signed up to implement the initiative 'John's Campaign' and incorporated this into a wider Carer's Strategy that was launched on December 4th 2017.

Meeting the national find, assess/investigate, and refer target remains challenging, primarily because the Trust continues to use a paper based system. National performance is set at 95% for each of the three reported components. Performance on the three reported components is included in the graphs below:

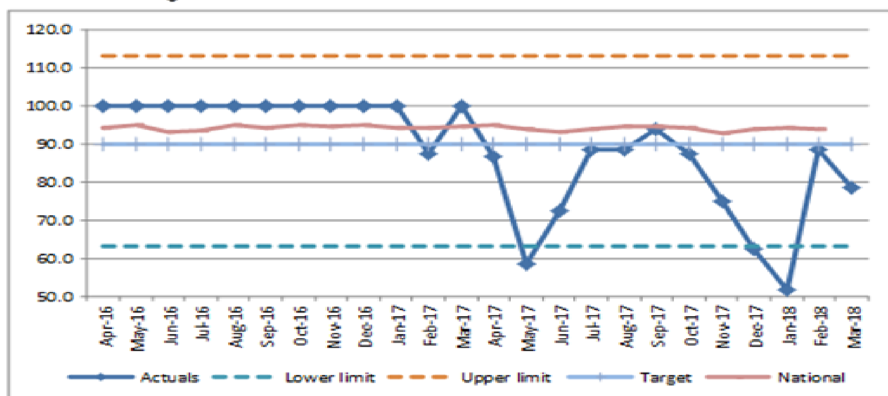
Trust FIND performance since January 2016



Trust ASSESS/INVESTIGATE performance since January 2016



Trust REFER performance since January 2016



Dementia screening in patients over 75 years of age who are admitted to the hospital as an emergency and stay longer than 72 hours are part of the standard contract and submitted to the Strategic Data Collection Service (previously UNIFY) on a monthly basis. Performance of more than 90% is required on all three sections of the return. Consistently since December 2017 our returns have been below the required level. To address this deficit we have scoped a number of strategies.

We gained agreement in April to begin scoping to move this process to nerve centre, the approximate timescale for this is Winter 2018.Whilst we wait for data collection to move onto Nerve centre we have developed strategies to improve the data collation and assessment processes.

The data process and figures is now monitored on a monthly basis by the Trust board and where needed exception reports are submitted. Whilst the screening is below the required level the patients who are eligible for dementia assessment do receive this via the AMT assessments. This is overseen by the Dementia Clinical Lead.

How Was This Achieved

The Dementia Steering Group was re-launched in September 2017 and oversees the improvements that are planned and implemented in dementia care within the Trust. The Dementia Strategy is based on the Dementia Assessment and Improvement Framework (NHS Improvement, October 2017) and is the strategy is focussed on seven key areas:

- diagnosis
- person-centred care
- patient and carer information and support
- workforce education and training
- leadership
- environment
- nutrition and hydration.

A 'Whose Shoes' dementia event was held on October 10th and this has been informative in identifying areas that are important to key stakeholders within and external to the Trust.

The training needs of health and social care staff with respect to dementia are set out in the Dementia Core Skills Education and Training Framework (Skills for Health, Health Education England and Skills for Care, 2015). All staff who join the Trust receive a dementia awareness session (Tier 1) on orientation day. The orientation day is scheduled each fortnight so captures all new starters at the very beginning of their employment regardless of their role. Nurses, Allied Health Professionals (AHPs) and Health Care Assistants (HCAs) also receive a dementia focused session on Induction - 'Through a patient's eyes', where a Social Care Institute for Excellence video is used to show how the world may appear to someone who is living with dementia. Dementia up-date is also part of the mandatory training day in order to provide staff with information on the key priorities we are working on with respect to dementia care in the Trust.

Staff who have regular contact with people who are living with dementia should receive Tier 2 training and a study day is held each month to enable staff to achieve this. To March 2018, 122 staff have completed this training.

The 'This is Me' document is nationally recognised as a tool to enhance person-centred care and is a vital tool in identifying individual preferences when someone may be unable to communicate these. The Forget-Me-Not logo has been developed as a means to identify people who have dementia.

Dementia Champions now have a revised role profile that identifies key responsibilities. Key performance indicators for champions' audits to determine:

- There is evidence that the person and their carers have been involved in planning their care.
- The 'This is Me' document has been completed and is available
- Patients on wards have had a cognitive assessment.
- Whether patients on their wards are receiving delirium assessments as part of routine nursing observations.
- Whether the 'forget-me-not' magnet is appropriately used to identify patients with dementia
- Whether the principles of the Mental Capacity Act (2005) are being adhered to.
- Whether patients requiring DoLs are appropriately identified and plans are put into place.

The current performance in FIND is being enhanced through changes in the way assessments are conducted, information collected and the monthly analysis carried out. Ultimately the aim is to incorporate data collection into Nervecentre, however, this will be a medium-term solution.

Monitoring and Reporting for Sustained Improvement

Understanding how the Trust is performing is a critical part of improving practice. the developments identified will be audited and the findings fed into the Dementia Steering Group and the safeguarding steering group.

Tier 1 and Tier 2 training figures are available monthly and reported to Health Education East Midlands bi-annually.

The annual PLACE audit provides valuable insights into dementia-friendly environmental considerations. The results demonstrate areas where the Trust is improving and identifies areas where more need to be done. Exception reports highlight adjustments that will improve the Trust scores and allow targeted work to be planned and implemented. The Trust aims to maintain its place above the East Midlands average for PLACE.

Growth in the Dementia Champions Network will be monitored by attendance at meetings and training completed. Dementia champions will help to promote patient-centred care in their wards and departments through audits and feedback to their areas. Results will be overseen by the Dementia Steering Group and feed into the MCA/DoLs audits completed by the Safeguarding Team.

3.8 Patient Experience – Using feedback from patients and their carers

Patient Experience is very important to the Trust and feedback from patients, family and friends is actively sought and welcomed. The Trust values the views of feedback as an opportunity to listen and learn from patients and families in order to make improvements to the care and services provided. The Trust has a number of mechanisms to gather feedback. These include Friends and Family Test (FFT), National Patient Surveys, Care Opinion and speciality specific surveys to understand how patients feel about our services.
All Trust staff, particularly clinical staff (doctors, nurses and allied health professionals) play a central role in encouraging and motivating patients, their family and friends to provide feedback regarding their experience. In the last period of time a number of approaches have been developed within the Trust and with the support of Meridian to improve feedback from patients, family and friends.

Friends and Family (FFT)

Friends and Family Test is further embedded into the patient feedback mechanisms, and is demonstrated by the consistency of the response and recommendation rate during 2017/18. National performance requirements are highlighted in the table. The FFT response and recommendation for 2017/18 is below:

Indicator	Plan / Standard	YTD Actuals
Response Rate: Friends and Family Inpatients	≥24.1%	23.15%
Recommended Rate: Friends and Family Inpatients	97%	98.3%

Response Rate: Friends and Family Emergency Department	≥12.8%	6.81%
Recommended Rate: Friends and Family Accident and Emergency	87%	92.2%
Recommended Rate: Friends and Family Maternity	96%	96.7%
Recommended Rate: Friends and Family Outpatients	96%	94.3%

The FFT response rates for the Emergency Department have fluctuated and saw a steady decrease during Quarter 4 of 2017/18. The Trust are aware of the increased volume of patients attending the Emergency Department during this period, and it is realistic to assume there may have been limited engagement with patients in relation to the FFT survey due to the increased demands and delays patient were experiencing in the department. To support the staff in this area, in March 2018 the department introduced the use of iPads, which is supported by volunteers.

In May 2017, the SMS text messaging for FFT was expanded to include the Outpatients Department which has seen a significant increase in the response rates exceeding the national benchmarking for outpatient departments. This has led to improvements in the environment of clinic areas, communication with patients when delays may occur, and ensuring at these times refreshments and car parking is facilitated.

Common areas for improvement within the Diagnostics and Outpatient division are well sighted and continue to work with all outpatient clinics to ensure a positive patient experience, reduce unnecessary waiting times and importantly ensure patients are advised and comfortable during any unexpected delays.

Car parking charges remain a concern for our population and feedback is shared with the Estates Department to enable views to be considered with future planning.

FFT has been rolled out to the following areas:

- Community Paediatrics
- Sexual Health Services
- Therapy Services

A number of these services are based in the community locations, which has provided an opportunity to gather feedback which historically has been difficult to capture. The utilisation of the SMS text messaging has seen a good level of response from these areas, and driving improvements locally.

Further software will be embedded in April 2018 to alert relevant staff to a poor experience in real-time, providing an opportunity to resolve issues during an inpatient admission for instance, the system will then require staff to record the action taken as a result of the feedback.

All Divisional Triumphrate Management teams receive their comment reports directly from Optimum Meridian. This allows them to understand where both positive and negative feedback has been reported and identify any areas of good practice or required areas for improvement, this includes whether the patient would recommend the Trust.

Optimum Meridian has expanded its functionality during 2017/18 to support the specialty surveys, incorporating SMS text messaging as a method of collecting this feedback. It provides real-time feedback dashboards and reports to relevant staff in the trusts which enable staff to identify areas for improvement. In addition all departments and wards receive weekly and monthly feedback reports which help to provide valuable intelligence relating to all aspects of their attendance to hospital including environment, staff attitude, and timeliness of appointments and how they felt care and treatment was delivered.

Further software will be embedded in April 2018 to alert relevant staff to a poor experience in real-time, providing an opportunity to resolve issues during an inpatient admission for instance, the system will then require staff to record the action taken as a result of the feedback.

Trust Patient Surveys

Specialty specific surveys have been developed in 2017/18 for the following services:

- Stroke Rehabilitation – service delivered at home
- Endoscopy
- Critical Care
- Research and Development
- Bereavement and End of Life

The feedback is recorded via the Optimum Meridian system which provides tailored reports to all relevant staff.

In March 2018, the Cancer Services Team with the support of the Patient Experience Team have developed tumour site specific cancer surveys for patients to understood patient experiences in relation to the service speciality, this includes:

- Breast Care
- Head and Neck
- Haematology
- Colorectal
- Upper GI
- Gynaecology
- Urology
- Lung

The feedback is reported to the Lead Cancer Nurse which is reported and shared with the specialist cancer nurses to be triangulated with other methods of feedback including the national cancer survey, complaint's, concerns and compliments.

National Patient Surveys

In addition to the internal trust patient surveys, the Trust reported the key findings of the National Patient Surveys to the Patient Safety & Quality Board (PSQB) providing a summary report of the annual national surveys which were undertaken during 2016/17 for the following services:

- Emergency Department
- Inpatient
- Children and Young People
- Maternity
- Cancer services

The Trust received detailed reports from the external company commissioned to carry out the survey, which is used in conjunction with the other methods of patient experience including complaints, concerns, compliments, incidents and coroner's inquest to identify themes and areas of improvement. Given the length of time since the surveys took place, the recommendations from the surveys have already been implemented or are in development in some divisions.

Care Opinion was introduced in September 2017 and allows people to share their experiences of health and care in ways which are safe, simple, and lead to learning and change, training is currently being provided to relevant staff to ensure all postings are responded to in a timely manner.

The Carers Charter was launched in December 2017, which is supported by the Patient Experience Team and Practice Development Matrons to identify carers specific needs early during their loved one's journey to ensure a responsive approach to care delivery, for example flexible visiting hours and introducing an option of having meal times together providing meals for both carer and patient.

3.9 Patient Experience – Safeguarding Vulnerable People

Aims for 2017/18

Improvements in safeguarding were a feature of the Trust's 2016 CQC focused follow up inspection, and for this reason remain a quality priority for the Trust. Improvements are monitored and reported through the Safeguarding Steering Group. The 2017/18 aims are listed below.

- Promote and Maintain Safe practice of all people who are working as part of the Trust. Specific focus will be on safeguarding being part of all risk assessments and care planning, to ensure interventions are in the patient's best interest. Safeguarding will initiate record keeping audits and work with Divisions. The Trust will continue to focus on ensuring MCA/DOLs is well embedded into care plans. Developing and embedding a "Making Safeguarding Personal for adults" and "Voice of the Child" supports this patient centred approach.

- Evidence improvement in the effectiveness of our care of vulnerable children, young people and adults includes a review of all safeguarding policies, procedures and training ensuring that these reflect national best practice and legislation. The Trust continues to focus on developing improved internal safeguarding reporting processes that are responsive to Serious Incidents and investigations embedding learning across the Trust.

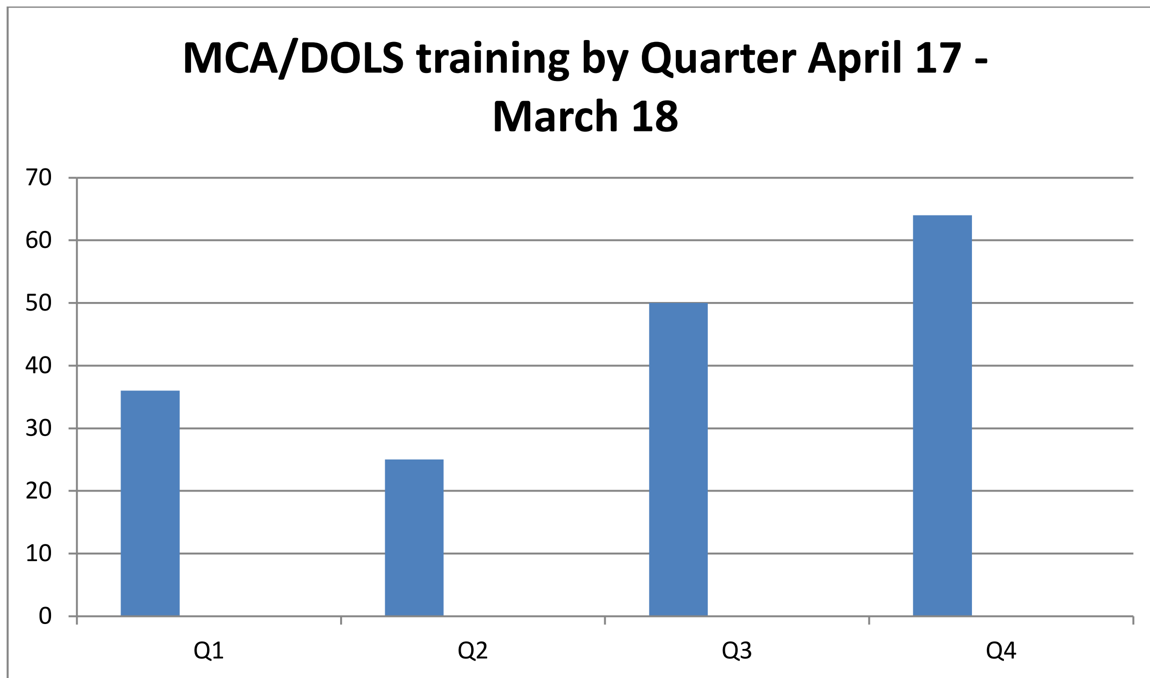
- Implementation of initiatives which understand and enhance Service User Experiences will focus on ensuring Patients' engagement in their person centred care and needs based on their 'Best Interest' and use of 'less restrictive interventions' and improve understanding of 'Transitions' from children's to adults where there are complex and or challenging behaviour.

Performance against this target

There are no national standards for safeguarding set. During 2017/18 the Safeguarding Strategy was revised to acknowledge the best practice around 'Think Family'. The Trust implemented the Think Family Safeguarding Strategy which underpins all the developments and improvements. The strategy acknowledged and promoted

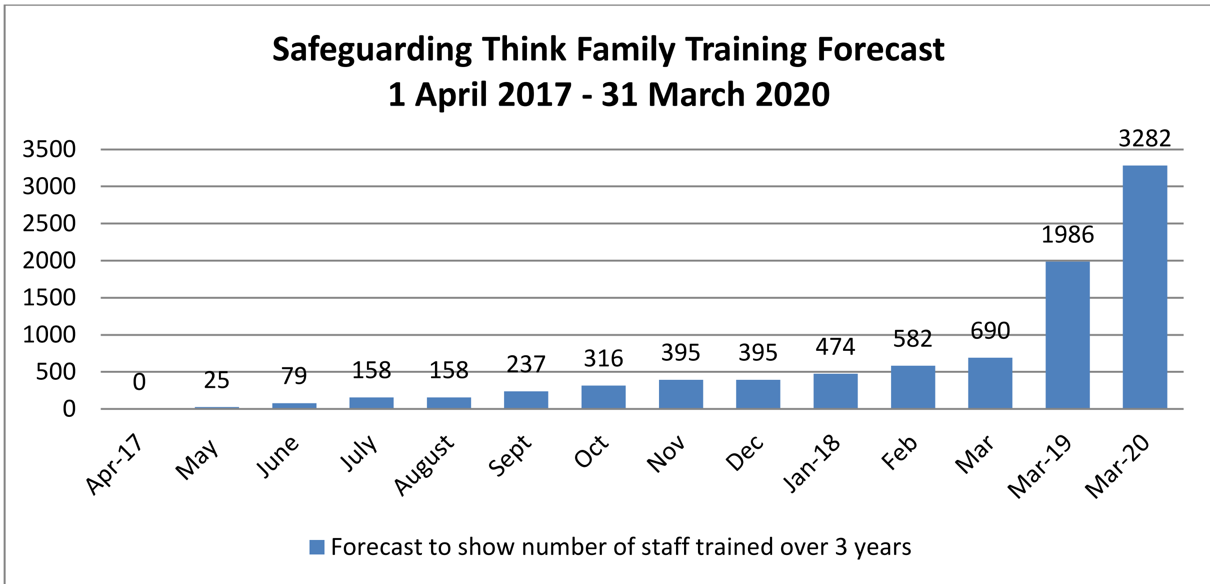
the ethos of 'Making Safeguarding Personal' and 'Voice of the Child' as it sees each person as an individual and acknowledges the needs of individual and their families.

The Trust has continued to maintain a clear focus on MCA/DOLS working with the Trust staff and partners to ensure that clear communication channels with wards and departments are maintained and build on the findings from MCA/DOLS our audits and development plan. The Trust has also employed a mental health nurse to help support staff with the more complex cases where mental capacity is an issue. We will continue to work with the Trust services to monitor and implement DOLS where needed. The Trust has used the learning from serious incidents and audits to refine the MCA/DOLS training and moving into the next year this training has been extended to a full day. The table below demonstrates the uptake during 2017/18.

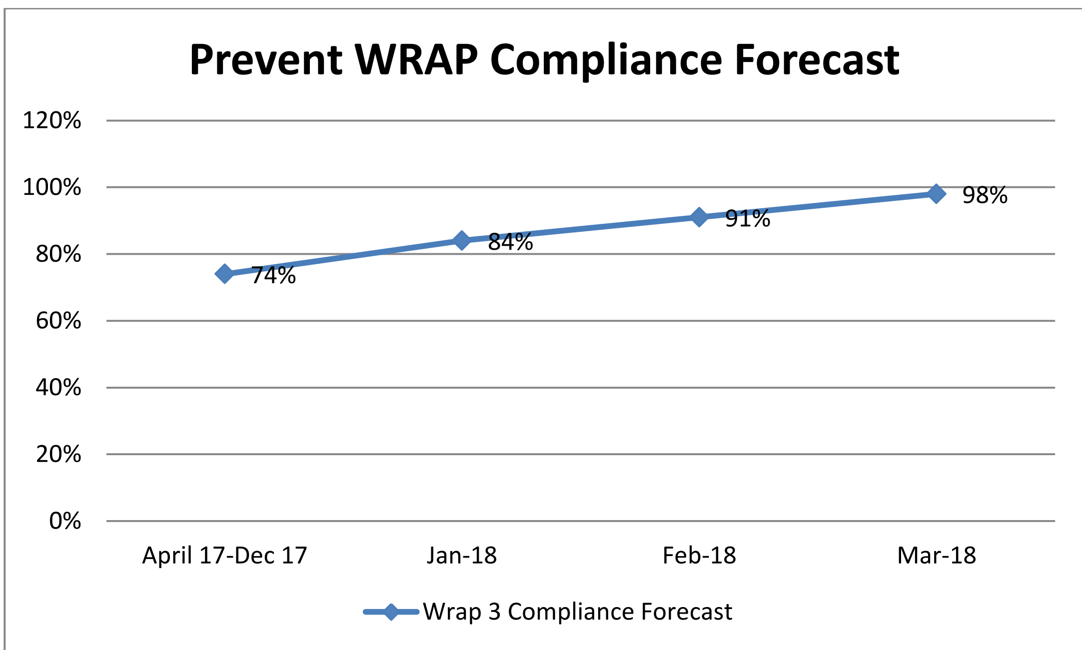


How was this achieved

We have revised our training to ensure we equip staff to fulfil their roles and responsibilities in respect of Safeguarding, this training is now Think Family and all clinical facing staff will undertake this training. As demonstrated in 2017/18 we have a training trajectory to ensure all relevant staff are trained by 2020. To mitigate the risk until this is complete we continue to provide safeguarding updates on the mandatory training dates.



We are one of the highest trainers in the country in respect of PREVENT and able to demonstrate a consistent return of over 90%, we achieved this by working with Learning and Development to ensure PREVENT was part of both the induction and mandatory update training. Moving forward it will remain part of mandatory update and also forms part of the Think Family Safeguarding training sessions.



All policies and procedures have been reviewed and are in date, these reflect new local and national guidance. We continue to work with the divisions to support transitions between service's for service users and families and where needed provide expert input into the relevant case meetings.
We have developed a duty system to ensure we respond to queries and requests for support. This allows us to respond in timely manner and ensure service provision is at the heart of what we do. Moving into 2018/19 we will use the information from these calls to help support analysis of trends and themes and key issues.

We are monitored externally with the use of the Safeguarding Adults Assurance Framework and for Children - The Section 11 reports. These are submitted to the CCG's and Safeguarding Boards upon request. We are now able to provide full assurance against all set bench marks. We use this document as an evolving bench mark and

it is overseen by the Safeguarding Steering Group. This full assurance demonstrates our developments in Safeguarding within SFHT in 2017/18.

Monitoring and reporting for sustained improvement

- We will use the data provided by the quarterly reporting mechanism to inform our work planning trajectory. This will be aligned to the Safeguarding development plan which has been refined to meet the Think Family Safeguarding agenda.

- We will continue to embed the developments in respect of MCA/DOLS and clearly evidence the work undertaken.

- Refine the training developments which were commenced in the final quarter of 2017/18. These include the development of a Think Family Safeguarding day for all clinical facing staff who join the Trust, and the refinement of the MCA training session from a half day to a full day to allow us to address some of the learning from serious incidents and local reviews.

- 2017/18 has been a year which has seen a large number of changes and developments in respect of the Think Family Safeguarding agenda and a key focus of the next year will be to ensure these are embedded and achievable whilst still working toward any refinements locally and nationally.

Continue to develop our reporting and data collation processes to allow us to evidence both as a team and a trust what we do in respect of Safeguarding. The training for MCA/DoLS has been reviewed and refreshed. This is now a full day and incorporates the interface with The Mental Health Act. The Trust have commenced a pilot of MVA/DoLS supervision with 2 wards (52 and 12). Within these groups the Trust are also looking at the development of the MCA paperwork and will trial the versions which will be cascaded out for consolation. Following the bench audit in September 2017 a 12/18 month development plan has been ratified. A timetable of monthly audit for MCA/DoLS has been commenced (April 2018).

3.10 Mandatory Key Performance Indicators

Indicators identified within the Single Oversight Framework for November 2017	**Target**	**Performance**	
		Yr2016/17	**Yr2017/18**
*Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92%	92.63%	91.5
*A&E : maximum waiting time of four hours for arrival to admission / transfer / discharge	>95%	94.51%	92.33
Cancer 2 week wait: all cancers	93%	95.9%	96.1
Cancer 2 week wait: breast symptomatic	93%	96.6%	97.2
Cancer 31 day wait: from diagnosis to first treatment	96%	97.8%	98.6
Cancer 31 day wait: for subsequent treatment – surgery	94%	100%	90.9
Cancer 31 day wait: for subsequent treatment –drugs	98%	98.9%	100
*Cancer 62 day wait: urgent referral to treatment	85%	83.6%	84.1
Cancer 62 day wait: for first treatment – screening	90%	89.2%	84.9
Maximum 6- Week wait for diagnostic procedures	99%	99.43%	96.59%
Clostridium difficile variance from plan	48	28	39
**Summary Hospital-level Mortality Indicator (SHMI)	100	95.15	101.62
VTE Risk assessment	95%	95%	95%

*Further detail of assurance over mandated and selected local indicators can be found in Appendix 3.

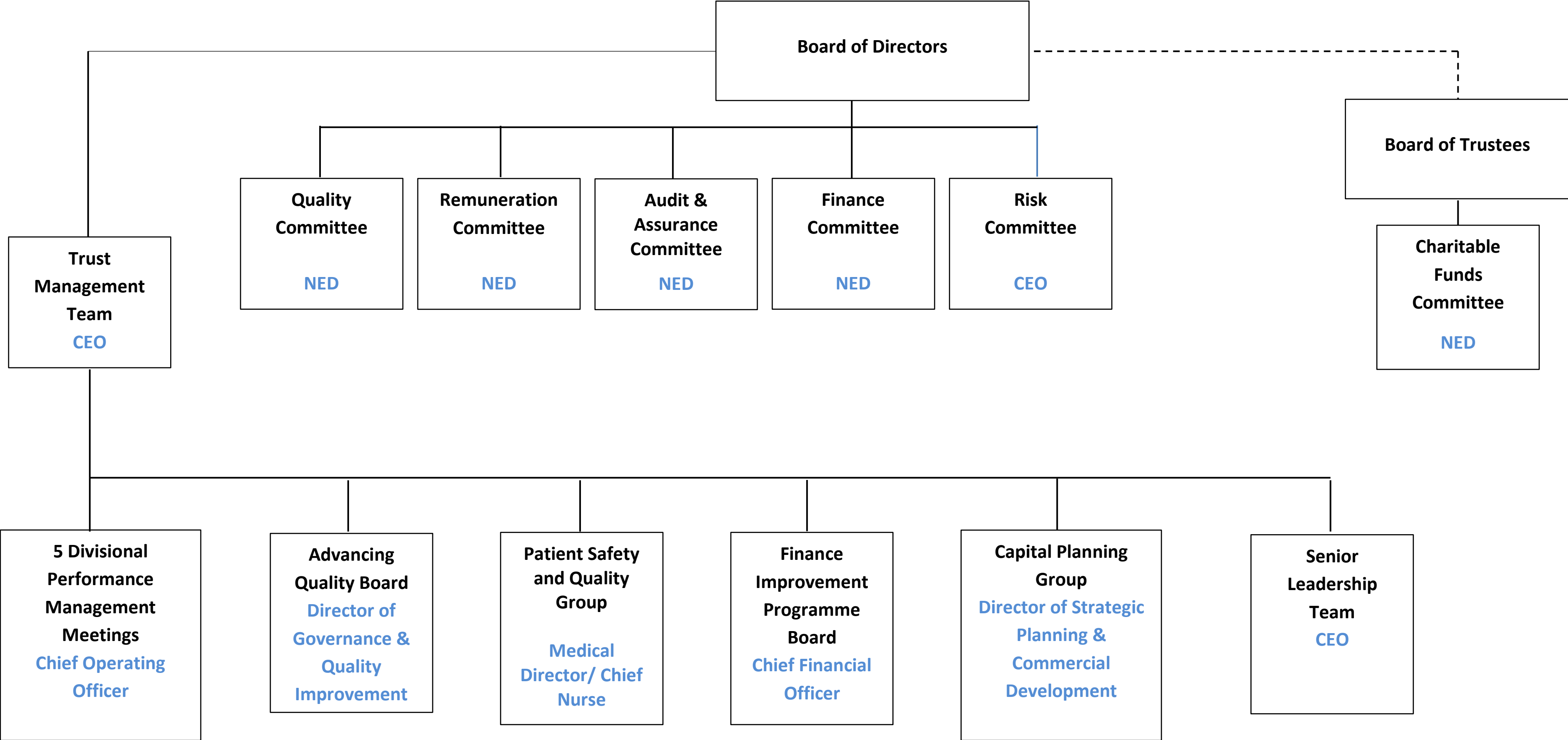
** The Summary Hospital-level Mortality Indicator (SHMI) is a rolling reporting period. The figures reported represent most current data available:

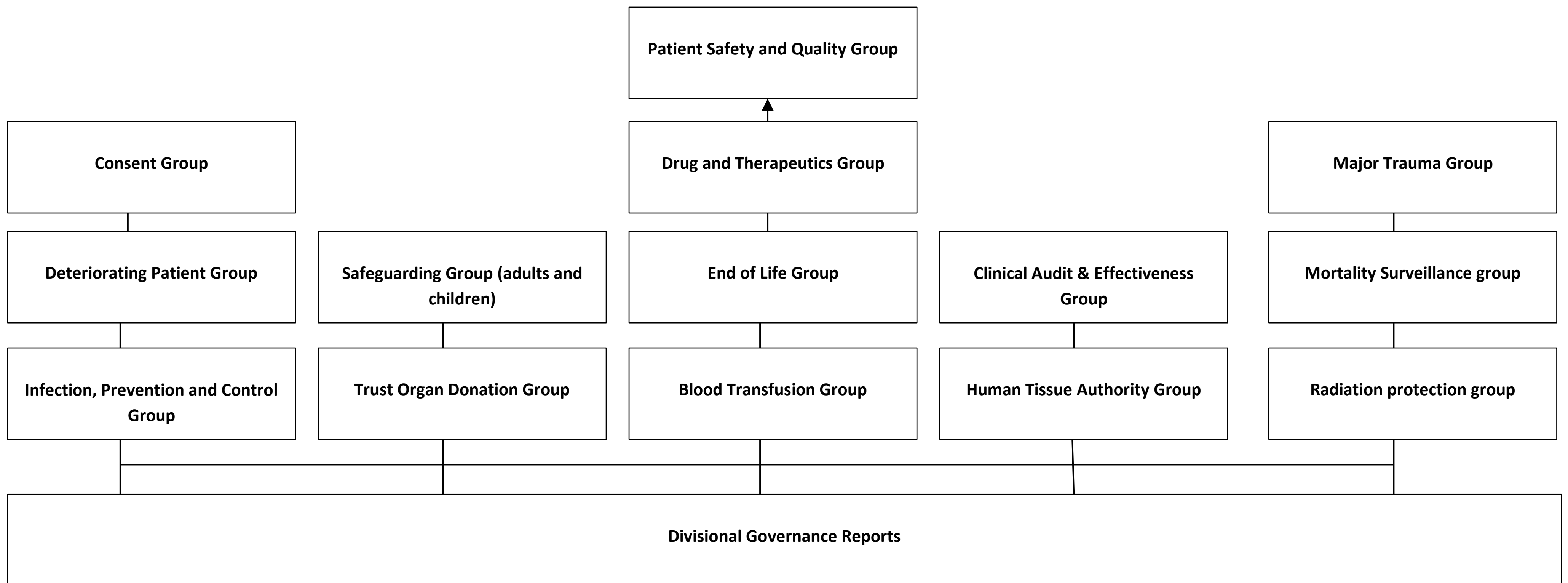
95.15 October 2015 - September 2016

101.63 October 2016 – September 20

Appendix 1

Sherwood Forest NHS Foundation Trust –Committee Structure – 2017/18





The Patient Safety and Quality Group (PSQG) meet on the first Wednesday of every month. PSQG is the key Governance Committee that operationally supports the delivery of safe, high quality care to patients. PSQG also provides an Assurance Report from each meeting to the Board of Directors via the Quality Committee.

Appendix 2. DPG Dashboard

Deteriorating Patient Dashboard February 2018

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Sepsis

ACTION NEEDED

At a Glance	Indicator	Standard	Set by	Period	Performance	Trend	RAG rating
Sepsis Screening	Sepsis Screening Adult Emergency Admissions	90%	SFH & CQUIN	Feb-18	100%		G
	Sepsis Screening Paediatric Emergency Admissions	90%	SFH & CQUIN	Feb-18	97.9%		G
	In-patient Sepsis Screening	90%	SFH & CQUIN	Feb-18	98.9%		G
Delivery of Sepsis Treatment	Delivery of Adult Sepsis Bundle in Emergency Admissions	90%	SFH & CQUIN	Feb-18	100.0%		G
	Delivery of Paediatric Sepsis Bundle in Emergency Admissions	90%	SFH & CQUIN	Feb-18	0 activity		G
	Delivery of Sepsis Bundle in in-patient areas	90%	SFH & CQUIN	Feb-18	100% (n:3)		G
HSMR	Sepsis HSMR (month)	100	Nat	Nov-17	58.44		G
	Rolling 12 months Sepsis HSMR	100	Nat	Dec 16 - Nov 17	79.31		G
Sepsis Mandatory Training	Mandatory Training - Nursing/Midwifery/HCA/ODP	90%	SFH	March 17-Feb 18	99%		G
	Mandatory Training - All Medical - adult module	90%	SFH	March 17-Feb 18	80%		A
	Mandatory Training - All Medical - paediatric module	90%	SFH	Nov 17 - Feb 18	71%	↑	R
	All Doctors in Training	90%	SFH	March 17-Feb 18	100%	↔	G
	Mandatory Training - Surgery	90%	SFH	March 17-Feb 18	Adult = 75.5%	↓	R
					Paed = 88.3%	↑	R
	Mandatory Training - Women & Children's	90%	SFH	March 17-Feb 18	Adult= 71.4%	↓	R
					Paed: 75%	↓	R
	Mandatory Training - Medicine	90%	SFH	March 17-Feb 18	Adult = 88.4%	↑	A
	Mandatory Training - Emergency & Urgent Care	90%	SFH	March 17-Feb 18	Adult= 71.6%	↓	R
					Paed = 86.7%	↔	R

Trust Acquired Gram Negative Bacteraemia
YTD = 61 (February 2018 = 7)

Top areas of focus for 03/18
1. Focus on medical mandatory training compliance
3. Planning for 18/19 CQUIN

Incidents

ON TRACK

Overall number of reported incidents under the Deteriorating Patient Datix Categories

F	M	A	M	J	J	A	S	O	N	D	J	F
11	10	3	5	8	5	5	7	9	6	6	4	8

Grade of Harm

	F	M	A	M	J	J	A	S	O	N	D	J	F
Grade 1 no harm	5	10	1	3	7	2	4	5	8	3	6	1	4
Grade 2 Low harm	6	0	2	2	1	3	1	2	1	3	0	3	1
Grade 3—Moderate	0	0	0	0	0	0	0	0	0	0	0	0	2
Grade 4—Severe	0	0	0	0	0	0	0	0	0	0	0	0	1
Grade 5—Catastrophic	0	0	0	0	0	0	0	0	0	0	0	0	0

Top Incident Categories:
1. Treatment unanticipated death = 2
2. Failure to escalate clinical care = 1
3. Failure to record observations = 1
4. Unexpected deterioration due to failure to act or monitor = 1
5. Unexpected transfer to NNU = 1

NEXT STEPS:
GSU to continue to review lessons learnt / incident trends and feed these into the quarterly reports

Specialties are recommended to review and update their risk register entries and ensure that they are consistent with their incident profile

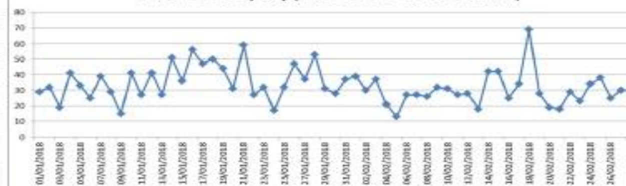
Audits/Projects

ON TRACK

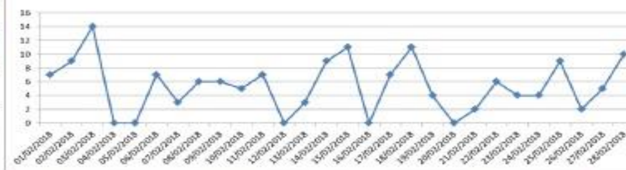
- AKI—redesign of audit tool has been completed and tested on both medical and surgical wards, further refinement needed. Report back to DPG in Apr-18
- NEWS 2
- Review of Observation & Escalation Policy
- Commissioned project for Training Department to conduct Key Skills Analysis for each speciality to ensure appropriate skill mix.

CCOT

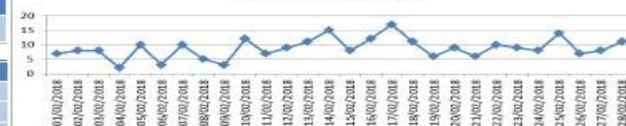
ON TRACK



The Graph above illustrates the total calls to CCOT from Jan 1st 2018 – 28th Feb 2018, These calls are a mixture of Nerve centre calls, Vocera calls, 888 bleeps and ART calls via 2222. Total calls for February this month have reduced from 1097 to 1037 calls.



151 patients in Feb 2018 had NEWS score of 7 and above were not followed up with a phone call to CCOT. (174 patients previous month.) Datix forms have been completed to highlight some of these incidents. No serious incidents have occurred in relation to these patients not escalated.



Actual patients seen by CCOT 246 patients

ART CALLS = 21 (22 prev. month)

AKI Alerts = 37 (28 prev. month)

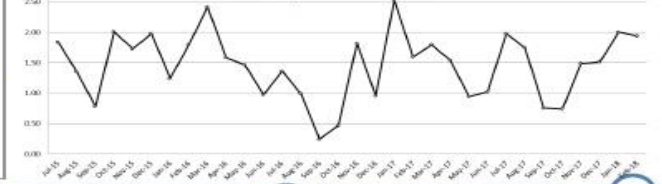
Training

ACTION NEEDED

*the figures represent total compliance for all staff members who are required to complete the module

Resus

ON TRACK



Total Arrests YTD	67
Medical Emergency Calls	56
Paediatric Calls	8
Unable to trace	0

NCAA 61
Non-NCAA 6

Avoidable CPR 15
- 2 Full Resuscitation status challenged
- 4 Had AND
- 2 Lack of Escalation

No of calls impacted by compliance to mandatory advanced resuscitation training: 0

* Cardiac arrest rate risen over the last 3 months. This is in line with previous year
* 1 'Potentially avoidable arrest' reviewed by consultant no harm
* 1 decision referred to medical team for review
* no trends/issues from medical emergency or paediatric calls.

NerveCentre Highlights

ON TRACK

Actions Completed	Actions Planned
NerveCentre e-obs/escalation on Ward 25	Digital Board Round Sign Off
Therapy Services Devices Issued	ED Scope Sign Off
Digital Board Round Consultation	Launch Digital Board Round
ED Scoping Exercise	Next Steps Planning

Nursing Metrics

ACTION AGREED

Question	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Total
83. Has Fluid Balance Chart been completed each day?	99	98	97	97	100	95	92	96	98	96	100	96%
87. Has the fluid balance (+/-) been calculated each day?	[illegible]	[illegible]	[illegible]	87	86	[illegible]	[illegible]	[illegible]	88	[illegible]	100	[illegible]
155. Has the Neurological Observations Chart been completed?	[illegible]	[illegible]	100	[illegible]	100	[illegible]	[illegible]	-	100	[illegible]	100	[illegible]
168. Were all six elements of Sepsis Six delivered within 1 hour of increase in NEWS?	[illegible]	100	100	[illegible]	100	100	100	-	-	-	100	92%
166. Have Observations been increased to required frequency?	[illegible]	[illegible]	100	[illegible]	90	100	100	100	100	-	100	96%
173. Evidence in nursing notes that RN had informed the CCOT (or NTL)?	100	100	100	[illegible]	-	[illegible]	-	100	-	100	-	[illegible]
Monthly Totals:	[illegible]	83%	97%	[illegible]	95%	88%	[illegible]	95%	95%	[illegible]	100%	81%

There has been an improvement noted across all elements of the Deteriorating Patient Dashboard, with 100% shown in all fields for the first time this year. The monthly total demonstrates the improvement over all the six key domains for the Deteriorating Patient. This dashboard continues to be a discussion point at all the Nursing, Midwifery & AHP Business meetings.

Appendix 3 Assurance over Mandated Indicators

Percentage of Incomplete Pathways within 18 Weeks for Patients on Incomplete Pathways at the End of the Reporting Period

Detailed Descriptor: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

National Definition - Numerator: The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks. Denominator: The total number of patients on an incomplete pathway at the end of the reporting period.

Criteria for Indicators:

- The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period;
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2017 to March 2018;
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and
- The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

The total population is based on all patients referred to the Trust for consultant led services and patients who have not been identified as such have not been considered within the calculation.

Percentage of Patients with a Total Time in A&E of Four Hours of Less from Arrival to Admission, Transfer or Discharge

Detailed Descriptor – Numerator: The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as: (total number of unplanned A&E attendances) - (total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge). Denominator: The total number of unplanned A&E attendances:

Criteria for indicator:

- The indicator is defined within the technical definitions that accompany 'Everyone counts: planning for patients 2014-15 – 2018-19' and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def1415-1819.pdf
- Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-

content/uploads/sites/2/2013/03/AE-Attendances- Emergency-Definitions-v2.0-Final.pdf.

The total population is based on all patients recorded as attending A&E and patients who have not been identified as such have not been considered within the calculation.

For walk-in patients arrival time is recorded as the time the patient is booked in on EDIS (Emergency Department Information System) at reception.

For Ambulance patients the Trust records arrival time as the unadjusted booking in time recorded on EDIS. There is no facility to record the ambulance handover time. The Trust is therefore reporting a longer time than required for this measure for ambulance patients. The Trust is planning on implementing a new system in ED in 2017-18 which will enable the recording of ambulance handover times and has been working with East Midlands Ambulance Service NHS Trust to ensure accurate data is captured for ambulance arrival in 2017-18.

Selected Local Indicator

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

This is an indicator chosen by the Governors and subsequently looked at by the external auditors as part of their quality inspection audit (not subject to the assurance) and update to management.

Detailed descriptor

PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition: all cancer two month urgent referral to treatment wait

Numerator: number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator: total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

Criteria for indicator: The total population is based on all patients referred to the Trust with suspected cancer and patients who have not been identified as such have not been considered within the calculation.

Annex 1 – Statements from Commissioners , Health Scrutiny Committee and Healthwatch .

This section includes the statements from our stakeholders about the Trusts quality performance during 2017/18 following review by Stakeholders

Statement from Mansfield and Ashfield and Newark and Sherwood Clinical Commissioning Groups (CCGs)

Sherwood Forest Hospitals NHS Foundation Trust

Sherwood Forest Hospitals Foundation Trust has continued to develop and deliver quality improvements across the organisation. Following concerns in previous years, staffing metrics, reduction in avoidable pressure ulcers, adult safeguarding and training are examples of where demonstrable change has been sustained. There has been a clear reduction in the number of serious incidents and never events, supported by a robust quality and risk framework.

Winter pressures added challenge across the local health system, and the trust was unable to maintain previous A&E performance, but they have worked closely with other providers and commissioners to minimise the impact on patients.

The Trust's continued partnership role in the Mid Nottinghamshire Alliance has contributed to wider improvement to services for our population.

Statement from the Health Scrutiny Committee

The Health Scrutiny Committee for Nottinghamshire welcomes the opportunity to comment on Sherwood Forest Hospitals NHS Foundation Trust's Quality Account.

In the context of the difficulties recruiting and retaining NHS staff across a wide variety of specialisms, the committee would like to see a greater emphasis on staff health and wellbeing as a stated priority, in particular, towards their mental health.

The committee commends within the Trust the use of Chief Nurse Awards and long service awards as a means of maintaining and improving morale.

The committee also commends the Trust for its systematic approach to improving Emergency Department performance by way of root cause analysis of all breaches.

The committee was pleased to hear about the Trust's ambition to be outstanding by 2021. In addition, the Trust's aim to move beyond a paternalistic model of care towards services that are developed in partnership with patients and service users is both laudable and insightful.

We request that the Trust reports to the committee the learning outcomes from serious incidents and Never Events (if they occu)r

Statement from Healthwatch

Statement in response to the Sherwood Forest Hospital Trust Quality Account 2017-2018

As the local independent watchdog for health and care, 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 Sherwood Forest Hospital Trust Quality Account 2017-18. In particular the sections on Staff, Friends and Family responses and Patient Experiences.

The report provides a helpful overview of the quality of services provided and review of activities and achievements, demonstrating the mandatory reporting requirements set out by NHS Improvement. The statement that Staff, Friends and Family responses, Care Opinion and Patient Experiences are collected illustrate the Trust's commitment to actively seek and welcome feedback. For example the introduction of an SMS test messaging for the Family and Friends Test has led to improvement in the environment of clinic areas and communication with patients when delays occur. We also see that further speciality specific surveys have been undertaken, however the number of responses received, findings, recommendations and subsequent improvements have not been shared in this report.

Following the 2016 Care Quality Commission inspection report, which featured improvements in safeguarding, the Trust has increased the take up by staff of MCA/DOLS training, revised the Safeguarding Strategy and used learning from serious incidents and audits to refine the MCA/DOLS training. However the detail of these incidents and audits is not stated.

The report describes the work of the Patient Experience Team (PET) who aim to resolve concerns and complaints quickly. While the PET data is analysed internally to identify themes, these are not described in the report, nor have they been shared with Healthwatch.

The four improvement campaigns that make up the Quality Strategy are challenging enough to drive improvement, however section 2.4 does not explain how the data will be collected or how the Trust will work to ensure that the voice of those who are seldom heard is included.

Over the last year Healthwatch have received a number experiences from patients regarding services provided by the Trust. Patient experiences including, 'member of staff absolutely brilliant', 'the staff made me feel reassured', 'staff were kind and good' and 'professional'. The negative experiences collected include delayed discharge, early discharge and staff communication.

We recommend the Trust shares quantitative and 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 to provide tangible evidence to the public of the positive work the Trust is doing.

Annex 2 – Statement of Directors responsibilities for the Quality Report

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:
    1. Board minutes and papers for the period April 2017 to March 2018
    2. Papers relating to quality reported to board over the period April 2017 to March 2018
    3. Feedback from commissioners dated 27 April 2018
    4. Feedback from local Healthwatch organisation dated 3 May 2018
    5. Feedback from Overview and Scrutiny Committee dated 10 May 2018
    6. The Trust's complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009, dated 2^{t} June 2017
    7. The 2016 national patient data survey dated 31 May 2017. The 2017 survey is expected to be published in May 2018
    8. The 2017 national staff survey dated March 2018
    9. The Head of Internal Audit's annual opinion of the trust's control environment dated 16 May 2018
    10. CQC Inspection report dated 9 November 2016
- 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
- The Quality report has been prepared in accordance with NHS Improvement's annual reporting 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

29th May 2018………..Date ………… ……………Chair

29th May 2018………..Date…… ……Chief Executive…

Glossary of Terms Used

Term	**Description**
A&E	Accident & emergency
AKI	Acute kidney injury
CCG	Clinical Commissioning Group
C Diff	Clostridium difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRT	Cardiac resynchronisation therapy
COPD	Chronic obstructive pulmonary disease
DH	Department of Health
ECHO	Echocardiogram
ED	Emergency department
EDASS	Emergency department avoidance support service
EMPSC	East Midlands Academic Health Science Network
EPACCS	Electronic palliative care co-ordination system
EPMA	Electronic prescribing and administration
FFT	Friends and Family Test
GP	General practitioner
HSCIC	Health & Social Care Information Centre
HSMR	Hospital standardised mortality ratio
IDAT	Integrated discharge advisory team
IG	Information governance
LCRN	Local clinical research network
LOS	Length of stay
LTC	Long term condition

MRSA	Methicillin resistant staphylococcus aureus
MSO	Medicines safety officer
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute of Health and Clinical Excellence
NIHR	National Institute for Health Research
NRIG	Nottinghamshire records information group
NRLS	National Reporting and Learning System
OBD	Occupied bed days
PDD	Predicted date of discharge
PEAT	Patient environment action team
PLACE	Patient led assessment care environment
PROMS	Patient reported outcome measures
PSIG	Patient safety improvement group
QIP	Quality improvement plan
RCA	Root cause analysis
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Children's Health
SFH	Sherwood Forest Hospitals
SHMI	Summary hospital mortality index
SSI	Surgical site infection
TTO	To take out
VTE	Venous thromboembolism
WHO	World Health Organisation
WTE	Whole time equivalent

Independent Auditors' Limited Assurance Report to the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Sherwood Forest Hospitals 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 Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement (NHSI)):

Specified Indicators	*Specified indicators criteria* (exact section where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Appendix 3 of the Quality Report.
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	Appendix 3 of the Quality Report.

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 in Appendix 3 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 Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and consider the implications for our report if we become aware of any material omissions.

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 March 2018;
- Papers relating to Quality reported to the Board over the period April 2017 to March 2018;

- Feedback from the Commissioners, Mansfield and Ashfield and Newark and Sherwood Clinical Commissioning Group dated 27/04/18;
- Feedback from local Healthwatch organisations, Healthwatch Nottinghamshire, dated 03/05/18;
- Feedback from the Overview and Scrutiny Committee, dated 10/05/18;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, for the annual complaints 2016/17, dated 02/06/17;
- The latest national patient survey (2016) dated 31/05/17;
- The 2017 national staff survey dated March 2018;
- Care Quality Commission inspection report, dated 09/11/16; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16/05/2018.

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 Sherwood Forest Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sherwood Forest Hospitals 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 Sherwood Forest Hospitals 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 Sherwood Forest Hospitals NHS Foundation Trust.

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The 18 week indicator is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. The data reported is subsequently updated by Sherwood Forest Hospitals NHS Foundation Trust for any identified errors through a continuous validation process. However, the process is not applied to the whole data set and focuses only on the longest waits, working backwards through the waits as far as capacity allows. This process operates similarly across the NHS.

In our testing we found a number of errors in the data: one where the clock had not been stopped when it should have been; one where a start clock had not been started when it should have been; and another where the clock had been incorrectly stopped when it should not have been. Each of these resulted in the patient's wait being reported, or not reported, incorrectly.

Sherwood Forest Hospitals NHS Foundation Trust was not able to review and update the whole data set used to calculate the indicator. Therefore, we were unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

Basis for Disclaimer Conclusion - Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

We identified that due to the current configuration of System One, the system used by Sherwood Forest Hospitals NHS Foundation Trust in A&E, we are unable to confirm the start and stop clocks to supporting evidence. This is because the system does not capture a history of supporting evidence for amendments to this data and there is no supporting evidence retained outside the system.

We also found that start clocks for ambulance arrivals are not being captured in line with NHSI's definition for "the Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge", which specifies that the clock start time for patients arriving by ambulance is when hand over occurs, or 15 minutes after the ambulance arrives at A&E, whichever is earlier. Sherwood Forest Hospitals NHS Foundation Trust currently uses the arrival time in department without adjustment, which would fall after ambulance arrival but before handover. The total number of arrivals by ambulance make up 22.5% of patients who attended A&E. The issue of difficulty in measuring ambulance arrival time due to lack of accurate data has been identified across a number of trusts, nationally.

In addition, we found stop clocks for admissions to wards in the hospital did not appear to be calculated in line with guidance that this should be based on physical departure time, but instead use the time of the decision to refer to ward. Sherwood Forest Hospitals NHS Foundation Trust admitted 19.84% of patients attending A&E to wards during 2017/18.

Disclaimer of conclusion

Because of the significance of the matters described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the incomplete pathways indicator.

Because of the significance of the matters described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the four hour waits in A&E indicator.

Based on our limited assurance 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"; and
- the Quality Report is not consistent in all material respects with the documents specified above.

PricewaterhouseCoopers LLP.

PricewaterhouseCoopers LLP
Donington Court,
Castle Donington,
DE74 2UZ

Date: 29 May 2018

The maintenance and integrity of the Sherwood Forest Hospitals 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.

Sherwood Forest Hospitals NHS Foundation Trust

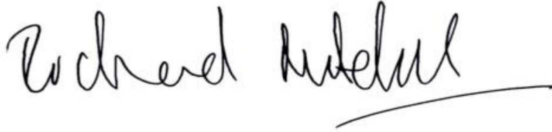
Annual accounts for the year ended 31 March 2018

Foreword to the accounts

Sherwood Forest Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Sherwood Forest Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……………………………………………



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Name	**Richard Mitchell**
Job title	**Chief Executive Officer**
Date	**29 May 2018**

Statement of Comprehensive Income
For the year ended 31 March 2018

	Note	2017/18	Restated 2016/17
		£000	£000
Operating income from patient care activities	2	249,726	237,963
Other operating income	3	54,955	57,476
Operating expenses	4, 6	(276,866)	(367,726)
Operating surplus/(deficit) from continuing operations		**27,815**	**(72,287)**
Finance income	9	33	28
Finance expenses	10	(14,467)	(13,625)
Net finance costs		**(14,434)**	**(13,597)**
Other gains / (losses) on disposal of non-current assets	11	(73)	(137)
Surplus / (deficit) for the year from continuing operations		**13,308**	**(86,021)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		-	-
Surplus / (Deficit) for the year		**13,308**	**(86,021)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	5	2,698	(2,796)
Total comprehensive income / (expense) for the period		**16,006**	**(88,817)**

Surplus/(deficit) for the year as stated above		**13,308**	**(86,021)**
Reversal of impairment	5	(37,277)	(202)
Impairment	5	756	42,281
LTP SFH		-	1,426
LTP (NUH)		-	11,216
Surplus / (Deficit) from continuing operations excluding the impact of impairments and LTP		**(23,213)**	**(31,300)**

Long Term Partnership (LTP) represent costs incurred with Nottingham University Hospitals NHS Trust in pursuit of the proposed merger in 2016/17.

The 2016/17 comparative figures have been restated to reflect changes made to the recognition of the financing and associated payments relating to the PFI scheme. Where appropriate the 2016/17 column states "Restated" in the notes to these accounts.

Statement of Financial Position
As at 31 March 2018

	Note	31 March 2018 £000	Restated 31 March 2017 £000	1 April 2016 £000
Non-current assets				
Intangible assets	12	4,279	4,505	5,335
Property, plant and equipment	13	265,362	226,297	271,856
Trade and other receivables	17	358	593	652
Other assets	18	-	-	-
Total non-current assets		**269,999**	**231,395**	**277,843**
Current assets				
Inventories	16	3,119	3,377	3,239
Trade and other receivables	17	26,175	21,796	14,159
Cash and cash equivalents	18	8,905	3,899	1,456
Total current assets		**38,199**	**29,072**	**18,854**
Current liabilities				
Trade and other payables	19	(27,765)	(32,335)	(30,492)
Borrowings	21	(11,289)	(12,188)	(11,479)
Provisions	22	(1,104)	(1,061)	(703)
Other liabilities	20	(2,419)	(561)	(6,810)
Total current liabilities		**(42,577)**	**(46,145)**	**(49,484)**
Total assets less current liabilities		**265,621**	**214,322**	**247,213**
Non-current liabilities				
Trade and other payables	19	(715)	(975)	(1,567)
Borrowings	21	(435,513)	(400,201)	(345,783)
Provisions	22	(828)	(863)	(389)
Other liabilities	20	-	-	-
Total non-current liabilities		**(437,056)**	**(402,039)**	**(347,739)**
Total assets employed		**(171,435)**	**(187,717)**	**(100,526)**
Financed by				
Public dividend capital		146,415	146,139	144,513
Revaluation reserve		14,517	11,942	14,949
Income and expenditure reserve		(332,367)	(345,798)	(259,988)
Total taxpayers' equity		**(171,435)**	**(187,717)**	**(100,526)**

The notes on pages 9 to 50 form part of these accounts and were approved aby the Board and signed on its behalf:

Name	**Richard Mitchell**
Position	**Chief Executive Officer**
Date	**29 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	**146,139**	**11,942**	**(345,798)**	**(187,717)**
Surplus for the year	-	-	13,308	**13,308**
Other transfers between reserves	-	(122)	122	**-**
Impairments	-	2,698	-	**2,698**
Transfer to retained earnings on disposal of assets	-	(1)	1	**-**
Public dividend capital received	276	-	-	**276**
Taxpayers' equity at 31 March 2018	**146,415**	**14,517**	**(332,367)**	**(171,435)**

Restated 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	**144,513**	**14,949**	**(279,817)**	**(120,355)**
Prior period adjustment	-	-	19,829	**19,829**
Taxpayers' equity at 1 April 2016 - restated	**144,513**	**14,949**	**(259,988)**	**(100,526)**
(Deficit) for the year	-	-	(86,021)	**(86,021)**
Other transfers between reserves	-	(211)	211	**-**
Impairments	-	(2,796)	-	**(2,796)**
Public dividend capital received	1,626	-	-	**1,626**
Taxpayers' equity at 31 March 2017	**146,139**	**11,942**	**(345,798)**	**(187,717)**

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. No charges have been payable by the Trust to the Department of Health.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	Restated 2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		27,815	(72,287)
Non-cash income and expense:			
Depreciation and amortisation	4.1	10,043	10,428
Net impairments	5	(36,521)	42,079
Income recognised in respect of capital donations	3	(241)	(140)
(Increase) in receivables and other assets		(4,142)	(7,579)
Decrease / (Increase) in inventories		258	(138)
(Decrease) in payables and other liabilities		(6,175)	(5,941)
Increase in provisions		8	832
Net cash (used in) operating activities		**(8,955)**	**(32,746)**
Cash flows from investing activities			
Interest received		27	29
Purchase of intangible assets		(275)	(665)
Purchase of property, plant, equipment and investment property		(6,045)	(7,381)
Sales of property, plant, equipment and investment property		32	78
Net cash (used in) investing activities		**(6,261)**	**(7,939)**
Cash flows from financing activities			
Public dividend capital received		276	1,626
Movement on loans from the Department of Health and Social Care		45,696	66,233
Capital element of PFI, LIFT and other service concession payments		(11,283)	(11,106)
Interest paid on PFI, LIFT and other service concession obligations		(12,221)	(11,627)
Other interest paid		(2,246)	(1,998)
Net cash generated from financing activities		**20,222**	**43,128**
Increase in cash and cash equivalents		**5,006**	**2,443**
Cash and cash equivalents at 1 April - brought forward		**3,899**	**1,456**
Cash and cash equivalents at 31 March	18.1	**8,905**	**3,899**

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 accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

The going concern concept is further covered in IAS 1 – 'Presentation of Financial Statements'. IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. Foundation Trusts therefore need to pay particular attention to going concern issues. In the event that a Foundation Trust is dissolved by Monitor any property or liabilities of the Trust may be transferred to another Foundation Trust, an NHS Trust or the Secretary of State.

For the year ending 2017/18 we are reporting a surplus of £13.3m which includes the impact of impairments on the valuation of buildings. Removing this gain, which was £36.5m, we are reporting a deficit of (£23.2m). This is favourable to the plan by £14.5m. Bonus and Incentive Sustainability and Transformation Funding (STF) of £10.3m was accounted for in 2017/18 following notification from NHSI.

To support this financial position we have received £37.7m of revenue support term loans (and £3.3m relating to 2016/17 creditors, which does not count against the trust in year borrowing.) £5.6m was also received to support the capital expenditure of £9.8m, and in year repayments of £1.0m were made against existing capital loans.

NHS Improvement has set a control total of a maximum deficit of (£34.0m) in 2018/19, which includes receipt of £12.4m Provider Sustainability Fund (PSF, previously known as STF). To qualify for this funding the trust must:-

• Accept its control total.
• Deliver 4 hour wait performance in a quarter that is the better of 90% or the equivalent quarter of 2017/18. (30%)
• Deliver the control total pre PSF (70%). £3.6m of the PSF is dependent on delivery of the combined financial position of all relevant organisations in the system

To support this deficit we will require £34.0m of cash support. NHS Improvement (NHSI) is aware of the need for cash support and the value has formally been notified via the submission of the financial plan on 8th March 2018, and updated plan submitted 30th April 2018. This has not formally been agreed, however planning guidance states that if control totals are agreed revenue funding via term loans will be available to deficit organisations.

Due to our PFI liabilities depreciation does not self-fund the capital expenditure. Cash receipt of incentive and bonus STF of £10.3m relating to 2017/18 will be sufficient to support the capital programme in 2018/19 and use of this cash flow for this purpose has been agreed by NHSI.

The Trust Board agreed a financial plan that would deliver the control total on 22nd February and further ratified this when commissioner contract values were known on 29th March 2018. Included within this is assumed financial improvement programme (FIP) delivery £17.3m. Development and delivery of the FIP programme includes dedicated support from the Project Management Team with a workstream lead identified for each area of the programme. Targets have been identified for each workstream based on opportunities with continuous processes moving schemes into delivery.

Given the evidence available to the Board of Directors as summarised within this report, there are circumstances that indicate the existence of a material uncertainty that may cast doubt about the Trust's ability to continue as a going concern. However the Trust has accepted its control total as issued by NHSI, revenue borrowing has been received for the early months of 2018/19 and the Trust has adopted a plan with clear assumptions of requirements to deliver, including a CIP programme of £17.3m for which an infrastructure is in place to support delivery. On this basis the accounts have been prepared on a going concern basis. The Board of Directors has taken steps to ensure this remains the case for the next 12 months.

Note 1.2 Critical judgements in applying accounting policies

In applying the Trust's accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate.

In preparing these accounts a judgement has been made relating to the restatement of the PFI finance lease liability and a decision made to continue to include the interest and related costs incurred by the SPV during the period of construction, as part of determining the initial fair value of the PFI assets and finance lease creditor.

The implicit interest rate recognised on the financial liability is 2.29% which compares to a rate of 3.07% if the initial fair value was based on construction and development costs alone. This has the impact of increasing the repayment of the finance lease liability and reducing the cost recognised in the Statement of Comprehensive Income and Expenditure (SoCIE). This equates to a SoCIE benefit of £1.4m for 2018/19 reducing to £0.1m in 2042/43 as the finance lease creditor is repaid.

The Trust Board has approved this approach as it is consistent with the accounting guidance in place during the period of construction.

Note 1.2.1 Sources of estimation uncertainty

There are no assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.3 Interests in other entities

The Trust is the Corporate Trustee of Sherwood Forest Hospitals General Charitable Fund. The Charity is not consolidated as the balances are not deemed material, however, the revenue and capital grants are reflected in the accounts.

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.

Where income has not been received prior to the year end but the provision of a healthcare service has commenced, i.e. partially completed patient spells, then income relating to the patient activity is accrued.

Conversely In year income has been received relating to the 'maternity pathway' which is received after 14 weeks for the whole period of treatment. Where income has been received prior to completion of the provision of the healthcare service, then income relating to the patient activity has been 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.

Income relating to Sustainability and Transformation Funding (STF) is recognised in the accounts in line with NHSI guidance which requires the trust to accepts its control total and deliver the required performance against the National 4 hour wait target.

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.

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

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. All property assets are reviewed by an independent valuer to ensure that, where of a material value, components of property assets are separately reported and depreciated accordingly.

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

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

Revaluation gains and losses

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 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 i.e:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the 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 service charge (charged to operating expenses), lifecycle replacement cost and the finance lease liability. The finance lease liability is further split into the principal repaid, the loan interest expense and the contingent rent in accordance with IAS 17, and reflects the fact that the lease rental may increase due to uncertain factors.

Lifecycle replacement costs are reviewed and charged to revenue or capital when they meet the capital definition and are then accounted for as part of the annual valuation assessment.

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	1	70
Dwellings	1	70
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	5
Furniture & fittings	5	10

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Note 1.8.2 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	5

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is valued on the basis of a first in first out basis. This is considered to be a reasonable approximation of fair value due to the high turnover of stocks.

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 cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 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, i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables

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

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

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

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

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

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

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

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

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

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

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

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices/independent appraisals and or discounted cash flow analysis.

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 1.12 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 1.12.1 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 1.12.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

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

Note 1.13 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.

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 1.14 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 23 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 23, 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 1.15 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 1.16 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 1.17 Corporation tax
No liability for corporation tax has been recognised or incurred when applying the current legislation.

Note 1.18 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 1.19 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 1.20 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 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

As required by IAS 8, the Trust is required to disclose any standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector. The Trust is not impacted by any of the standards, amendments or interpretations that have been issued.

Change published	Financial year for which the change first applies
IFRS 9 Financial Instruments	*Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.*
IFRS 14 Regulatory Deferral Accounts	*Not yet EU-endorsed.** *Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.*
IFRS 15 Revenue from Contracts with Customers	*Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.*
IFRS 16 Leases	*Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.*
IFRS 17 Insurance Contracts	*Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.*
IFRIC 22 Foreign Currency Transactions and Advance Consideration	*Application required for accounting periods beginning on or after 1 January 2018.*
IFRIC 23 Uncertainty over Income Tax Treatments	*Application required for accounting periods beginning on or after 1 January 2019.*

Note 1.24 Operating Segments

No segmental analysis is shown as Sherwood Forest Hospitals NHS Foundation Trust acts solely in the UK and operates as a segment providing healthcare. The "Chief Operating Decision Maker" is deemed to be the Trust Board.

The Board currently receives only high level financial information and does not therefore review information or allocate resources in any way that could be perceived to represent operating segments.

The Trust is split into 5 clinical divisions, Urgent and Emergency Care, Medicine, Surgery, Women's and Children's and Diagnostics & Outpatients. In addition there is a supporting corporate function. All of these divisions are engaged directly in the provision of healthcare and hence are reported as one segment."

A detailed analysis of all income is disclosed in note 2 to these accounts.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Acute services		
Elective income	36,171	38,029
Non elective income	86,683	73,588
First outpatient income	18,670	16,180
Follow up outpatient income	31,763	30,787
A & E income	16,012	14,646
High cost drugs income from commissioners (excluding pass-through costs)	13,483	12,852
Other NHS clinical income	45,810	50,910
All services		
Private patient income	88	119
Other clinical income	1,046	852
Total income from activities	**249,726**	**237,963**

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	12,943	13,320
Clinical commissioning groups	231,455	220,566
Department of Health and Social Care	-	-
Other NHS providers	1,455	368
NHS other	9	-
Local authorities	2,730	2,738
Non-NHS: private patients	88	119
Non-NHS: overseas patients (chargeable to patient)	24	41
NHS injury scheme	1,022	811
Non NHS: other	-	-
Total income from activities	**249,726**	**237,963**
Of which:		
Related to continuing operations	249,726	237,963
Related to discontinued operations	-	-

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 22.84% to reflect expected rates of collection. (22.94% 2016/17)

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	24	41
Cash payments received in-year	6	13
Amounts written off in-year	5	-

Note 3 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	731	741
Education and training	11,177	11,651
Receipt of capital grants and donations	241	140
Charitable and other contributions to expenditure	357	365
Non-patient care services to other bodies	9,397	6,871
Sustainability and transformation fund income	17,335	15,004
Rental revenue from operating leases	1,475	1,478
Other income	14,242	21,226
Total other operating income	**54,955**	**57,476**
Of which:		
Related to continuing operations	54,955	57,476
Related to discontinued operations	-	-

Sustainability and Transformation Fund income relates to income received for meeting agreed operational and financial targets.

Note 3.1 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	(249,726)	(237,963)
Income from services not designated as commissioner requested services	1,110	930
Total	**(248,616)**	**(237,033)**

Note 3.2 Profits and losses on disposal of property, plant and equipment

No land and buildings assets used in the provision of commissioner requested services have been disposed of during the year.

Note 4.1 Operating expenses

	2017/18	Restated 2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	857	642
Purchase of healthcare from non-NHS and non-DHSC bodies	1,589	1,657
Purchase of social care	-	-
Staff and executive directors costs	195,414	195,991
Remuneration of non-executive directors	144	144
Supplies and services - clinical (excluding drugs costs)	25,488	25,378
Supplies and services - general	2,919	1,555
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,187	21,747
Inventories written down	-	-
Consultancy costs	97	720
Establishment	2,881	3,089
Premises	17,297	19,715
Transport (including patient travel)	641	677
Depreciation on property, plant and equipment	8,411	8,933
Amortisation of intangible assets	1,632	1,495
Net impairments	(36,521)	42,079
Increase/(decrease) in provision for impairment of receivables	50	370
Increase/(decrease) in other provisions	299	1,031
Audit fees payable to the external auditor		
audit services- statutory audit	77	62
other auditor remuneration (external auditor only)	8	7
Internal audit costs	121	157
Clinical negligence	10,738	8,919
Legal fees	138	209
Education and training	522	805
Rentals under operating leases	338	401
Early retirements	29	52
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	20,919	21,287
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	131	115
Hospitality	140	151
Losses, ex gratia & special payments	36	70
Other	284	10,268
Total	**276,866**	**367,726**
Of which:		
Related to continuing operations	276,866	367,726
Related to discontinued operations	-	-

Other costs for 2016/17 relate to LTP (2017/18 nil)

Note 4.2 Audit Related Assurance Services

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	8	7
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**8**	**7**

Note 4.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 5 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(36,521)	42,079
Total net impairments charged to operating surplus / deficit	**(36,521)**	**42,079**
Impairments (credited) or charged to the revaluation reserve	(2,698)	2,796
Total net impairments	**(39,219)**	**44,875**

Land and Buildings are valued on an annual basis to reflect their market value. The valuations accords with the requirements of the Royal Institution of Chartered Surveyors RICS Valuation - Professional Standards 2014 UK edition (known as ‘the Red Book’) in so far as these are consistent with IFRS and NHS guidance. Any movements in the carrying value are reflected in the SOCIE / SOCIE Reserves as required.

Note 6 Employee benefits

Note 6 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	147,458	137,365
Social security costs	13,693	13,178
Apprenticeship levy	713	-
Employer's contributions to NHS pensions	17,125	16,228
Temporary staff (including agency)	16,775	29,576
Total gross staff costs	**195,764**	**196,347**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**195,764**	**196,347**
Of which		
Costs capitalised as part of assets	299	297

Note 6.1 Retirements due to ill health

During 2017/18 there were 4 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £121k (£437k in 2016/17).

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

Note 7.1 Directors' remuneration	**2017/18**	**2016/17**
The aggregate amounts payable to directors were:	**Total**	**Total**
	£000	**£000**
Salary	1257	1703
Taxable benefits	4	2
Employer's pension contributions	131	68
Total	**1,392**	**1,773**

Further details of directors' remuneration can be found in the remuneration report.

2016/17 figures restated to include agency costs in addition to salaried directors.

Note 7.2 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.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 8 Operating leases

Note 8.1 Sherwood Forest Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Sherwood Forest Hospitals NHS Foundation Trust is the lessor.

Contingent Rent described in Operating Lease revenue is a technical disclosure resulting from the IFRS disclosure requirements in respect of the PFI asset.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	1,475	1,478
Contingent rent	-	-
Other	-	-
Total	**1,475**	**1,478**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	547	1,365
- later than one year and not later than five years;	1,279	4,901
- later than five years.	32	835
Total	**1,858**	**7,101**

Note 8.2 Sherwood Forest Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Sherwood Forest Hospitals NHS Foundation Trust is the lessee.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	338	401
Contingent rents	-	-
Less sublease payments received	-	-
Total	**338**	**401**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	368	253
- later than one year and not later than five years;	327	278
- later than five years.	-	-
Total	**695**	**531**

Note 9 Finance income

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

	2017/18	Restated 2016/17
	£000	£000
Interest on bank accounts	33	28
Total	**33**	**28**

Note 10.1 Finance expenditure

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

	2017/18	Restated 2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,246	1,997
Main finance costs on PFI and LIFT schemes obligations	4,835	4,974
Contingent finance costs on PFI and LIFT scheme obligations	7,386	6,654
Total interest expense	**14,467**	**13,625**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**14,467**	**13,625**

Note 10.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

No amounts have been included in finance costs (2015/16 nil) and no compensation has been paid to cover debt recovery costs under this legislation

Note 11 Gains / (losses) on disposal/derecognition of non-current assets

	2017/18	Restated 2016/17
	£000	£000
Profit on disposal of non-current assets	32	78
Loss on disposal of non-current assets	(105)	(215)
Total (losses) on disposal of non-current assets	(73)	(137)

Note 12.1 Intangible assets - 2017/18

	2017/18	2016/17
	Software licences	Software licences
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**13,021**	**12,356**
Transfers by absorption	-	
Additions	2,173	665
Reclassifications	(1,089)	
Gross cost at 31 March 2018	**14,105**	**13,021**
Amortisation at 1 April 2017 - brought forward	**8,516**	**7,021**
Transfers by absorption	**-**	
Provided during the year	1,632	1,495
Reclassifications	**(322)**	
Amortisation at 31 March 2018	**9,826**	**8,516**
Net book value at 31 March 2018	**4,279**	
Net book value at 1 April 2017		**4,505**

Note 13.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**17,291**	**191,072**	**1,658**	**525**	**33,311**	**9,596**	**425**	**253,878**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	2,459	168	-	3,368	1,598	2	**7,595**
Impairments	-	(756)	-	-	-	-	-	**(756)**
Reversals of impairments	70	39,905	-	-	-	-	-	**39,975**
Revaluations	-	(4,600)	-	-	-	-	-	**(4,600)**
Reclassifications	-	525	-	(525)	801	288	-	**1,089**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(5,069)	(28)	-	**(5,097)**
Valuation/gross cost at 31 March 2018	**17,361**	**228,605**	**1,826**	**-**	**32,411**	**11,454**	**427**	**292,084**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**-**	**-**	**-**	**21,355**	**6,000**	**226**	**27,581**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**4,600**	**-**	**-**	**2,500**	**1,274**	**37**	**8,411**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	(4,600)	-	-	-	-	-	**(4,600)**
Reclassifications	-	-	-	-	322	-	-	**322**
Disposals / derecognition	-	-	-	-	(4,964)	(28)	-	**(4,992)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**19,213**	**7,246**	**263**	**26,722**
Net book value at 31 March 2018	**17,361**	**228,605**	**1,826**	**-**	**13,198**	**4,208**	**164**	**265,362**
Net book value at 1 April 2017	**17,291**	**191,072**	**1,658**	**525**	**11,956**	**3,596**	**199**	**226,297**

Note 13.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - restated	**17,191**	**239,749**	**1,496**	**-**	**30,885**	**7,395**	**294**	**297,010**
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	1,875	162	525	3,536	2,235	131	**8,464**
Impairments	-	(45,077)	-	-	-	-	-	**(45,077)**
Reversals of impairments	100	102	-	-	-	-	-	**202**
Revaluations	-	-	-	-	-	-	-	-
Reclassifications	-	(5,577)	-	-	-	-	-	**(5,577)**
Disposals / derecognition	-	-	-	-	(1,110)	(34)	-	**(1,144)**
Valuation/gross cost at 31 March 2017	**17,291**	**191,072**	**1,658**	**525**	**33,311**	**9,596**	**425**	**253,878**
Accumulated depreciation at 1 April 2016 - restated	**-**	**-**	**-**	**-**	**19,775**	**5,168**	**211**	**25,154**
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	**-**	**5,577**	**-**	**-**	**2,475**	**866**	**15**	**8,933**
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-
Reclassifications	-	(5,577)	-	-	-	-	-	**(5,577)**
Disposals/ derecognition	-	-	-	-	(895)	(34)	-	**(929)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**21,355**	**6,000**	**226**	**27,581**
Net book value at 31 March 2017	**17,291**	**191,072**	**1,658**	**525**	**11,956**	**3,596**	**199**	**226,297**
Net book value at 1 April 2016	**17,191**	**239,749**	**1,496**	**-**	**11,110**	**2,227**	**83**	**271,856**

Note 13.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	17,361	6,213	-	-	11,993	4,203	154	**39,924**
Finance leased	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	221,427	-	-	-	-	-	**221,427**
PFI residual interests	-	-	1,826	-	-	-	-	**1,826**
Owned - donated	-	965	-	-	1,205	5	10	**2,185**
NBV total at 31 March 2018	**17,361**	**228,605**	**1,826**	**-**	**13,198**	**4,208**	**164**	**265,362**

Note 13.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	17,291	3,455	-	525	10,724	3,588	186	**35,769**
Finance leased	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	186,624	-	-	-	-	-	**186,624**
PFI residual interests	-	-	1,658	-	-	-	-	**1,658**
Owned - donated	-	993	-	-	1,232	8	13	**2,246**
NBV total at 31 March 2017	**17,291**	**191,072**	**1,658**	**525**	**11,956**	**3,596**	**199**	**226,297**

Note 14 Donations of property, plant and equipment

The trust received donations during the year of £546k . (2016/17 £460k). No restrictions were placed on these donations of which £140k funded the purchase of capital assets.

Note 15 Revaluations of property, plant and equipment

An independent revaluation was undertaken of the Trust's buildings by the District Valuer with an effective date of 31st March 2018.

Consistent with previous years, a Modern Equivalent Asset (MEA) approach was undertaken referenced to National Indices acceptable to the RICS. Consideration was given to improvements carried out during the year and where appropriate asset lives were adjusted accordingly.

Note 16 Inventories

	31 March 2018	31 March 2017
	£000	£000
Drugs	1,245	1,178
Work In progress	-	-
Consumables	1,849	2,126
Energy	25	73
Other	-	-
Total inventories	**3,119**	**3,377**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £26,678k (2016/17: £25,554k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 17.1 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	6,339	6,899
Accrued income	16,363	12,311
Provision for impaired receivables	(264)	(439)
Prepayments (non-PFI)	1,142	1,154
Interest receivable	6	-
VAT receivable	1,496	1,179
Other receivables	1,093	692
Total current trade and other receivables	**26,175**	**21,796**
Non-current		
Trade receivables	-	-
Accrued income	-	-
Provision for impaired receivables	(784)	(590)
Prepayments (non-PFI)	-	-
PFI lifecycle prepayments	59	63
Interest receivable	-	-
VAT receivable	-	-
Other receivables	1,083	1,120
Total non-current trade and other receivables	**358**	**593**
Of which receivables from NHS and DHSC group bodies:		
Current	21,086	17,738
Non-current	-	-

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**1,029**	**659**
Prior period adjustments	-	-
At 1 April - restated	**1,029**	**659**
Transfers by absorption	-	-
Increase in provision	50	370
Amounts utilised	(31)	-
Unused amounts reversed	-	-
At 31 March	**1,048**	**1,029**

Receivables are classed as impaired based on national guidance relating to compensation recovery unit claims, age and following advice from our external debt collection agencies.

Note 17.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	21	-	28	-
30-60 Days	22	-	42	-
60-90 days	22	-	12	-
90- 180 days	85	-	80	-
Over 180 days	898	-	867	-
Total	**1,048**	**-**	**1,029**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	19,973	-	2,539	-
30-60 Days	620	-	583	-
60-90 days	128	-	195	-
90- 180 days	1,773	-	548	-
Over 180 days	1,790	-	1,502	-
Total	**24,284**	**-**	**5,367**	**-**

The majority of carrying debt relates to NHS organisations, therefore no significant credit risk is assumed in non impaired receivables.

The significant movement between years relates to the Bonus and incentive Sustainability and Transformation funding of £10.30m.

Note 18.1 Cash and cash equivalents movements

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

	2017/18	2016/17
	£000	£000
At 1 April	**3,899**	**1,456**
Prior period adjustments	-	-
At 1 April (restated)	**3,899**	**1,456**
Net change in year	5,006	2,443
At 31 March	**8,905**	**3,899**
Broken down into:		
Cash at commercial banks and in hand	6	5
Cash with the Government Banking Service	8,899	3,894
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**8,905**	**3,899**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**8,905**	**3,899**

Note 18.2 Third party assets held by the trust

Sherwood Forest Hospitals NHS Foundation Trust held cash and cash equivalents of £1k which relate to monies held by the the foundation trust on behalf of patients or other parties (2016/17 £1k). 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	-	-
Monies on deposit	-	-
Total third party assets	**-**	**-**

Note 19.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	4,276	18,815
Capital payables	6,016	2,813
Accruals	8,842	3,956
Receipts in advance (including payments on account)	26	63
Social security costs	2,082	1,900
Other taxes payable	1,721	1,527
Accrued interest on loans	555	364
Other payables	4,247	2,897
Total current trade and other payables	**27,765**	**32,335**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
Other taxes payable	-	-
Other payables	715	975
Total non-current trade and other payables	**715**	**975**
Of which payables from NHS and DHSC group bodies:		
Current	4,562	6,546
Non-current	715	975

Note 20 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	2,419	561
Total other current liabilities	**2,419**	**561**
Non-current		
Deferred income	-	-
Total other non-current liabilities	**-**	**-**

Note 21 Borrowings

		Restated	
	31 March 2018 £000	31 March 2017 £000	1 April 2016 £000
Current			
Loans from the Department of Health and Social Care	1,706	906	373
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	9,583	11,282	11,106
Total current borrowings	**11,289**	**12,188**	**11,479**
Non-current			
Loans from the Department of Health and Social Care	175,924	131,028	65,328
Other loans	-	-	
Obligations under finance leases	-	-	
PFI lifecycle replacement received in advance	-	-	
Obligations under PFI, LIFT or other service concession contracts	259,589	269,173	280,455
Total non-current borrowings	**435,513**	**400,201**	**345,783**

Note 22.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Annual Leave	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2017	**398**	**94**	**714**	**-**	**718**	**1,924**
Arising during the year	14	94	263	-	2	**373**
Utilised during the year	(47)	(80)	-	-	(164)	**(291)**
Reversed unused	-	(33)	-	-	(41)	**(74)**
At 31 March 2018	**365**	**75**	**977**	**-**	**515**	**1,932**
Expected timing of cash flows:						
- not later than one year;	47	75	977	-	5	**1,104**
- later than one year and not later than five years;	188	-	-	-	462	**650**
- later than five years.	130	-	-	-	48	**178**
Total	**365**	**75**	**977**	**-**	**515**	**1,932**

Pensions relate to liabilities for employees who retired pre 1994 for whom the Trust retains responsibility for the payments being made.

Equal Pay relates to untaken annual leave as at 31 March, which is due to employees and is being carried forward into the next financial year.

Other relates to outstanding liabilities with HMRC for Option to Tax VAT.

All cash flows reflect the expected or known date of payment.

Note 22.2 Clinical negligence liabilities

At 31 March 2018, £115,177k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2017: £122,520k).

Note 23 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(42)	(79)
Gross value of contingent liabilities	**(42)**	**(79)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(42)**	**(79)**
Net value of contingent assets	-	-

The contingent liability relates to the element of insurance excess (on Public and Employee claims) not provided for based on the current estimate of future payment.

Note 24 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	645	2,693
Intangible assets	-	114
Total	**645**	**2,807**

Note 25 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 26 On-SoFP PFI, LIFT or other service concession arrangements

The Trust is currently committed to two on-statement of financial position PFI schemes as the transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Government Accounting Manual. The Trust is required to account for the PFI scheme 'on-statement of financial position' and therefore the Trust treats the assets as if it were assets of the Trust.

Further details can be found in note 1.7.5.

The Trust has entered into private finance initiative contracts with:

a) Central Nottinghamshire Hospitals plc to construct and refurbish the Trust's buildings on the King's Mill and Newark hospital sites and then to operate them (estates, facilities management and life cycle replacement) for the Trust for the period to 2043. The contract requires that throughout the contract they are maintained to category B building standards. This PFI is known as the Modernisation of Acute Services (MAS). The MAS PFI scheme was completed and all assets were brought into use by 31 March 2012, with an estimated capital value of £366.5m.

b) Leicester Housing Association (LHA), to construct a day nursery and out of hours facility, on the King's Mill hospital site. All assets were brought into use by 2002, with a current estimated capital value of £1.3m. Throughout the term of the agreement there is a requirement to keep the premises clean tidy and in good order and to keep in good and substantial repair and condition in accordance with the Operating Agreement.

In respect of both PFI schemes the Trust has the rights to use the specified assets for the length of the Project Agreements. At the end of the Project Agreements the assets of both schemes will transfer to the Trust's ownership for no additional consideration.

The annual charge relating to the MAS scheme is subject to an annual inflation uplift based on RPI. The LHA schemes are a fixed charge over the life of the contract. All liquidity and associated market and financing risks for both schemes rests with Central Nottinghamshire plc and Leicester Housing Association respectively.

Note 26.1 Imputed finance lease obligations

Sherwood Forest Hospitals NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

		Restated	
	31 March 2018	31 March 2017	1 April 2016
	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**742,323**	**765,866**	**788,681**
Of which liabilities are due			
- not later than one year;	23,810	23,543	22,815
- later than one year and not later than five years;	100,945	98,559	96,599
- later than five years.	617,568	643,764	669,267
Finance charges allocated to future periods	(473,151)	(485,411)	(497,120)
Net PFI, LIFT or other service concession arrangement obligation	**269,172**	**280,455**	**291,561**
- not later than one year;	9,583	11,282	11,106
- later than one year and not later than five years;	39,613	44,778	40,359
- later than five years.	219,976	224,395	240,096

Note 26.2 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	31 March 2017	1 April 2016
	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	1,646,000	1,691,607	1,736,416
Of which liabilities are due:			
- not later than one year;	47,263	45,608	44,799
- later than one year and not later than five years;	203,574	197,716	191,734
- later than five years.	1,395,163	1,448,283	1,499,883

Note 26.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18	2016/17
	£000	£000
Unitary payment payable to service concession operator	44,403	43,987
Consisting of:		
- Interest charge	4,835	4,974
- Repayment of finance lease liability	11,283	11,106
- Service element and other charges to operating expenditure	20,186	20,567
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	713	686
- Contingent rent	7,386	6,654
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	20	34
Total amount paid to service concession operator	**44,423**	**44,021**

Note 27 Off-SoFP PFI, LIFT and other service concession arrangements

Sherwood Forest Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2018	31 March 2017
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	131	115
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	309	296
- later than one year and not later than five years;	1,329	1,292
- later than five years.	4,930	5,277
Total	**6,568**	**6,865**

Note 27.1 Off-SoFP PFI, LIFT and other service concession arrangements

Sherwood Forest Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

Leicester Housing Association

The Trust is currently committed to one 'off statement of financial position' PFI scheme relating to residential accommodation for the King's Mill site. The transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Government Accounting Manual, but the Trust does not have control. Accordingly the Trust does not recognise the scheme as an asset of the Trust.

The arrangement is with Leicester Housing Association, and includes the construction of new residential accommodation and the upgrade of existing accommodation combined with a 35 year contract to manage and operate the accommodation. The Trust has guaranteed to utilise a minimum level of the overall accommodation but the majority of risks associated with operating and letting the properties have been transferred to Leicester Housing Association. The estimated capital value of the scheme is £5.7m

The annual charge is fixed over the life of the contract and the only liability to the Trust is a minimum room usage guarantee. All liquidity and associated market and financing risks rests with Leicester Housing Association.

The Trust has recognised the following items within its accounts for the year ended 31 March 2018:

	31 March 2018 £000	31 March 2017 £000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	131	115
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	309	296
- later than one year and not later than five years;	1,329	1,292
- later than five years.	4,930	5,277
Total	**6,568**	**6,865**

An adjustment has been made to the 31 March 2017 comparator to reflect a change to the underlying accounting of the rental income guarantee.

Note 28 Financial instruments and Related Disclosures

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

The key risks that the Trust has identified are as follows:

Note 28.1 Financial Risk

Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's) and the way those CCG's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Note 28.2 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.

Note 28.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

Note 28.4 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in note 17 to the annual report and accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the end of the year.

Note 28.5 Liquidity Risk

The Trust’s net operating costs are incurred under annual service agreements with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash to meet all its commitments when they fall due. This is regulated by the Trust’s compliance with the ‘Use of Resources Risk Rating’ system created by NHSI, the Independent Regulator.
The Trust has identified a cash shortfall in its 2018/19 operational plan, and requires borrowing support from the Department of Health and Social Care. Monthly applications for cash support are made in line with the financial plan.
The Board continues to monitor its monthly and future cash position and has governance arrangements in place to manage cash requirements throughout the year. The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.6 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

Note 28.7 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	22,113	-	-	-	**22,113**
Cash and cash equivalents at bank and in hand	8,905	-	-	-	**8,905**
Total at 31 March 2018	**31,018**	**-**	**-**	**-**	**31,018**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	18,268	-	-	-	**18,268**
Cash and cash equivalents at bank and in hand	3,899	-	-	-	**3,899**
Total at 31 March 2017	**22,167**	**-**	**-**	**-**	**22,167**

Note 28.8 Restated Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	131,934	-	**131,934**
Obligations under PFI, LIFT and other service concession contracts	280,455	-	**280,455**
Trade and other payables excluding non financial liabilities	33,310	-	**33,310**
Provisions under contract	1,450	-	**1,450**
Total at 31 March 2017	**447,149**	**-**	**447,149**

Note 28.9a Restated 1 April 2016 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	65,701	-	**65,701**
Obligations under PFI, LIFT and other service concession contracts	291,561	-	**291,561**
Trade and other payables excluding non financial liabilities	27,553	-	**27,553**
Provisions under contract	1,092	-	**1,092**
Total at 31 March 2017	**385,907**	**-**	**385,907**

Note 28.10 Fair values of financial assets and liabilities

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

Note 28.11 Maturity of financial liabilities

		Restated	
	31 March 2018	31 March 2017	31 March 2017
	£000	£000	£000
In one year or less	54,540	58,698	32,416
In more than one year but not more than two years	99,809	27,678	23,314
In more than two years but not more than five years	170,946	150,947	224,283
In more than five years	151,481	209,826	211,944
Total	**476,776**	**447,149**	**491,957**

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	5	1	27	6
Bad debts and claims abandoned	316	25	359	13
Stores losses and damage to property	5	17	2	43
Total losses	**326**	**43**	**388**	**62**
Special payments				
Compensation under court order or legally binding arbitration award	3	22	1	1
Ex-gratia payments	41	14	26	6
Total special payments	**44**	**36**	**27**	**7**
Total losses and special payments	**370**	**79**	**415**	**69**
Compensation payments received		-		-

Note 30 Related parties

The Trust undertakes a large number of related party transactions with other Government bodies. The significant transactions are as follows:

A full schedule by NHS organisation is available on request.

	Income	Expenditure	Debtor	Creditor
Customer Name	£'000	£'000	£'000	£'000
Mansfield & Ashfield CCG	126,978	1,012	2,718	1,743
Newark & Sherwood CCG	65,802	37	259	431
NHS England	32,915	6	14,816	115
Hardwick CCG	15,447	-25	731	14
Health Education England	10,977	13	112	0
Southern Derbyshire CCG	7,131	0	65	0
Nottingham North & East CCG	6,213	43	41	51
NHS Property Services	6,254	3,169	0	63
Rushcliffe CCG	6,079	134	76	55
Nottingham University Hospitals	3,734	3,179	480	1,731
Nottingham County Council	3,037	162	281	196
Nottingham Health Care NHS Foundation Trust	1,614	1,422	298	237
Lincolnshire West CCG	2,988	4	85	4
Nottingham City CCG	3,299	114	11	1
University Hospitals of Leicester	1,350	43	331	10
South West Lincolnshire CCG	1,198	-2	213	0
Bassetlaw CCG	831	1	6	2
North Derbyshire CCG	710	0	28	0
Derby Teaching Hospitals NHS Foundation Trust	398	217	152	51
Chesterfield Royal Hospital FT	324	54	125	45
Derbyshire County Council	191	0	33	0
Ashfield District Council	0	18	0	0
Nottingham West CCG	2,052	12	40	15
NHS litigation Services	16	10,767	60	0
CQC	1	246	0	0
NHS Blood & Transport	0	770	0	21
HMRC Revenue and Customs -Other taxes and duties and NI contributions	0	14,406	0	3,802
NHS Pensions Scheme	0	17,125	0	2,361

The Department of Health is the parent department for all Foundation Trusts.

The Trust as Corporate Trustee also has a relationship with Sherwood Forest Hospitals General Charitable Fund, where income of £546k (2016/17 £460k) has been recognised in these accounts. In addition a recharge of £53k (2016/17 £45k) has been made in relation to management / staff costs.

The Trust has relationships with a large number of Governments bodies, including Councils and other NHS Purchasers and Providers. A full schedule by NHS organisation is available on request.

The Trust made no payments to related parties for whom the Chair, Non Executive or Executive Directors are named Directors.

Note 31 Prior period adjustments

Minor presentational changes due to alignment with the Government Accounting Manual, and the movement of impairments which are now shown in expenditure in current and comparative figures have been made.

In addition the comparative information disclosed has been amended under IAS 8 due to a change in accounting for the annual PFI charge and associated lease liability. This has resulted in a £42.0m gain in b/fwd Income and expenditure reserves as at 1 April 2016 and an additional £5.1m operating gain recognised in 2016/17. These adjustments were offset by a reduction in the carrying value of the lease liability as at 31 March 2017 of £47.1m.

The specific items that have been affected in the Statement of Financial position are detailed below:

	Original	Restated	Movement
Borrowings Current liabilities 31 March 2017	(7,191)	(12,188)	4,997
Borrowings Non current liabilities 31 March 2017	(452,345)	(400,201)	(52,144)
Income and Expenditure reserve 31 March 2017	(392,945)	(345,798)	(47,147)
Income and Expenditure reserve 1 April 2016	(302,004)	(259,988)	(42,016)
Operating Expenditure 2016/17	367,274	367,726	(452)
Interest Expenditure 2016/17	19,208	13,625	5,583
Surplus/(deficit) for the year 2016/17	(91,152)	(86,021)	(5,131)

Note 32 Events after the reporting date

There are no non-adjusting events after the reporting period which affect the financial information and disclosures made in these accounts.

Independent Auditors' Report to the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Sherwood Forest Hospitals 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.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.1.2 to the financial statements concerning the Trust's ability to continue as a going concern.

Sherwood Forest Hospitals NHS Foundation Trust has been reliant on external cash support from the Department of Health to meet its liabilities as they fall due and forecasts that significant financial support will be required for the foreseeable future.

These conditions, along with the other matters explained in note 1.1.2 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Explanation of material uncertainty

See note 1 to the financial statements for the directors' disclosures of the related accounting policies and note 1.1.2 for the directors' judgements relating to the going concern assumption for further information.

Sherwood Forest Hospitals NHS Foundation Trust recorded a deficit from continuing operations excluding the impact of impairment in 2017/18 of £23.2 million. The Trust is forecasting a deficit of £46.4 million in 2018/19 before the receipt of £12.4 million of Provider Sustainability Fund income, which is dependent on meeting financial and performance targets.

Sherwood Forest Hospitals NHS Foundation Trust has been reliant on external cash support from the Department of Health on a rolling monthly basis throughout 2017/18 and based on its financial plan for 2018/19, significant external financial support will be required for the foreseeable future. The 2018/19 plan assumes £34 million in revenue loan support will be required.

What audit procedures we performed

We focused on whether it was appropriate for Sherwood Forest Hospitals NHS Foundation Trust financial statements to be prepared on a going concern basis and whether the disclosures in the Annual Report and the financial statements were sufficient for a user of the financial statements to clearly understand the reasons behind the Trust's deficit and the associated material uncertainty.

The Group Accounting Manual confirms that group bodies must 'prepare their accounts on a going concern basis unless informed by the relevant national body or the Department of Health and Social Care sponsor of the intention for dissolution without transfer of services or function to another entity'.

At the date of our audit report, we concur with the directors' view that the going concern basis of accounting is an appropriate basis for the preparation of these accounts; however we performed the following procedures to test the projections made by management:

- we compared the Trust's 2017/18 Cost Improvement Programme (CIP) performance outturn against the targeted savings and considered the degree to which the 2018/19 CIP programme has been developed;
- we identified that the Trust has signed income contracts with its main commissioners for the period up to 31 March 2019; and
- we obtained the financial plan submitted to NHS Improvement for 2018/19 and compared the 2017/18 outturn position to the planned financial performance in 2018/19.

We also read the disclosures included within note 1.1.2 and confirmed that these provided the user with sufficient information to understand the reasons behind the material uncertainty, in particular the need for future reliance on external support, which has not been formally agreed with the Department of Health.

As a result of this work, we concluded that the forecasts used by Sherwood Forest Hospitals NHS Foundation Trust in its determination of the appropriateness of the going concern basis of accounting were consistent with the evidence available. We also concluded that there is a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern for the reasons above.

Our audit approach

Context

2017/18 is our first year as external auditors for Sherwood Forest Hospitals NHS Foundation Trust.

Sherwood Forest Hospitals NHS Foundation Trust provides acute healthcare services across Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire. It is funded predominantly by local Clinical Commissioning Groups ("CCGs") and NHS England.

NHS Improvement has placed Sherwood Forest Hospitals NHS Foundation Trust in segment 3 of its Single Oversight Framework as at 31 March 2018. NHS Improvement's Single Oversight Framework is the framework for overseeing providers and identifying potential support needs. Segment 3 is described by NHS Improvement as 'Providers receiving mandated support for significant concerns'.

Overview

1. Overall materiality: £6,093,620 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 statements.
3. Our key audit matters were:
   - Risk of fraud in revenue and expenditure recognition;
   - Valuation of property, plant and equipment;
   - Accounting treatment for the Trust's PFI scheme; and
   - Going concern.

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. In addition to going concern, described in the Material Uncertainty relating to going concern section above, we determined the matters described below to be the key audit matters to be communicated in our report. 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 *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 2 - 4 for further information.* We focussed on this area because there is a heightened risk due to: • The risks surrounding the financial sustainability of Sherwood Forest Hospitals NHS Foundation Trust, as described in the section 'Material uncertainty relating to going concern'; and • Due to the wider financial challenge in the NHS, the pressure Sherwood Forest Hospitals NHS Foundation Trust is under to achieve its forecast 2017/18 deficit set out in its plan submitted to NHS Improvement and gain access to the available Sustainability and Transformation funding; and therefore the incentive to recognise income 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 considered revenue recognition to be a risk, in particular revenue streams from the Clinical Commissioning Groups ("CCGs") and NHS England, which together comprise £244.4 million of the Trust's £304.7 million of income. The service level agreements with the CCGs consist of standard monthly instalments. A monthly adjustment is then negotiated with the CCGs to reflect actual levels of activity. The value of the adjustment is subject to management judgement. The Trust can also earn Commissioning for Quality and Innovation (CQUIN) revenue as a percentage of the contract value for demonstrating improvements in quality and innovation in specified areas of patient care. The Trust negotiated a final year end agreement with its two lead commissioners for the CCG contract of £190.2 million. In 2017/18 the Trust had an increased incentive to achieve its financial Control Total, in order to receive Sustainability and Transformation Fund money. We considered the risk to be focussed on the existence of	***Journals*** We tested a sample of journal transactions that had been recognised in both income and expenditure, focussing in particular on those that arose from unexpected account combinations. We agreed the journal entries to supporting documentation, for example invoices and cash transactions. Our testing found that they were supported by appropriate documentation and that the income 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 income 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 invoice and cash receipts/payments where appropriate. For a sample of CCG income, we obtained the signed contract and agreed its value to the income recognised during the year. For a sample of income from over and under performance against the contract we agreed the income to supporting evidence. This included inspecting information from the year-end intra-NHS balance agreement process to identify any significant differences between the income and debtors reported with NHS organisations. No material issues were identified from the work performed. ***Expenditure*** We performed testing to identify whether there were any unrecorded liabilities. We: • tested a sample of payments made and invoices received after 31 March 2018 to supporting documentation, to check that, where they related to the 2017/18 financial year, an accrual was recognised appropriately; and • compared accrued expenses recognised as at 31

income from material CCG contracts. We also considered expenditure recognition to be a risk. Given the incentive described above we focussed on the completeness of expenditure in the Statement of Comprehensive Income and of liabilities recorded in the Statement of Financial Position. We focused our work on the elements of income and expenditure that are most susceptible to manipulation: • non-standard journal transactions; • expenditure accruals; and • unrecorded liabilities.	March 2018 with that recognised in the prior year to identify differences in the accruals recognised year on year. 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 *See notes 13 and 15, and the full set of accounting policies to the financial statements (note 1.7) for details of the accounting policies applied in the valuation of land and buildings.* Property, plant and equipment represents the second largest balance in the Statement of Financial Position. 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. Property, Plant and Equipment as at 31 March 2018 has a Net Book Value of £265.4 million of which £246 million is land and buildings. All Property, Plant and Equipment 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 valuation of Sherwood Forest Hospitals NHS Foundation Trust's portfolio of land and buildings was undertaken as at 31 March 2018 by Sherwood Forest Hospitals NHS Foundation Trust's valuation expert.	We obtained the valuation reports directly from Sherwood Forest Hospitals 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. We concluded that the methodology and approach applied by the Trust's independent expert are reasonable. We looked at the assumptions and inputs used in the valuation of specialised buildings. This included testing the floor area for a sample of assets upon which the valuer conducted their valuation. We investigated some differences between the information used by the Trust's valuer and the records held by the Estates department, and concluded the valuation was based on appropriate information. We also undertook a sample test to confirm whether buildings had been correctly identified as specialist or non-specialist. We found no material issues from these procedures. We tested whether the change in valuation was correctly accounted for and appropriately disclosed in the financial statements and found that it was.
Accounting treatment for the Trust's on-Statement of Financial Position PFI schemes *See notes 26, 26.1 and 26.2, and the full set of accounting policies to the financial statements (note 1.7.5) for details of the accounting policies applied in relation to the Trust's on-Statement of Financial Position PFI schemes.* As a result of the adoption of International Financial Reporting Standards (IFRS) in 2009/10, the Trust's largest PFI scheme, relating to King's Mill and Newark hospitals, is recognised on the Statement of Financial Position. This resulted in the creation of a significant asset and an associated finance lease liability when the PFI scheme was initially recognised. The Trust disclosed the fair value of this being £366.5 million in the draft financial statements. A Unitary Payment (UP) is paid by the Trust to the PFI operator each year, which in the Trust's PFI accounting model for 2017/18 is £45.5 million. It is required to be split between 5 different elements – service expenditure, contingent rental, finance costs, lifecycle events and	We compared the Trust's existing approach with the requirements set out in the 2009 Department of Health guidance entitled 'Accounting for PFI under IFRS'. We identified that the Trust was only splitting the Unitary Payment between 3 elements – service expenditure, finance costs and repayment of the finance lease liability. The Trust has changed its approach to split the Unitary Payment between the 5 elements required by the guidance, and this was reflected in the draft financial statements. The Trust updated its accounting policies in note 1.7 to the financial statements to reflect the changes made. The Trust also included a Prior Period Adjustment in the draft financial statements in note 31, which explains the basis for adjusting the 2016/17 numbers. On receipt of the draft financial statements we looked at the underlying PFI accounting model and agreed the updated accounting entries to supporting evidence, for example by agreeing figures to the operator's financial close model.

repayment of the finance lease liability. It is uplifted on an annual basis through indexation.

The accounting requirements are set out in the Group Accounting Manual. It refers to more detailed guidance the Trust is required to follow. These documents are the Treasury guidance 'Accounting for PPP arrangements including PFI contracts under IFRS' in chapter 7 of the FReM, and the 2009 Department of Health guidance entitled 'Accounting for PFI under IFRS'.

As part of our first year audit procedures, we read the Trust's audited 2016/17 financial statements. This identified that the Unitary Payment was not split into the 5 different elements required by the guidance. Given the size of the amounts involved we compared the Trust's underlying accounting model to the requirements set out in the Department of Health guidance to identify variations.

We agreed that the Trust's updated split of the Unitary Payment was undertaken appropriately. However, we identified that the initial fair value of the scheme had been overstated. The Trust updated their PFI accounting model to reduce the fair value from £366.5 million to £332.8 million. This change has had the impact of reducing the finance lease liability as at 31 March 2018 to £268.4 million, compared with a value of £290.6 million in the draft financial statements. The impact on the Statement of Comprehensive Income was not material so the Trust did not update the financial statements in this regard. The impact would have been a £1.6 million increase in the finance cost for both 2017/18 and 2016/17.

There were no material issues for this matter in the final financial statements.

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.

In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

The audit was conducted at Sherwood Forest Hospitals NHS Foundation Trust's largest site in Mansfield (Kings Mill Hospital) where the main finance team is based.

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	£6.093 million
How we determined it	2% of revenue
Rationale for benchmark applied	We have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate. *2017 materiality was applied by the Trust's previous external auditors.*

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £250,000 (2016/17: £215,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

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.

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, 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 Sherwood Forest Hospitals 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.

The Trust's outturn position for 2017/18 is a deficit from continuing operations excluding the impact of impairment in 2017/18 of £23.2 million. The Trust is forecasting a deficit of £46.4 million in 2018/19 before the receipt of £12.4 million of Provider Sustainability Fund income, which is dependent on meeting financial and performance targets. The Trust has been reliant on external cash support from the Department of Health on a rolling monthly basis throughout 2017/18 and based on its financial plan for 2018/19, significant external financial support will be required for the foreseeable future. The 2018/19 plan assumes £34 million in revenue loan support will be required. These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable deployment of resources to deliver the Trust's strategic priorities.

The Trust is subject to a Section 111 license condition, which requires it to ensure that sufficient and effective management and clinical leadership capacity and capability is in place. This condition remains in place at the date of the audit report. This provides evidence of weaknesses in leadership which may impact on the Trust's ability to achieve its strategic objectives.

We have concluded that, except for the matters above, the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2018.

Other matters on which we report by exception

We are required to report to you if:

- The statement given by the directors 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 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: 29th May 2018